European Monitoring Centre for Drugs and Drug Addiction

ÖBIG REITOX FOCAL POINT AUSTRIA

2014 NATIONAL REPORT (2013 data) TO THE EMCDDA by the National Reitox Focal Point

AUSTRIA

New Development and Trends

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New Development and Trends

Authors:

Marion Weigl
Martin Busch
Alexander Grabenhofer-Eggerth
Ilonka Horvath
Charlotte Klein
Elisabeth Türscherl

In cooperation with:

Hans Kerschbaum
Klaus Kellner

Expert assistance by the Federal Ministry of Health:

Johanna Schopper

Project assistant

Monika Löbau

Translator:

Susanne Ofner

Translation editor:

Catherine Danner-Jones

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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 Austrian 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 2013/14. For a list of publications by Austrian academics or articles in academic journals written by Austrian (co-)authors, please consult the Annex. The publications that have been used for this report have also been included in the bibliographical part.

Summary and discussion of major trends

Legislation, strategies and economic analysis

The legal framework has not changed in the reporting year. In Austria's new Government Programme for the period 2013–18 the issue of addiction is mentioned in the context of the national strategy paper on prevention and addiction that is being developed. Based on a preparatory Delphi survey, a strategy paper is currently being drafted for subsequent discussion at the political level. Vienna reports that the new 2013 addiction and drug strategy is oriented towards a more comprehensive approach to addiction (SDW 2014). Vienna's integrative approach to addiction and drug policy based on the 1999 drug policy programme, will thus be continued. The policy focus again is on the social integration of addicted persons and on low-threshold support services.

Drug use in the general population and specific targeted groups

A new survey on drug use among the 15 to 64 age group has been made available. Cannabis continues to be the only illicit drug for which relevant prevalence rates are found among the general population. In contrast to a number of media reports, the use of *new psychoactive substances* plays an insignificant role and has further declined in party settings.

Prevention

In the area of prevention, the focus is on the implementation of well-established measures, such as the programmes *Eigenständig werden* [Become independent] and *plus*, both of which aim at promoting life skills, though in different age groups. In the reporting period, the evaluation of the *plus* programme was completed, and shows that positive effects can best be achieved if the programme is run regularly and fully (i.e. including the integration of parents), with the sequence of lessons as intended. Under these conditions, it becomes apparent that compared to the control groups, the rise in experience of use (cigarettes, alcohol) is significantly lower,

behavioural problems tend to occur less often, and the students' school achievements, as well as social behaviour, are improved.

High-risk drug use

Opioid use, typically in the context of polydrug use, currently accounts for the largest share of high-risk drug use in Austria. Approximately 85% of all clients of drug support and treatment centres indicate opioids as their primary drugs. At present, the number of high-risk drug users (with varying shares of opioids involved) is between 28 000 and 29 000 in Austria. 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 high-risk drug users is female, and 15% is under 25 years old. Snorting continues to be a frequent form of opioid use. Between 11 000 and 15 000 people tend towards injecting drug use. All available drug monitoring data indicate a pronounced decline in high-risk opioid use among the 15 to 24 age group (fewer persons taking up risky patterns of use). It cannot yet be assessed whether this indicates a sustainable development and thus a decrease in illicit addiction problems as such, or a shift towards other substances (cannabis, methamphetamine). In Upper Austria, there are indications of a growing local methamphetamine scene.

Drug-related treatment

At the federal and provincial levels, the focus of activities in the reporting period has been on optimising addiction treatment, particularly opioid substitution treatment and complementary psychosocial support, for persons with opioid addictions. Endeavours have been made to establish integrated systems (at least across different substances, but also with regard to better links between health care and psychosocial services, and the integration of addiction services into the general health-care system). A number of provinces report improvements in the supply situation regarding substitution treatment for persons with opioid addictions. According to recent analyses, there are obvious regional differences: for instance, in Carinthia opioid substitution treatment is mostly delivered in specialised centres, whereas in other provinces, it is primarily established doctors who provide OST. The role that general practitioners play in this context also depends on the province in question, but in sum, 71% of all opioid substitution treatments are delivered by GPs, and 29% by medical specialists.

Data from treatment centres confirm that opioids continue to predominate as primary drugs, while cocaine is rather insignificant. Cannabis again ranks second as a primary drug, after opioids, and has played an increasingly important role in a numerical sense. In Upper Austria, the growing methamphetamine scene is reflected in the treatment figures as well. In 2013, 16 989 persons were undergoing opioid substitution treatment, which is approximately 60% of all persons with opioid problems. The in-treatment rate has risen further, which is a very positive development.

(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. The figures relating to HIV still lie at low levels. In 2013, a total of 122 fatal drug overdoses were recorded in the context of autopsies. Another 16 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 138 drug-related deaths due to drug overdoses is assumed for 2013 (2012: 161 cases). Another positive development, apart from the general decline in drug-related deaths, is that the proportion of persons aged under 25 has decreased further. It was as high as 43% in 2004 and has gone down to 19% in 2013. This seems to be due primarily to the aforementioned smaller number of persons starting to use opioids.

In addition to the treatment of addiction, selling and exchanging syringes plays a major role in preventing infections: more than 4.5 million syringes were sold or exchanged in the context of drug support services, mostly at low-threshold centres. Treating hepatitis infections in drug users has become increasingly important. Experts have also discussed the option of dispensing naloxone in low-threshold settings as an emergency prophylaxis in the case of overdose.

Social correlates and social reintegration

Drug users have again been strongly affected by social problems such as homelessness, unemployment and debt. For instance, in the 2013 population of DOKLI clients, only 4% of the clients undergoing inpatient treatment had jobs, which again is the smallest percentage among all groups of clients. In addition, only approximately 60% 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, recreational activities are organised. The existing housing programmes have been continued.

Drug-related crime

In 2013, the number of reports to the police related to narcotic drugs has risen massively with regard to total figures, as well as to misdemeanours and felonies. This development results particularly from the increase in reports connected to cannabis and amphetamine. On the other hand, declines have been recorded in the number of reports relating to heroin and opioids, medicines containing narcotic drugs, psychotropic medicines and mephedrone. The number of temporary waivers of reports saw an increase in 2013, both regarding total figures and regarding cannabis, mushrooms containing psilocin, psilotin or psilocybin, as well as psychotropic substances. The total number of convictions under the SMG has slightly gone down as against the previous year, with only convictions under SMG Section 27 showing a slight rise. In 2013, the principle of treatment instead of punishment was again applied more often. Experts continue to point 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 predominates more clearly than ever, while decreases are apparent for heroin and medicines containing narcotic drugs or psychotropic substances. Increases have been recorded for amphetamine and methamphetamine, and massive increases regarding cannabis. According to a recent Eurobarometer survey, a higher proportion of Austrian young people than the European average think it is hard to obtain illicit substances (including new psychoactive substances/NPS). On the other hand, more Austrians than the European average indicate that it is easy to access the legal substances alcohol and tobacco. At least in the party and clubbing scenes, NPS have played a less important role than they still did two years ago. Ecstasy pills containing very high doses of MDMA have again been found: their average MDMA content has risen further and is now twice as high as a few years ago, and often at levels that pose considerable health risks. Around 20% of the drugs tested by *checkit!* in the party scene contained ingredients that constituted significant health hazards (e.g. methoxetamine in ecstasy pills, levamisole in cocaine and 4-MA in speed), so that users had to be warned.

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Introduction

This is the 19th 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 2014). 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 2013c) and refers to the reporting periods from summer 2013 to summer 2014, while routine statistics refer to the year 2013. A list of recent academic publications in Austria or by Austrian (co-)authors, as well as the Austrian projects made available for the European EDDRA database, and other relevant Austrian websites are given in the bibliographical part. The Annex provides a number of additional tables with detailed information and data. Every year the REITOX Focal Points also submit annual standard tables and structured questionnaires to the EMCDDA. 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 contributed 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 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. In addition to the SMG, the Act on New Psychoactive Substances (NPSG; BGBl I 2011/146 v. 29. 12. 2011) which entered into force in 2012 has served as an important legal basis. A typical feature of Austria's drug policy is the wide range of alternatives to punishment that are possible under the SMG. 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 in 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

During the reporting period, only a small number of modifications of the existing legal basis have been drafted and submitted for expert examination. Until summer 2014, no decisions were made in this matter (Bayer, personal communication). The amendments to the Narcotic Substances Regulation, the Narcotic Substances Limit Quantities Regulation, the Regulation on Psychotropic Substances, as well as the Psychotropic Substances Limit Quantities Regulation were adopted in order to implement international regulations (CND Decision 56/1), as in future, GHB is to be classified as a narcotic drug and not as a psychotropic substance. The amendment

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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.

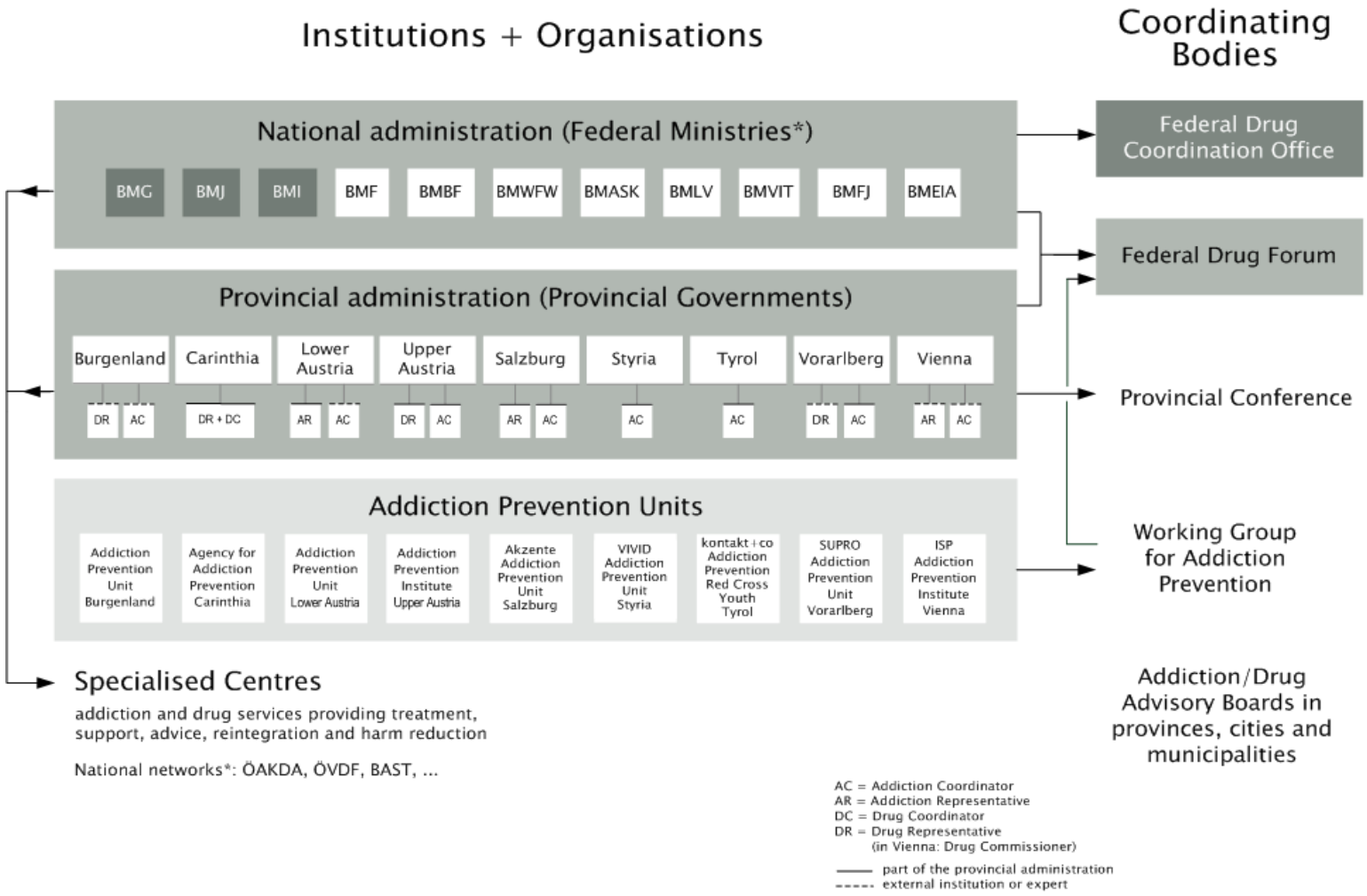
to the Narcotic Substances Regulation also includes the provision that in future, the social insurance funds shall issue to doctors forms for opioid substitution treatment

1.3 National action plan, strategy, evaluation and coordination

The political and administrative framework has not seen major changes during the reporting period (see also Figure 1.1). Austria's new Government Programme for the period 2013–18 (Bundesregierung 2013), in the chapter on health, explicitly mentions the issue of addiction, with regard to the objective of establishing prevention and health promotion for specific target groups as a guiding principle. This objective also includes drawing up a national strategy on prevention and addiction (which will encompass alcohol, tobacco and non-substance-related types of addiction as well). Another relevant aspect is measures to maintain psychological health, with a focus on early detection, which are also listed under this objective. The child and youth psychiatry plan, which is mentioned under the objective of growing up in good health (child and youth health care) and is to be drawn up by 2015, is a further important contribution. The objective on nationwide access to local health care provision of the best possible quality, independent of age, income, gender, ethnic origin and state of health, includes the establishment of primary health-care services of assured quality at the local level, as well as multiprofessional or interdisciplinary services in outpatient settings. This is relevant as established doctors, and particularly general practitioners, play an essential role in the delivery of opioid substitution treatment at the regional level.

With regard to **modifications of the drug or addiction policy framework** at the federal or provincial levels, a working group was convoked at the Federal Ministry of Health, to draft a coherent addiction prevention and addiction policy programme, on the basis of the Delphi survey (see GÖG/ÖBIG 2013c), for subsequent discussion at the political level (Schopper personal communication).

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



* See List of Abbreviations

Source and graphic representation: GÖG/ÖBIG

Another noteworthy development of the addiction policy framework is Vienna's 2013 addiction and drug strategy, in which the concept of addiction has been modified to include relevant new aspects and subjects (SDW 2014). The integrative approach to addiction and drug policy based on Vienna's 1999 Drug Policy Programme will thus be continued. The focus is again on the social integration of addicted persons, and on low-threshold support services. However, activities in the area of drugs and addiction have to be permanently adapted to take into account new substances and forms of addiction. A far-sighted addiction and drug policy must thus redirect its focus accordingly, and must be implemented in line with current needs. Setting strategic goals for legal substances (alcohol, nicotine and medicines) is particularly important in this context. Vienna's 2013 addiction and drug strategy lays down the following strategic goals and principles for four focal areas (SDW 2013):

» Prevention: Everybody, taking into account their individual situation, should have control over their own lives, should be able to voice and accept criticism and to experience pleasure, and they should be socially integrated. Consequently, prevention activities are based on a respectful, participative and emancipatory view of human beings, who take responsibility for their actions, and on an approach that understands the development of addiction patterns as a dynamic process. In addition to early detection and early intervention, the focus is on promoting life skills and risk competence, and on orientation towards specific target groups.

» Advice, support and treatment: People with addiction problems should become healthier both subjectively and objectively, and be integrated into social life. A wide range of services provided by specialised centres, as well as other actors in the health and social care system, should be guaranteed by means of long-term cooperation (see also section 5.2). Emphasis is laid on the importance of established doctors as the first contact point and the need for specialised training.

» Labour market programmes and social integration: Addicted persons should be able to have control over their lives and to find a meaning in life, through (re-)integration into the labour market and social (re-)integration (see also section 8.3). Breaking free from the cycle of addiction, unemployment and social marginalisation is the basis for appropriate interventions. Early detection, the taking of individual needs and demands into account, and access to social firms, are the core elements of this approach.

» Public spaces and security: The aim is to establish socially acceptable forms of coexistence for all groups of people in public spaces and in communities. Addicted persons should be integrated into the Vienna addiction and drug services network (SDHN), or into the general health and social care system, in line with their needs (see also section 9.3). A coordinated overall strategy that includes social workers, doctors, teachers and the police is necessary to attain these goals. The main aspects here are alternative places where addicted persons can spend their time, destigmatisation, as well as mobile social work.

The reorientation of Vienna's 2013 addiction and drug strategy has also expanded the tasks of the *Addiction and Drug Coordinator of the City of Vienna*, Vienna's new *Addiction and Drug Representative* and the *Addiction and Drugs Advisory Council*: they now include new important aspects, and themes such as responses to non-substance-related forms of addiction and legal addictive substances such as alcohol (SDW 2014).

The reporting period saw several **events** that focused on drug policy topics, e.g. a panel discussion on the need for a new narcotic substances act organised on the occasion of the 15-year anniversary of Schweizer Haus Hadersdorf (Schweizer Haus Hadersdorf, November 2013), or the expert meeting 'Life for Sale' on (criminal) drug laws and treatment, held in October 2013 at Linz Johannes Kepler University.

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, in the reporting period a study on the cost of addiction was published, which concludes that the (uncontrolled) use of narcotic substances (alcohol, tobacco, illicit drugs) and gambling results in an annual cost totalling EUR 777 million, with EUR 278 million accounted for by illicit substances (Kreutzer 2013).[2] This cost comprises health-care expenditure, social expenditure and state expenditure (for police and court activities), and is estimated to amount to EUR 135 mill., EUR 51 mill. and EUR 96 mill., respectively. In addition to these costs, the annual loss in productivity is estimated to be another EUR 18 mill., so that the total national cost arising due to the use of illicit drugs is EUR 300 mill.

2
According to the author, all estimates are based on official statistics, a smoker's model developed by the Institute for Advanced Studies (IHS), and the publication by Metz, Schwarz and Fischer (2012) described in last year's report (GÖG/ÖBIG 2013c).

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). For the 15 to 24 age group, data from the Flash Eurobarometer can be used.

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. For making estimates of drug use in youth scenes, data from projects such as *MDA basecamp* or *checkit!*, as well as specialised surveys can occasionally be used.

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 had experience of ecstasy, cocaine and amphetamines, and approximately 1% and a maximum of 2% have had some experience of opioids (see Table A1 and Table 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, high prevalence rates are found 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, indicate insignificant prevalence levels, in contrast to the great interest in this theme reflected by media coverage.

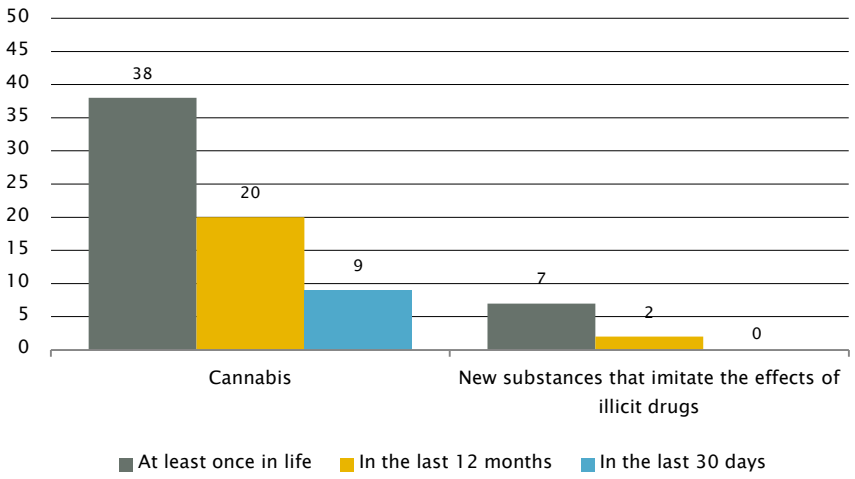
2.2 Drug use in the general population

No studies on drug use in the general population were published in the reporting period. Vienna's 2013 drug monitoring survey (IFES 2013) was already presented last year (GÖG/ÖBIG 2013c).

2.3 Drug use in the school and youth population

Regarding drug use among young people, June 2014 saw the publication of the Flash Eurobarometer 'Young people and drugs' (European Commission 2014a and 2014b)[3], which provides a number of Austrian data on prevalence of use (see Figure 2.1) and risk awareness (see Figure 2.2).

Figure 2.1:
Lifetime, annual and 30-day prevalence rates in the 15 to 24 age group, regarding cannabis and new substances that imitate the effects of illicit drugs; percentages; in 2014



Note: The original question about new substances imitating the effects of illicit drugs was, 'New substances that imitate the effects of illicit drugs such as cannabis, ecstasy, cocaine, etc. may now sometimes be available. They are sometimes called new psychoactive substances and can come in different form, for example herbal mixtures, powders, crystals or tablets. Have you ever used such substances?'

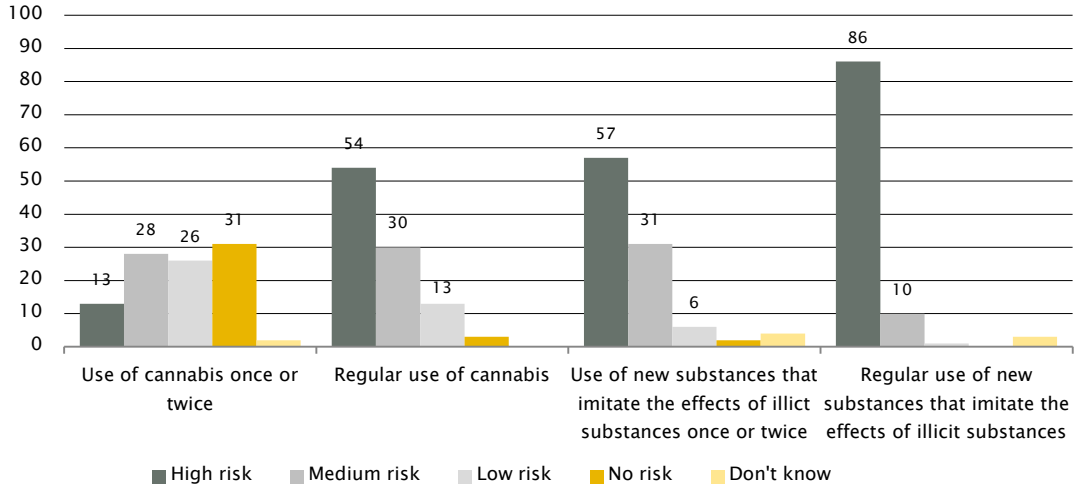
Source: European Commission 2014b; graphic representation: GÖG/ÖBIG

Lifetime prevalence of cannabis use is slightly above the figures given in other studies among the same age group (see Table A2). Lifetime prevalence of new substances that imitate the effects of illicit drugs has turned out to be higher than expected as well. One must bear in mind, however, that data on prevalence of use that are gathered in population surveys are not at all exact and can be influenced by many factors (e.g. social desirability, social atmosphere, etc. – see also GÖG/ÖBIG 2009a). According to the respondents' estimates, the health risks involved in the use of new substances imitating the effects of illicit drugs are considerably higher than for cannabis, with regard to both experimental use and regular use.

3
For the Flash Eurobarometer report "Young people and drugs", more than 13 000 persons aged between 15 and 24 from all over the EU were randomly selected and, from 3 to 23 June 2014, surveyed by means of computer-aided phone interviews. 501 respondents were from Austria.

Figure 2.2:
Risk assessment of the use of cannabis and 'new substances that imitate the effects of illicit drugs' in the age group from 15 to 24; percentages; in 2014

The original question was, 'To what extent do you think the following may pose a risk to a person's health?'

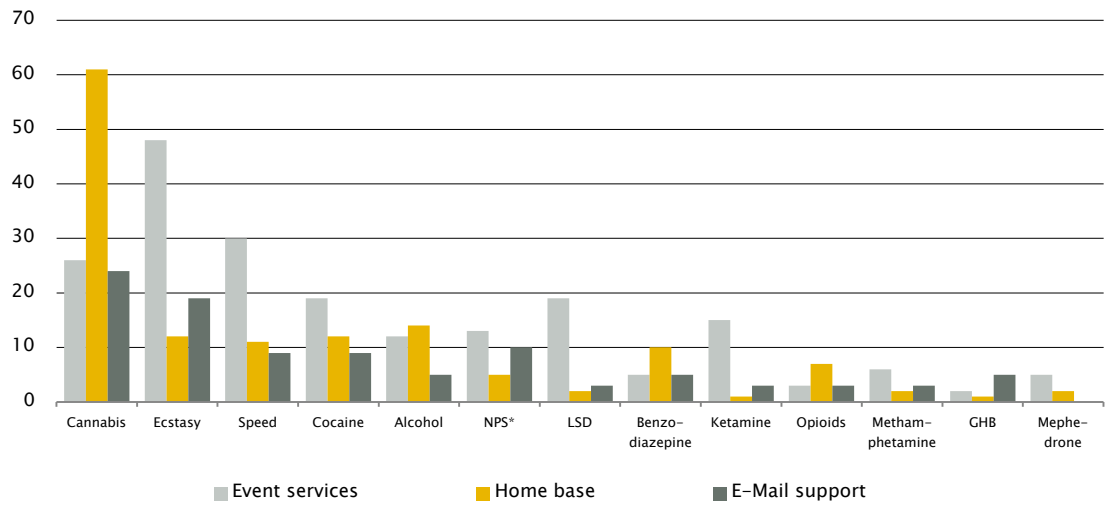


Source: European Commission 2014b; graphic representation: GÖG/ÖBIG

2.4 Drug use among targeted groups

Indirect information on substances used in party settings can be obtained from the substances mentioned in advice talks at *checkit!* (see sections 7.2 and 10.4). Depending on the type of support setting, the predominant substances are cannabis or ecstasy (see Figure Figure 2.3). *New psychoactive substances* (NPS) rank third in the context of e-mail support (after cannabis and ecstasy (SHW 2014d). The percentage of e-mail enquiries in which NPS were discussed has gone down by 18 percentage points as against 2011. From a comparison of the drug-checking results in the course of time, the *checkit!* team concludes that deliberate use of NPS in party settings is the exception rather than the rule, and that young people tend to use MDMA and amphetamine as these substances are more easily available.

Figure 2.3:
checkit!: Substances mentioned in advisory talks by setting; percentages; in 2013



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

Source: SHW 2014d; graphic representation: GÖG/ÖBIG

This also applies to the advice services by *MDA basecamp* (see section 7.2), where cannabis and ecstasy/amphetamine 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 2014). NPS were mentioned less often than in previous years, and often because users feared that new psychoactive substances might have been added, without their knowing, to drugs they had bought. In sum, the available data indicate a further decline in the importance of NPS in party settings.

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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 and also encompass forms of addiction that are not substance-related. In addition, general prevention measures in the context of universal prevention are an important basis for subsequent substance-related interventions. Specific activities and interventions regarding legal substances as well as non-substance-related 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 these measures are aimed at enhancing the life skills of children and young people, as well as discussing their patterns of risk behaviour.

In addition to a number of standard programmes carried out at nationwide level *(Eigenständig werden* [Become independent] and *plus*; see Tables Table A33 to Table A 35), 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 Units)[4], the Ministry of Education (BMBF), 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 a few 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 2013, ARGE Suchtvorbeugung held an expert meeting that focused on young people's lifeworld(s). Expert meetings and other conferences take place regularly at the provincial level as well, with themes covering the entire field of prevention.

4
For a list of all services of the nine Units please visit www.suchtvorbeugung.net/suchtpraeventionsinfo/Hauptseite (in German).

3.2 Environmental prevention[5]

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, as well as health promotion[6], 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 consuming alcohol and tobacco, as well as for spending time in public places, have been described in the 2012 report (GÖG/ÖBIG 2012). In 2013, Styria adopted a new Act on the Protection of Young People (LGBl 2013/81 v. 14. 5. 2013), which includes the following amendments:

» It is now prohibited for young people aged under 16 not only to consume, but also to buy and possess, alcoholic drinks and tobacco products, both in public places and in private settings.
» The Act now explicitly mentions alcopops (which are prohibited for young people aged under 18).

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).

The reporting period saw further activities to lay the foundation for *early childhood interventions* (see GÖG/ÖBIG 2013c), which aim at ensuring appropriate, early services for families with newborn babies and/or young children who need specific support (including families with addiction problems).[7] Since early in 2014, model projects have been implemented in five provinces, and the experience gleaned, combined with the fundamental project, will provide a good basis for establishing and expanding *early childhood intervention* networks in Austria.

5
According to the EMCDDA, environmental prevention strategies focus on the entire society and aim at altering people's immediate cultural, social, physical and economic environments.

6
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.

7
For further information see www.fruehehilfen.at (website in German).

School social work[8] is another important intervention that can influence the specific situation of school students and thus contribute to prevention. In summer 2013, guidelines to help implement school social work in Austria were published (Lehner et al. 2013). In Austria, school social work is part of youth and family welfare, and thus a field that falls within the provinces' competence. For this reason, the organisational structures and focuses with regard to goals, work routines and methods differ according to province. Since 2010, the Federal Ministry of Education has supported pilot projects in order to enable a common perspective on the issue and the development of school social work.

3.3 Universal prevention[9]

For an overview of the activities regarding universal prevention and its general framework please consult SQ22/25. **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.

The most relevant prevention programmes in school settings are *Eigenständig werden* [Become independent] and *plus* (see also Table A33 and Table A34). Both programmes have been offered in all provinces for a few years now, and are based on promoting life skills. While *Eigenständig werden* focuses on primary school students, *plus* is oriented towards students aged 10 to 14.

Plus was jointly developed by the Addiction Prevention Units on behalf of ARGE Suchtvorbeugung (the coordinating body of the Addiction Prevention Units) and uses social learning to enhance life skills. In addition to approaches to narcotic substances (including legal substances), new media and patterns of use are discussed, taking into account the students' age and gender. Subjects such as communication skills, coping stress and conflict management are treated as well.

8
For further information please consult http://schul-sozialarbeit.at (23 June 2014; in German).

9
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 all equally likely to develop patterns of substance use.

A recent evaluation report[10] provides the following results, compared to control groups (Juen 2013):

» Among the *plus* students aged 14 (i.e. in the fourth year of the programme) the increase in those who had experienced cigarette and alcohol use was found to be significantly lower than in the control classes.
» Furthermore, a significantly smaller rise in behavioural problems (students' self-assessment) and problems with peers became apparent in the *plus* classes.
» According to the teachers, the students' behaviour at school (learning as well as social behaviour) and their considerateness had significantly improved by the end of the four-year programme.
» They also said that the students' school achievements (in total, as well as in the subareas of German and Mathematics) were significantly higher at the end of the programme.

In view of the results it has been recommended to continue the programme with the same duration and sequence of lessons, and to ensure that the teachers are able to implement it as intended. Other points are to encourage more young teachers to take part in the programme, and to ensure the integration of parents.

Tyrol has developed a new service for communicating the theme of young people's protection: *ARENA* (kontakt+co 2014/1): at an interactive parents' evening, the parents are invited to visit different info-points where students inform them about relevant aspects of youth protection. The ideas that the students have in response to the parents' input are the starting point for discussions. The students have either been trained beforehand by *JugendschutzMOBIL* mobile youth protection staff or have had some other opportunity to get familiar with the theme.

The prevention activities in **kindergartens** and **family settings** have been continued. They mainly consist of further training programmes for multipliers and the provision of information materials, as well as parents' evenings. Many activities also directly address parenting skills. The Austrian Red Cross Youth and Rotary[11] plan to implement the *Freunde* [Friends] programme[12] throughout Austria. In December 2013, the first train-the-trainer seminar took place, whose participants will now run training programmes for kindergarten teachers in all provinces (kontakt+co 2014/1). Kindergartens in which two thirds of the staff have participated in the training will get a certificate. The programme is based on a life-skills approach and specifically aims at enhancing the children's emotional and social skills, as well as their personalities. In Lower

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10
For the evaluation, students and teachers from *plus* classes and control classes were interviewed five times between 2009 and 2013, based on quantitative questionnaires. The teachers in *plus* classes were also asked about the extent and method of implementation. At the outset, 2 107 students took part in the survey, and at the end their number was 1 825.

11
Rotary consists of international Rotary Clubs of business leaders who provide funding for community projects, among other activities.

12
For further information please consult http://www.freunde-oesterreich.at/Default.aspx (23 June 2014; in German).

Austria, a new join-in theatre for kindergartens *(Schmetterling & Pandabär* [Butterfly and panda bear]) has been available since early in 2014. It includes further training for kindergarten teachers and integrates parents, with the focus on enhancing life skills (Hörhan, personal communication).

The proven prevention methods at the workplace, in recreational settings and at the community level continue to be implemented. The majority of prevention measures taken at the **workplace** aim to prevent apprentices 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 apprentices. 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. 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. **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.

In Tyrol a new initiative was started in the reporting period: on *MOBILsports Gameday*, children and young people, especially those who have not yet joined any (sports) clubs, are encouraged to try new, unusual sports as an alternative recreational activity (kontakt+co 2013/4). The *MOBILsports Gameday* is run with the assistance of young people and the *MOBILteams* staff. On this day, children and young people should first of all have a chance to experience that one can have fun and relax without drinking, without spending money, and without commercial entertainment.

3.4 Selective prevention in at-risks groups and settings[13]

For an overview of selective prevention measures and their framework please consult SQ26. These include, for instance, services for **children in families with addiction problems**, and mainly consist of training for 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.

A number of established interventions that continue to be implemented address **young people** in specific settings, such as **social education services, labour market programmes** and **employment**

13
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).

projects. For the majority of these settings, the focus is on further training programmes for trainers in these services and projects. Activities that directly address young people aim at enhancing risk competence. For instance, in 2013 Tyrol's mobile *it's-up2U* workshops for apprentices and young people in labour market programmes of the Public Employment Service were organised throughout the province (kontakt+co 2014/1).

In **recreational settings**, the focus is on communicating a critical approach to psychoactive substances (risk competence), as well as offering alternatives to substance use. The club and party scene is a typical setting for such programmes. In spring 2014 *MDA basecamp* started the pilot phase of a drug checking service at the *MDA basecamp* headquarters in Innsbruck (Tyrol), aimed at prevention and harm reduction[14] (see also Chapter 7). Since 2013, individual *JUZ coaching* is offered for staff of youth centres, youth clubs, etc. in the province of Salzburg. Here one or several persons can obtain advice with regard to risk behaviour and drug use among young people in their centres (Akzente Fachstelle Suchtprävention 2014).

The specific situation of **people with an immigration background** may be connected to an elevated risk of developing an addiction, because **immigration** can in itself be an event in life that is traumatising and subsequently triggers addiction. 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 this field, the existing measures are mostly continued, and no new programmes have been developed in the reporting period. In Lower Austria, the participants in the 10-month intercultural prevention training, with a total of 110 teaching units and 20 hours of shadowing, have completed the programme, and further training programmes for staff of integration offices and for immigration and refugee workers have been organised (Hörhan, personal communication).

3.5 Indicated prevention[15]

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 instances of risky or addictive patterns of behaviour and related behavioural disorders, and in most cases refer to alcohol use. In all provinces, further training programmes in motivational brief intervention to respond to young people with (risky) patterns

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14
For further information please visit www.mdabasecamp.com/drug-checking/plotphase-dc (26 February 2024; in German)

15
The focus of indicated prevention is on individuals 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 situation. 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.

of use have regularly been offered to staff in diverse fields (e.g. youth work in recreational settings; see also Table A 35). *Step by step* trainings (a programme promoting uniform responses to incidents at school, as well as early detection and crisis intervention) and other measures (booklets, events) have again been organised in many provinces. The specific measures described in previous reports continue to be implemented; no new services have been developed. Early detection and making contact with young people at risk were also discussed at a focus group that GÖG organised in March 2014 (see section 7.4).

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.

4 High-Risk Drug Use

4.1 Introduction

According to the EMCDDA definition, high-risk drug use (HRDU) is 'recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high probability/risk of suffering such harms' (EMCDDA 2013)[16]. This definition corresponds to Austria's definition of problem drug use. In Austria, it has always been emphasised that it is primarily patterns of use and not substances as such that are either risky or safe. High-risk drug use thus refers to drug use that is accompanied by physical, psychological and/or social problems. If exclusively legal problems have ensued, the term high-risk drug use does not apply.

As of 1993, the capture-recapture (CRC)[17] method has been used for prevalence estimates of high-risk drug use in Austria (see Uhl and Seidler 2001). The data basis is pseudonymised data from reports connected to opioids (see section 9.2), the substitution registry (see section 5.3) and drug-related deaths (see section 6.4.). Furthermore, the nationwide documentation system of clients of Austrian drug services (DOKLI) provides additional information that is very helpful for the interpretation of the results obtained (see section 5.3).

Polydrug use including opioids, which are often injected, has traditionally played a significant role in Austria. One especially noteworthy development of recent years is the fact that young opioid users prefer snorting as their route of administration, and in many cases 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 Busch et al. under preparation and GÖG/ÖBIG 2013d).

According to recent estimates covering 2012 and 2013 respectively, a nationwide prevalence of 28 000 to 29 000 high-risk opioid users, most of them polydrug users, seems plausible (see ST7 and ST8). This means that approximately five out of 1 000 Austrians aged between 15 and 64

16
The EMCDDA's definition of problem drug use, which has been adopted so far, is 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'. The motives for revising the definition and using a new term (i.e. 'high-risk drug use' replacing 'problem drug use') is that additional substances (e.g. cannabis or methamphetamine) have been included, and that a clearer definition has been deemed necessary (EMCDDA 2013).

17
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).

are in this group. Three out of four are men, and 15% are under 25 (43% are aged between 25 and 34).

Besides the prevalence of high-risk drug use involving opioids, the prevalence of injecting drug 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 (40% to 50%) is extrapolated to all high-risk drug users who take opioids, the estimated number of (primarily) injecting drug users lies between 11 000 and 15 000 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 severer drug problems.

Compared to illicit drugs, the prevalence rate of alcohol dependence 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 would thus considered to be alcoholics.

4.2 Prevalence and trends in HRDU

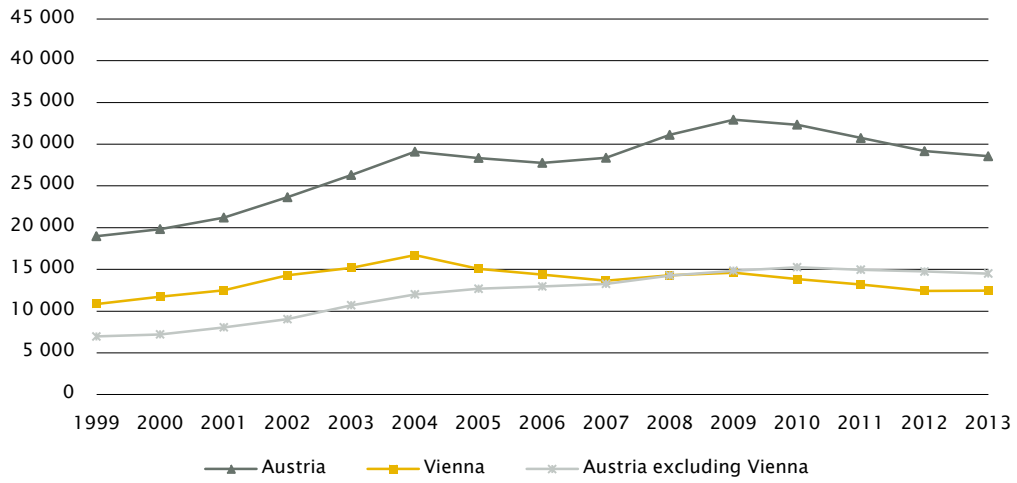
In Austria, scientific estimates of the prevalence of high-risk drug use are available for opioids and polydrug use involving opioids.

Figure 4.1 reveals a strong rise in the early 2000s, to almost 30 000 persons in 2004/5. Since then, figures around 30 000 have been recorded, and since 2009, a slight decline in prevalence has become apparent.

If the developments in Vienna and in Austria without Vienna are studied separately, marked differences become apparent. While the figures for Vienna were increasing until 2004, they have remained stable since then, and have been slightly declining in recent years. In the rest of Austria outside Vienna, the prevalence rates have, however, continued to go up, and have only stabilised as of 2010. Whereas in Vienna the number of high-risk drug users was estimated as being slightly higher until 2009; as of that year, the prevalence rate for Austria excluding Vienna is estimated as being higher. 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 Vienna. Vienna, as Austria's only large city[18], is most strongly affected by drug problems.

18
Drug addiction is still more frequently found in urban areas than in rural communities.

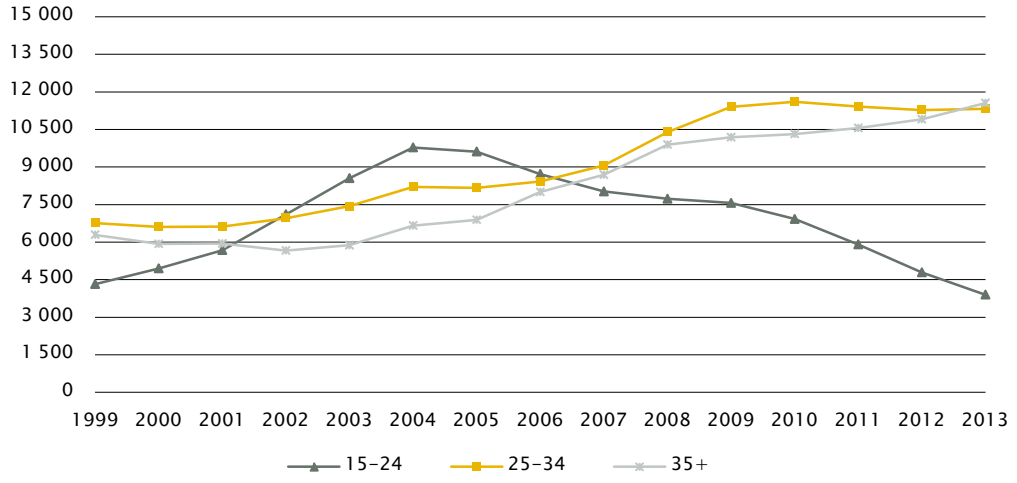
Figure 4.1.
Prevalence estimate of high-risk drug use involving opioids in Austria, in Vienna and in Austria excluding Vienna; over time, absolute figures, 1999–2013



Note: For the period from 1999 to 2012, the moving mean from three years has been used (e.g. for 1999, the mean from 1998 to 2000), and in the case of 2013, the estimate for this year has been given.

Source: 2014 prevalence estimates, GÖG/ÖBIG 2013d; calculation and graphic representation: GÖG/ÖBIG

Figure 4.2:
Prevalence estimate of high-risk drug use involving opioids; absolute figures, by age group, over time, 1999–2013

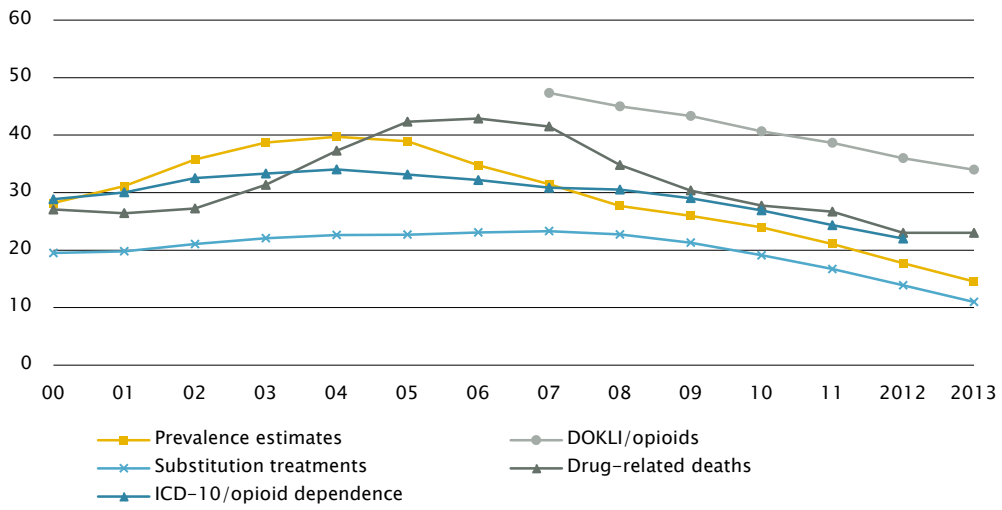


Note: For the period from 1999 to 2012, the moving mean from three years has been used (e.g. for 1999, the mean from 1998 to 2000), and in the case of 2013, the estimate for this year has been given.

Source: 2014 prevalence estimates, GÖG/ÖBIG 2013d; calculation and graphic representation: GÖG/ÖBIG

For a more detailed study of the background of prevalence trends, age-stratified estimates are useful (see Figure 4.2). Here the prevalence rates in the youngest age group (15 to 24) have doubled from 2000 to 2004. In other words, during this period a larger number of young people and young adults have started to develop high-risk patterns of drug use. Since then, the prevalence rates have again gone down considerably for this age group (= fewer persons taking up high-risk use patterns). As the generation that started HRDU between 2000 and 2004 is getting older, the number of older high-risk drug users has continued to rise.

Figure 4.3:
Percentage of persons aged under 25 in the prevalence estimate, in the DOKLI documentation system, in the group receiving OST, among hospital discharges and among drug-related deaths; time series (moving mean), 2000–2013



Note: **DOKLI/opioids:** All clients of advice and support centres covered by DOKLI indicating opioids as their primary drug. **ICD-10 (opioids):** Persons with F11.2 (Opioid dependence) as the principal or secondary diagnosis discharged after inpatient treatment. In all data sources, for 2000 up to the latest-but-one year included, the mean from three years has been given in order to compensate for random fluctuations (moving mean). For the latest year covered, raw figures were used.

Sources: 2014 prevalence estimates; GÖG/ÖBIG 2013d, DOKLI, eSuchtmittel, statistics on drug-related deaths, BMG diagnosis and service documentations of Austrian hospitals; calculation and graphic representation: GÖG/ÖBIG

The strong decline in the number of young high-risk opioid users is reflected in all drug monitoring data sources (see Figure 4.3) and has been confirmed by reports from practitioners. The DOKLI data indicate a decrease in recent years in the number of persons with opioids as their primary drug, and a rise in persons who solely use cannabis as their primary drug (Busch et al. under preparation. This may be due to several hypothetical reasons:

» High-risk drug use in Austria tends to shift towards cannabis or *new psychoactive substances* (NPS). However, currently there are no signs of a strong rise in high-risk NPS use (see sections 2.4, 7.2 and 10.4). Furthermore, only approximately one out of three clients covered by DOKLI who indicated cannabis as their primary drug were regarded as high-risk cannabis users at the start of treatment (GÖG/ÖBIG 2013d).

» The decrease in high-risk use of opioids (in the context of polydrug use) can be due to a shift towards stimulants such as methamphetamine or mephedrone. Regarding methamphetamine, there are indications of a local scene in Upper Austria (see sections 4.3, 5.3.1, 9.2 and Table A14). In the case of mephedrone use, a larger scene existed in Styria (GÖG/ÖBIG 2012), whereas in recent years high-risk mephedrone use has been found to decline again.

» High-risk drug use as such is tending to decline in Austria. An explanation for the rise in cannabis as the primary drug among DOKLI clients is that, due to greater capacity, it has become possible to also admit clients whose drug use is less risky.

The developments in the next three years will reveal which of the three hypotheses is correct, and to what extent. On the whole, there are indications of a change in the drug situation or patterns of use, respectively, though one must not forget that opioids continue to predominate with regard to drug use that requires treatment.

The 2014 drug epidemiology report (Busch et al. 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 means of 3-sample CRC estimates, taking into account the data on drug-related deaths.

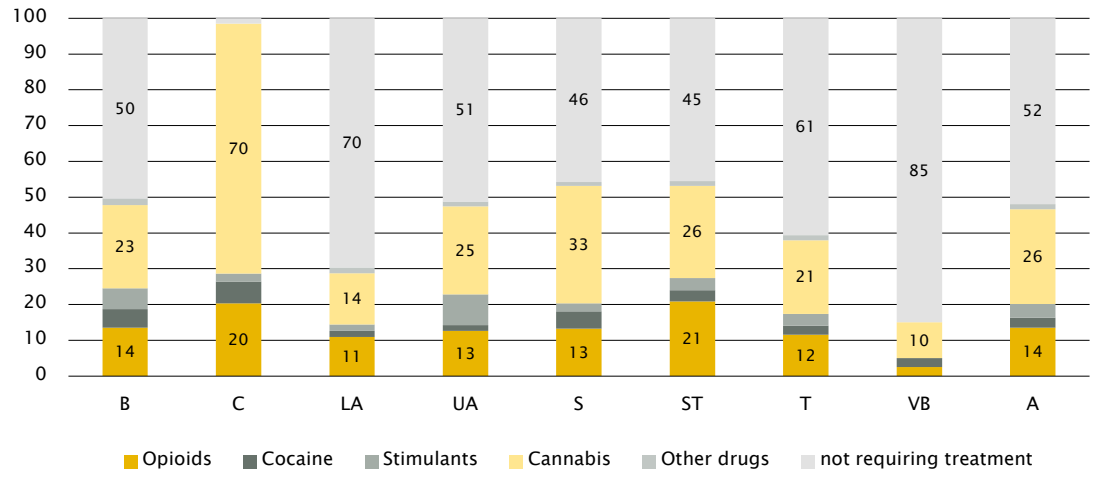
It should also be mentioned that, because of methodological limitations, results obtained through the CRC method only permit rough approximations. A more detailed description of methodological problems is given in, for instance, Uhl and Seidler 2001, ÖBIG 2003, GÖG/ÖBIG 2006 and GÖG/ÖBIG 2010c.

4.3 Characteristics of high-risk drug users based on data from non-treatment sources

Analyses of patterns of drug use among persons examined under SMG Section 12[19] (here, data from all provinces except Vienna are available) show that the vast majority of examinations indicate either a need for treatment due to opioid use or a need for treatment due to cannabis use.

19
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 2013, a total of 6 110 results of examinations of 5 792 persons are available (several persons were examined more than once in 2013). A total of 3 118 examination results included information on drug use; and in 209 examinations drug use was reported to be 'unknown'. 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. Figure 4.2 relates to those 3 118 examination results which included information on drug use.

Figure 4.4:
Drug use deemed to require treatment, based on the hierarchical[20] primary drug definition, among persons examined in accordance with SMG Section 12; by province, percentages, in 2013



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

This is in line with other data from the treatment sector (e.g. DOKLI; see Busch et al. 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 Carinthia, the percentage of examinations in which cannabis use requiring treatment is diagnosed is comparably large, and 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 4.4 points rather to pronounced differences in examination practices in the individual 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 section 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, but sometimes also injected by opioid users (Schwarzenbrunner, personal communication). For this reason, the data on health-related measures have been analysed separately.

20
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 4.4 uses the hierarchical 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.

Figure 4.4 reveals that in Upper Austria, the proportion of stimulants as the primary drug is highest (9%). This percentage has risen in the past three years (2011: 1%; 2012: 3%). If the hierarchical primary drug definition is not used (i.e. if clients can name several primary drugs), it shows that for 84 out of a total of 792 drug users examined in Upper Austria, need for treatment due to amphetamine use[21] has been diagnosed. This is more than half of all persons examined who indicated amphetamine as their primary drug. In 26 out of 84 examinations in which amphetamine use requiring treatment was found, treatment due to use of opioids or cocaine was indicated as well. In addition, in 126 cases the public health officers found amphetamine use that did not require treatment (see Table 4.1). In view of this information, and combined with other drug monitoring data (see sections 5.3.1, 9.2 and Table A14), is seems to be safe to assume that there is a local scene of high-risk methamphetamine or amphetamine users in Upper Austria.

Table 4.1:
Amphetamine use that requires/does not require treatment, based on examinations by public health officers under SMG Section 12; in 2013

Amphetamine use	B	C	LA	UA	S	St	T	VB	A
Treatment required	8	17	17	84	9	17	11	1	164
No treatment required	6	9	62	126	13	8	5	1	230
Total	14	26	79	210	22	25	16	2	394

Note: 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. No data from Vienna are therefore available.

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

21
As methamphetamine is not recorded as a separate category, the public health officers tick the main category amphetamine whenever methamphetamine use that requires treatment is found.

5 Drug-Related Treatment: Treatment Demand and Treatment Availability

5.1 Introduction

Austria has a nearly 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), neither of which are 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 number of different substances with different active ingredients 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 section 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[22] [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 bibliographical part).

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

22
See http://suchthilfekompass.goeg.at/ (in German).

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

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. The focus of the current activities at both federal and provincial levels continues to be on optimising addiction treatment, particularly opioid substitution treatment of patients with opioid addictions, and complementary psychosocial support. For instance, the dialogue organised by the Ministry of Health on addiction problems and opioid substitution treatment for opioid users has been continued in the reporting period (Schopper, personal communication). In three working groups under the aegis of the *Committee on Quality and Safety in Substitution Treatment*, experts from the fields of medicine, law and psychosocial support are to prepare recommendations for medically assisted treatment of assured quality for patients addicted to opioids. These quality standards are to reflect the state of the art, practical experience, as well as the specific situation in Austria, and will serve as an interdisciplinary reference framework for all professionals who are involved in questions of substitution treatment of patients with opioid addictions.

At the provincial level, the reporting period saw, for instance, the publication of Vienna's 2013 addiction and drug strategy, which focuses on integrating addiction treatment into the general health and social care system, and on enhancing interdisciplinary cooperation (see section 1.2). In Salzburg, a framework strategy for an integrated addiction support and treatment system is being prepared, which will be based on an approach that integrates different substances, and on a structured treatment and support chain composed of outpatient, inpatient and rehabilitation interventions, as well as binding agreements for establishing links between providers (Schabus-Eder, personal communication). Parallel to this, the psychiatric treatment of adults including patients with addiction disorders will be restructured. In Tyrol, endeavours are being made to improve the links between medical and psychosocial treatment (Gstrein, personal communication). Lower Austria has started to draw up guidelines for practical responses (advice, support and treatment) to persons with active addictions (Hörhan, personal communication).

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[23] (see Table 5.1 and section 4.3). The number of persons examined per 100 000 inhabitants aged between 15 and 64 also strongly differs according to province, e.g. 15 in Vorarlberg and 205 in Vienna. In approximately half of all patients examined throughout Austria, no need for treatment under Section 11, para. 2 of the SMG is deemed to be indicated. Figure 5.1 illustrates which health-related measures that were deemed to be necessary in 2013 for persons showing patterns of opioid use requiring treatment (see also Busch et al. under preparation). 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 section 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 2013

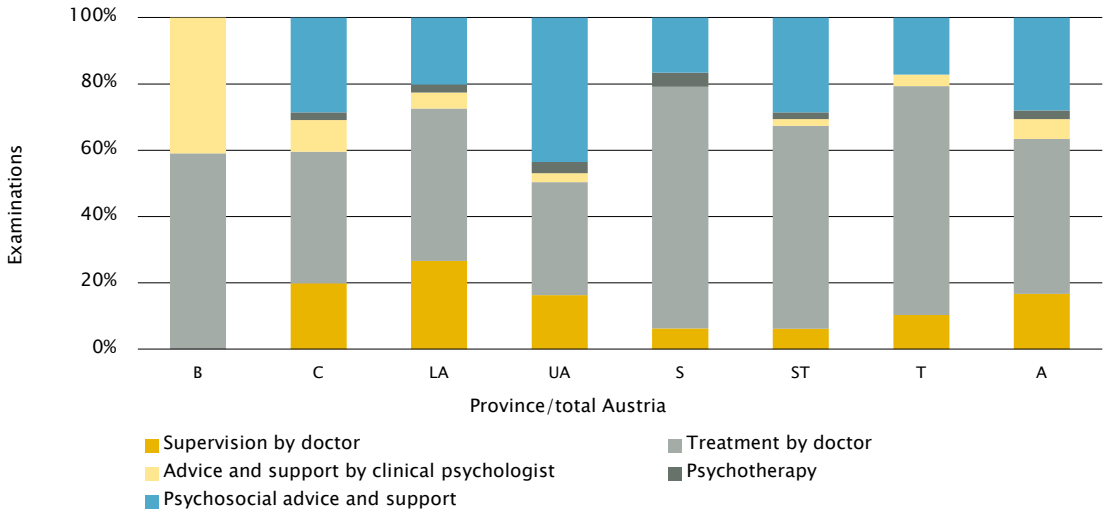
Type of health-related measure (under)	Proportion in total examinations per province									
	B	C	LA	UA	S	St	T	VB	V	A
No health-related measure required.	48%	20%	60%	32%	36%	41%	37%	43%	64%	52%
SMG Section 11, para. 2, fig. 1[1]	7%	58%	13%	41%	21%	11%	30%	3%	4%	17%
SMG Section 11, para. 2, fig. 2[2]	11%	14%	7%	9%	15%	12%	8%	0%	27%	17%
SMG Section 11, para. 2, fig. 3[3]	20%	10%	2%	2%	2%	1%	4%	0%	1%	2%
SMG Section 11, para. 2, fig. 4[4]	3%	1%	1%	4%	3%	2%	2%	0%	3%	3%
SMG Section 11, para. 2, fig. 5[5]	16%	40%	14%	33%	33%	31%	35%	58%	1%	16%
Number of examinations	155	408	1 199	792	323	294	364	40	2 535	6 110
Number of persons examined	154	345	1 130	733	316	282	344	38	2 450	5 792
Percentage of persons examined per 10 000 persons aged between 15 and 64	80	94	105	77	88	35	70	15	205	102

[1] = supervision by doctor
[2] = treatment by a doctor (including withdrawal and opioid substitution treatment)
[3] = advice and support by a clinical psychologist
[4] = psychotherapy
[5] = psychosocial advice and support

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

23
SMG Section 11 defines under which conditions persons should be made to undergo a certain type of health-related measure due to misuse of substances or dependence on drugs.

Figure 5.1:
Health-related measures in accordance with SMG Section 12[24] deemed to be necessary for opioid users requiring treatment; percentages, in 2013



Note: The reports by the district health authorities mention opioid misuse, 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 (indication of multiple measures is possible). Double counts of persons cannot be ruled out either. 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. No data are therefore available for Vienna. For Vorarlberg, no data are given as during the reporting period, only one opioid user who was deemed to require treatment was examined.

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

5.2.2 Treatment systems

The **organisation and availability of opioid substitution treatment** for patients using opioids strongly depend on regional strategies (centralised v. decentralised supply structures). This becomes particularly apparent in Map 5.2 and Figure 5.3. 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 July 2014, 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 theoretically be eligible for OST delivery[25]).

24
The provisions of SMG Section 12 cover examinations of persons who are assumed to be misusing narcotic drugs.

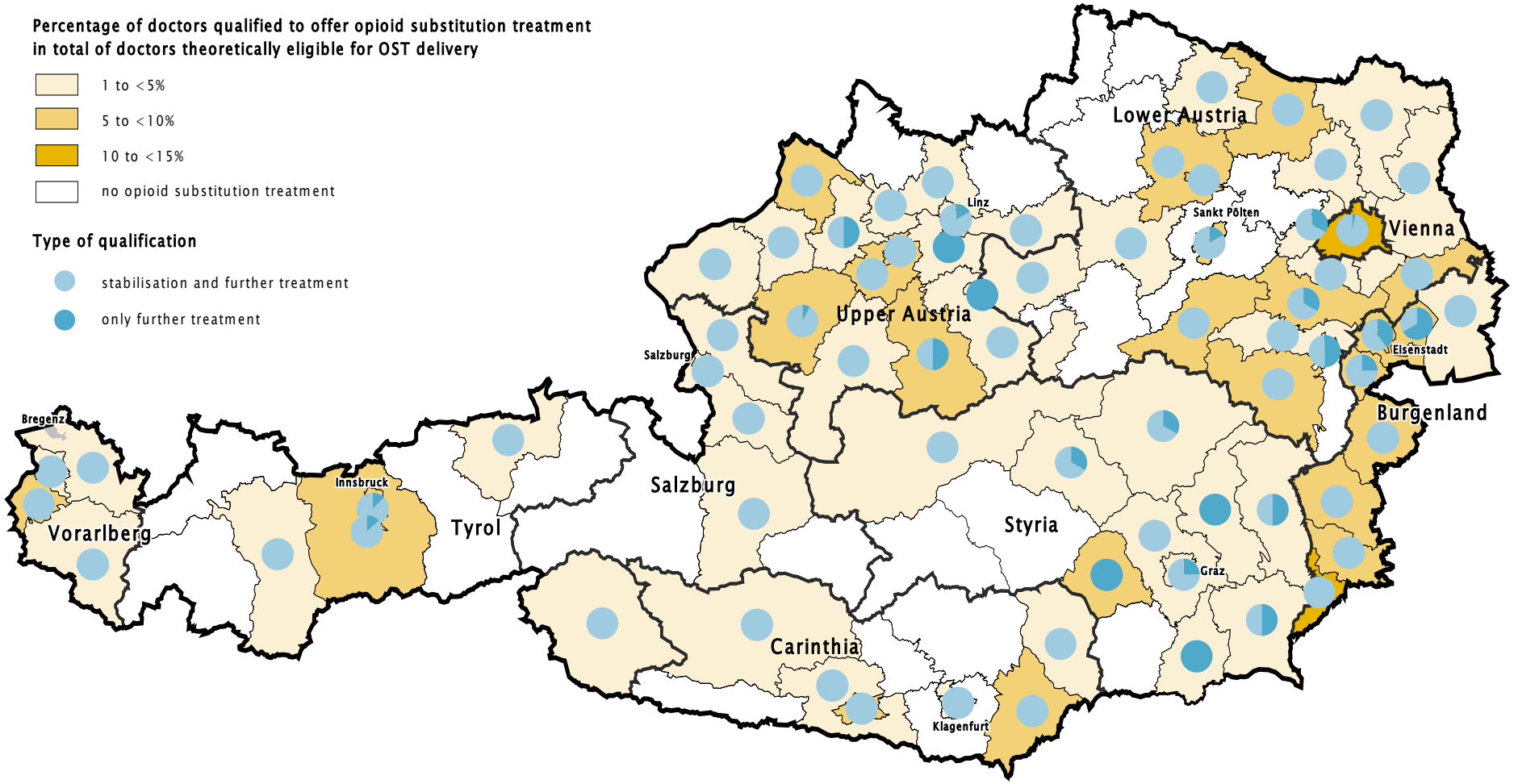
25
The map includes all doctors who, according to the list of doctors of the Austrian Medical Association, are either general practitioners or doctors specialising in psychiatry and psychotherapy medicine, or in child and youth psychiatry (additional specialisation: neuropaediatrics).
The data on established doctors are from 2014, with their main office addresses at that time. The data on doctors entitled to deliver OST have been taken from the list of OST doctors (LISA) maintained at the Ministry of Health.

The map also provides information on the distribution of those doctors who are entitled to both define the stabilising 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[26] in 2013, in relation to the population aged 15 to 64. As a rule, availability of services near a person's place of residence is desirable, in order to ensure the best possible access to services for all who need them. Map 5.3 gives an overview of inpatient opioid substitution treatment services. In Salzburg, a second institutional OST service for opioid users has again been made available; it is run by *Drogenberatung Salzburg* and is aimed at clients from the city of Salzburg, as well from the districts of Salzburg-Umgebung and Hallein (Schabus-Eder, personal communication).

By June 2013, a total of 597 doctors were on the list of doctors entitled to give OST, with 515 (86%) actually delivering opioid substitution treatment. Map 5.1 in section 5.2.2 shows the distribution of doctors entitled to deliver opioid substitution treatment. One has to bear in mind that, on the one hand, not all doctors who are qualified to give opioid substitution treatment and who have been registered as eligible 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).

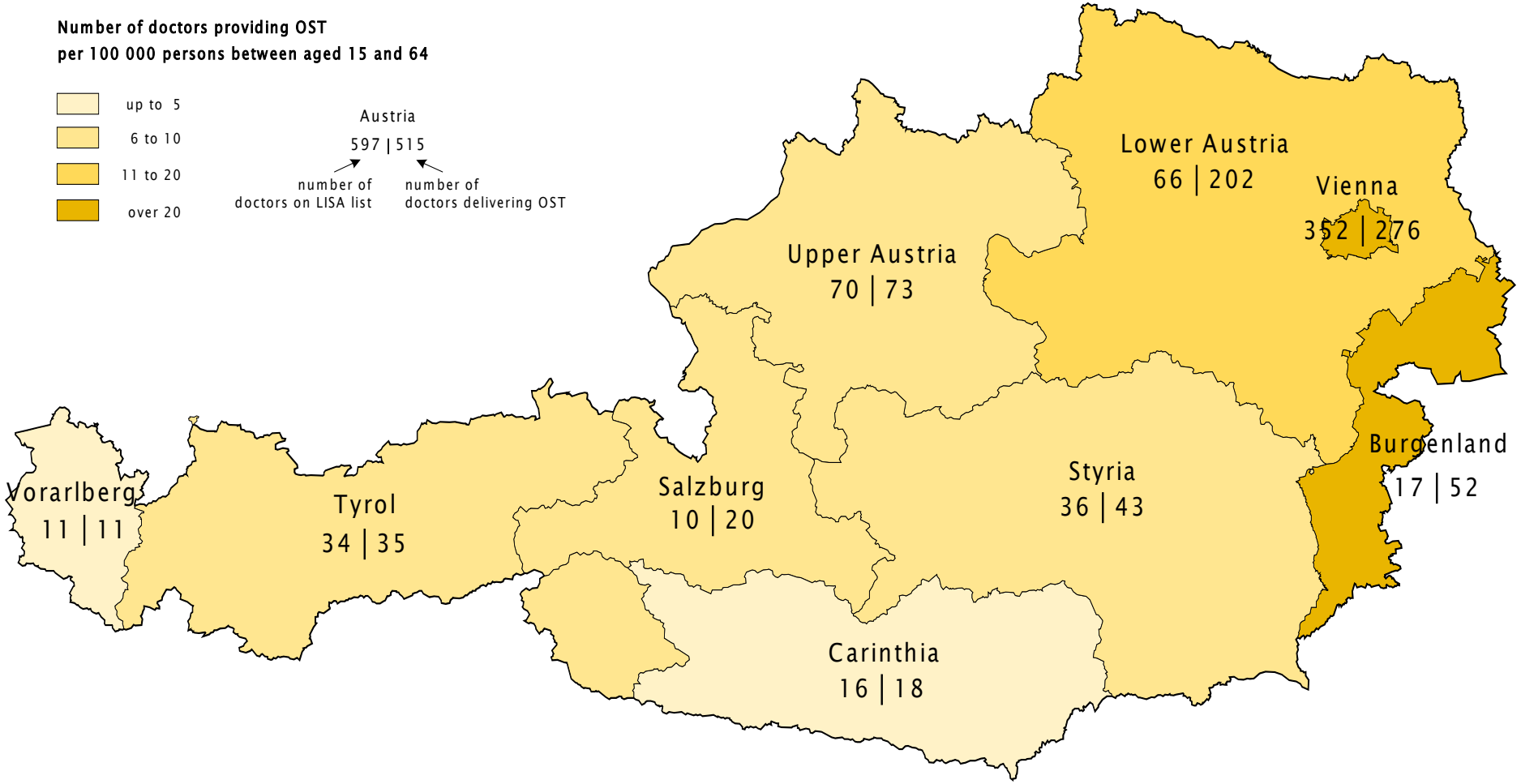
26
Doctors may also provide treatment to addicted patients from other provinces. This means that, in some provinces, a larger number of doctors is actually available than given in the LISA list of doctors qualified for delivering opioid substitution treatment. On the other hand, there are provinces where fewer doctors than those eligible according to the LISA list actually provide treatment.

Map 5.1:
Distribution of doctors entitled to deliver oral opioid substitution treatment in Austria; as at July 2014



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 July 2014

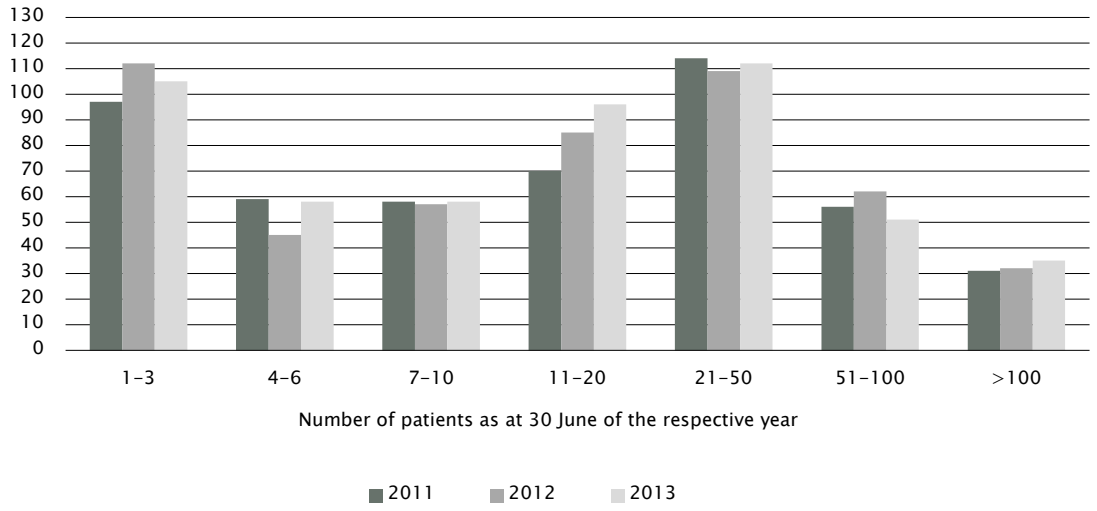


Source: BMG (LISA list) and eSuchtmittel; graphic representation: GÖG/ÖBIG

In Styria a further training curriculum was developed, based on the Regulation on Further Training, and implemented in May 2014 as a 20-hour programme, with an additional 20 hours covered by e-learning (Ederer, personal communication). According to Ederer, this programme, as well as the web-based substitution checklist for doctors delivering OST (see GÖG/ÖBIG 2013c) has helped increase the number of doctors qualified for delivering opioid substitution treatment in Styria (by June 2014: 40 doctors). In order to improve the quality of treatment and to assist doctors delivering OST, it has been possible since 2013 to offer psychosocial support provided by staff of a centre declared as eligible in accordance with SMG Section 15[27].

Figure 5.2 shows the pronounced differences in, and the development of, the number of patients treated per doctor in the past three years. While 163 doctors (32%) delivered treatment to 6 or less patients, 86 doctors (17%) treated more than 50 substitution patients in 2013. A possible explanation for this is 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.

Figure 5.2:
Development of the number of patients receiving opioid substitution treatment per doctor; from 2011 to 2013

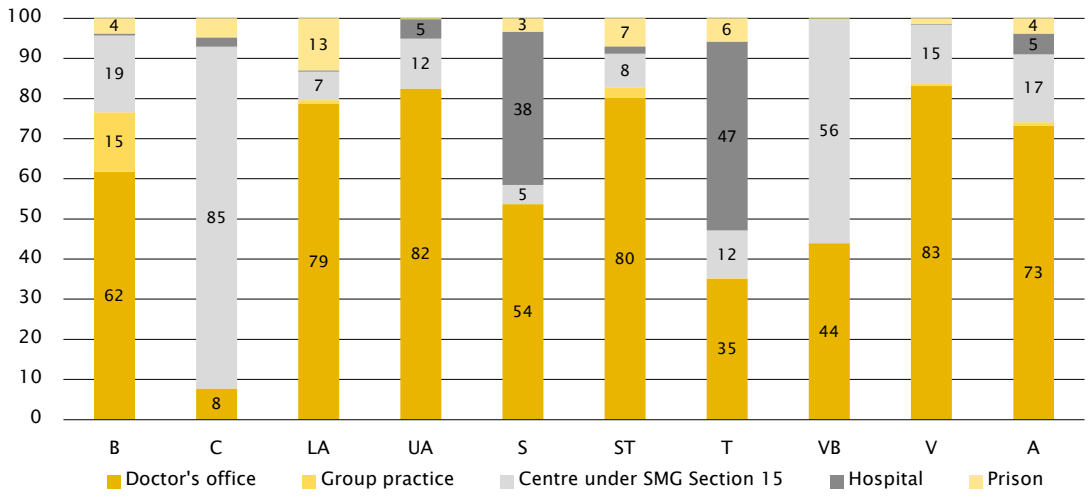


Sources: eSuchtmittel; calculation and graphic representation: GÖG/ÖBIG

27
SMG Section 15 relates to centres that are eligible for providing health-related measures with regard to the misuse of narcotic substances.

Figure 5.3 below shows in which type of setting opioid substitution treatment is most often delivered in Austria. As in Map 5.2, the figures again reflect organisational differences in the individual provinces.

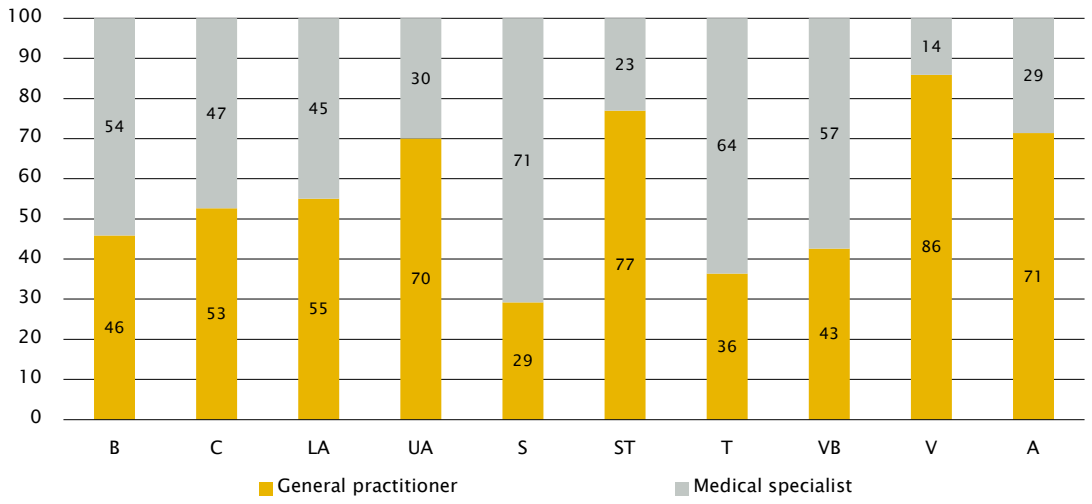
Figure 5.3:
OST delivery in practice – type of treatment setting according to clients' place of residence; in 2013



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

shows that, in Austria, general practitioners play an important role in the provision of OST treatment to clients with opioid addictions. Again, considerable differences are apparent in the individual provinces: whereas in Salzburg 71% of OST treatments are delivered by medical specialists, in Vienna, general practitioners account for 86% of opioid substitution treatments.

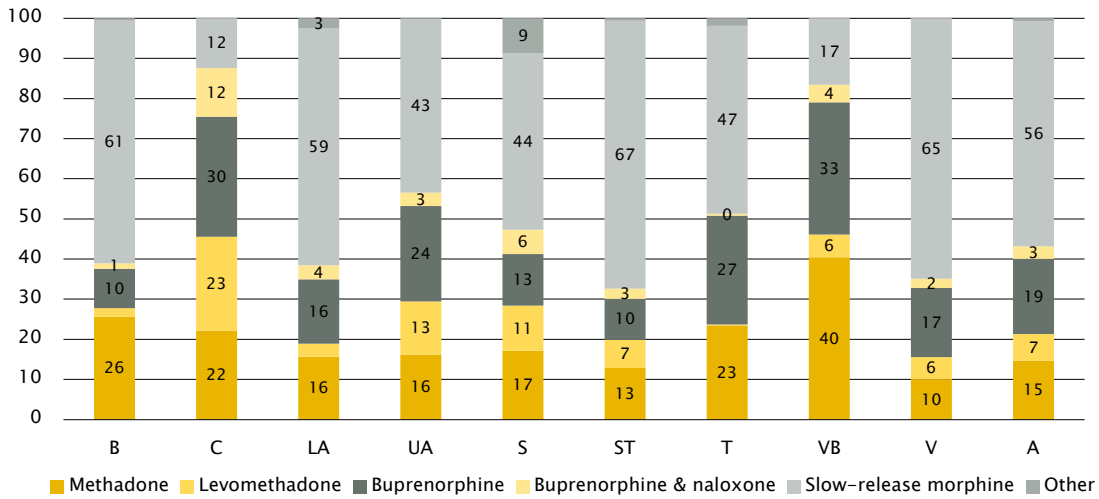
Figure 5.4:
OST delivery in practice – percentage of clients treated by medical specialists v. general practitioners; by province and independent of place of treatment; as at 30 June 2013



Source: 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 (19%) and methadone (15%). 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 5.5). Differences are also found with regard to the age of clients and type of substitution medicine prescribed (see Figure 5.6). The proportion of older clients being prescribed slow-release morphine tends to be slightly above average.

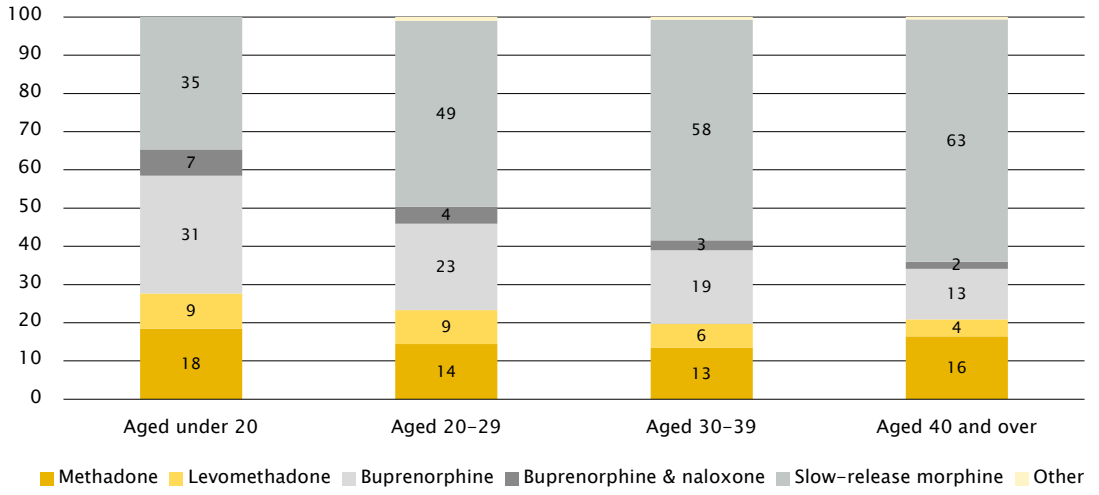
Figure 5.5:
Persons in opioid substitution treatment in Austria by substitution medicine and province; percentages, in 2013



Note: The figures relate to 16 786 of a total of 16 989 people, as no data on the substitution medicine prescribed are available for the remaining 203 people (1%). 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 5.6:
Persons in opioid substitution treatment in Austria by substitution medicine and age; percentages, in 2013

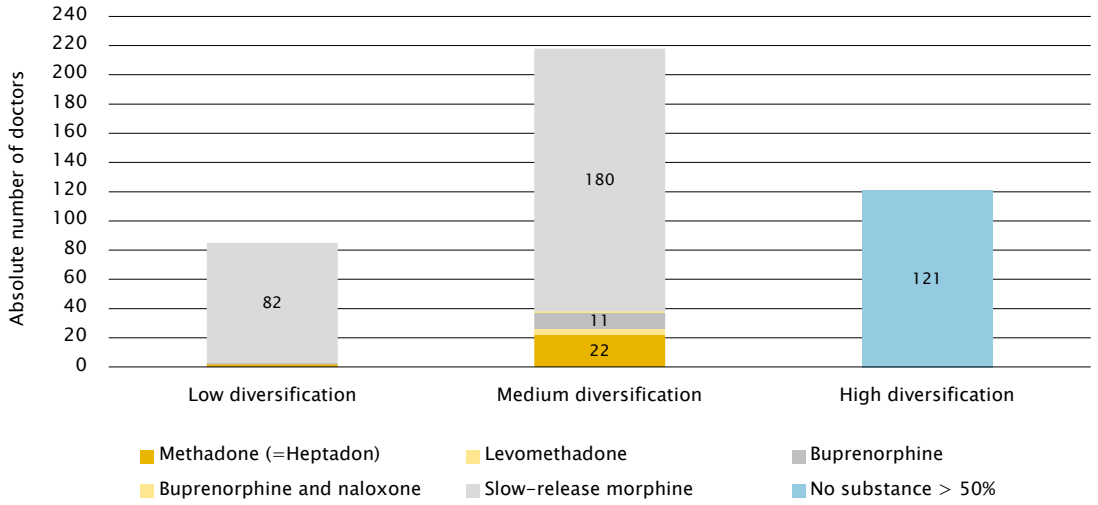


Note: The figures relate to 16 786 of a total of 16 989 people, as no data on the substitution medicine prescribed are available for the remaining 203 people (1%). If the substitution medicine was changed in the course of the year, the substance prescribed most recently was entered.

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

Another interesting aspect here is which of the available substances the doctors delivering OST tend to prescribe. The main advantage of a diversification of available substitution medicines is that doctors are able to choose among different substances and prescribe the medicine that is most appropriate for the patient's individual needs. However, Figure 5.7 shows that very many doctors[28] preferably prescribe the same substance to the majority of their patients: approximately half (n = 218) decide in favour of one substance for the majority of clients (49%–79%), mostly slow-release morphine, i.e. the diversification of substances is at a medium level. One out of five doctors (n = 85) prescribe the same substitution medicine to almost all clients (> 79%), again mainly slow-release morphine, which is a low degree of diversification. Less than one third of doctors (n = 121) use a wide range of substances (i.e. none of the available substitution medicines is prescribed to more than 50% of clients), and thus in fact make use of the diverse medicines that are available. One possible reason for low levels of diversification is that the substitution medicine that is most often administered (mostly slow-release morphine) is regarded as significantly better than the other available substances and is thus preferred.

Figure 5.7:
Diversification with regard to the prescription of different substitution medicines; in 2013



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

The Vienna Addiction and Drug Coordination (SDW 2014) reports the following figures on Vienna's continued *cooperation project to ensure the intended use as prescribed of substitution medicines* (GÖG/ÖBIG 2011b): from the end of 2008 to the end of 2013, the following modifications of prescription practices have become apparent: a total of approximately 3 000 cases were reported to public health officers, and for 18%, a change to daily-dose-dispensing of substitution medicines was decided. 83% of all patients are dispensed their substitution medicine daily,

28
This figure is based on a special analysis in which all doctors treating five patients or more were taken into account.

and 69% of them have Substitol® prescriptions. 68% of these patients have to open the capsules in the pharmacy. Since the start of the project, the health authorities have referred 1 631 patients to the Institute for Addiction Diagnostics for further examination.

A study[29] that is worthy of mention in this context examines the suitability of a product combining buprenorphine and naloxone for the substitution treatment of patients with opioid addictions at the offices of established doctors. According to Jagsch et al. (2013), the retention rate for this combination product is similar to other substances: after 6 and 12 months of treatment in outpatient settings, the retention rates were approximately 57% and 46%, respectively. Other parameters considered include the patients' satisfaction with the treatment (around two out of three said they were satisfied or very satisfied), and the doses administered. It is pointed out that, in contrast to other studies (on buprenorphine and methadone), it became apparent in this survey that patients who needed higher doses in the beginning dropped out significantly more often. This is attributed to a possibly stronger clinical instability on the part of these patients. Apart from doses, the duration of the patients' heroin addiction and young age at first drug use have been described as relevant factors for dropping out of treatment. Jagsch et al. conclude that the combination product of buprenorphine and naloxone is suitable for prescription to patients with opioid addictions who are treated by established doctors.

The retention rates given in the above study are slightly below those calculated for a longer period in the epidemiological report on drugs, which was published last year (GÖG/ÖBIG 2013d): according to this publication, the retention rate after 12 months is 79% in the case of patients taking slow-release morphine. For persons treated with methadone, the calculated retention rate for this period is 59%, and the results for the combination product of buprenorphine and naloxone are at a similar level.

Regarding the prescription of **benzodiazepines** in the context of OST, since 2013 the *I.K.A. interdisciplinary contact point* in Graz (Styria) has tested the implementation of treatment agreements on benzodiazepines, concluded between addicted patients in opiate maintenance therapy on the one hand and the I.K.A. on the other (Ederer, personal communication).

As far as the **organisation and availability of other treatment options, as well as advice and support with regard to addiction** are concerned, differences between individual provinces have become apparent as well. One has to take into account here that inpatient treatment of addiction is available all over Austria, at least in theory (see GÖG/ÖBIG 2012). For an overview of centres specialising in addiction services (excluding centres exclusively oriented towards alcohol addiction) please consult Maps 5.3 and 5.4. 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

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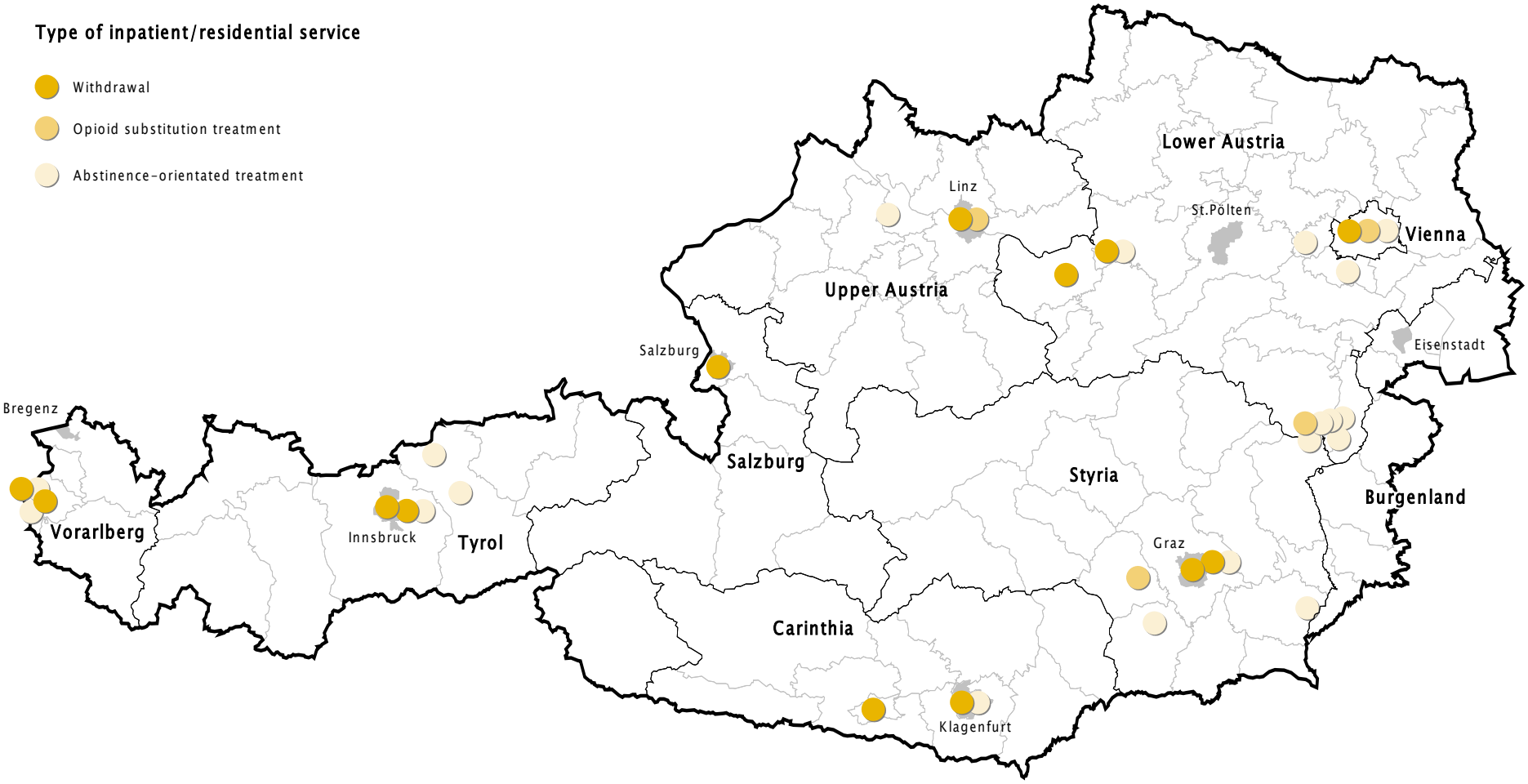
29
The study is a prospective, open-label, multicentric survey conducted at 25 locations (doctors' offices, specialised outpatient clinics and prisons) in Austria. From April 2008 to August 2011, 339 persons were admitted to the study, and on grounds of incomplete data, a total of 307 persons were actually included in the analysis. For every patient, 12 possible surveying dates were scheduled. The clients had either been newly prescribed substitution medicines or had switched to the buprenorphine-and-naloxone combination product.

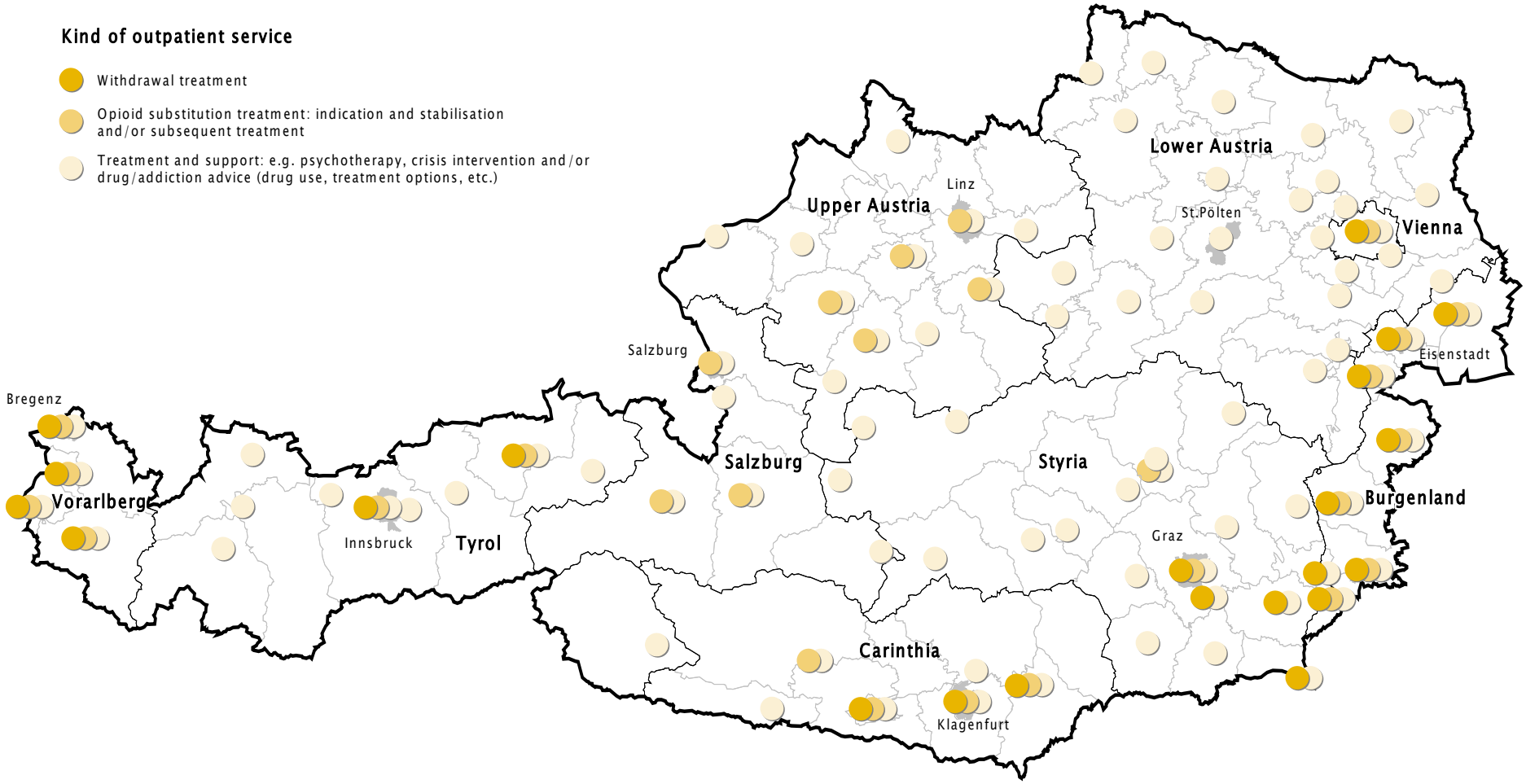
complex. For instance, a number of services providers of the Vienna addiction and drug services network (SDHN) are located outside Vienna. In a number of other provinces, the situation is similar. It should also be taken into account that addicted persons may receive treatment and support services in 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 cities and municipalities where drug services are available.

Map 5.3:
Specialised inpatient/residential treatment services for addiction patients in Austria; in 2014



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 2014



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

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. However, waiting times depend on many different factors (see GÖG/ÖBIG 2012) and may vary greatly. The Lukasfeld treatment unit (Vorarlberg) has reported that the new detoxification department, which is now part of the regular services, has had very positive effects: its capacities are being increasingly used, and the number of patients who complete the regular treatment has also increased in 2013 (Stiftung Maria Ebene 2014).

One challenge has been to document all cases in as much detail as possible, to enable monitoring while ensuring anonymity. Even though Vienna has changed its system to subject-related funding, it is still possible as a rule for clients to get advice, treatment and support without disclosing their identity. The expenses for anonymous services are reimbursed in the context of subject-related funding, with a markup factor on the indirect costs of personalised (i.e. non-anonymous) clients. These services are documented through ad-hoc measures in the Viennese documentation system. Medium- or long-term treatments of anonymous patients with active addictions are primarily delivered at the *jedmayer* centre run by the Vienna Addiction and Drug Coordination.

In the reporting period, the focus was rather on **advancing the existing services** than on developing new, innovative measures. Young people continue to be an important target group that requires specific attention and specific support, even though the available data indicate a decrease in the number of young people with opioid addictions (see section 4.2). Since March 2014, the *JUNO* emergency accommodation centre in Klagenfurt (Carinthia) has run a pilot project that aims to enhance the early detection of severe psychiatric and substance-related disorders in *JUNO's* young clients, to motivate them to start treatment, and thus to prevent subsequent negative effects resulting from high-risk drug use (Prehslauer, personal communication; see also Chapter 7).

With regard to older addiction patients, Vienna has taken steps to enable addiction-related treatment of older patients at home (SDW 2014). In order to avoid confusion regarding competences – especially in the case of multimorbid addiction patients or patients showing signs of premature ageing – clearing talks across different fields of intervention and service providers have been organised.

The Schweizer Haus Hadersdorf (SHH) treatment centre plans to start comprehensive online services, based on the results of a master's thesis (Gegenhuber 2013)[30]. According to Gegenhuber, the existing online services are primarily oriented towards secondary prevention and address young drug users. In the survey, SHH's clients indicated that they were interested in online advice services and would actively use them. What would be important to them is for online services to be available around the clock, for their data to be protected and for the

30
The study comprises a literature review and an internet search on existing online services, as well as interviews with 30 clients of Schweizer Haus Hadersdorf, conducted between 10 February and 15 May 2013.

advisers to be professionals. Other demands include a continuity of advisory services, anonymous advice and having an opportunity to get a personal impression of the adviser. The online support services that SHH plans to offer will thus be oriented towards existing quality standards, and will be linked to a peer support platform run by former clients, with guidance by SHH staff.

The 2014 annual report of the Dialog association (Verein Dialog 2014) underlines the importance of diverse services in order to address specific target groups and to respond to new demands. This includes the established open services such as *Frauensache* [Women's domain] and *Beyond the line*, or the *young people's team of the Gudrunstrasse integrative addiction advisory centre* (including outreach work), and the (new) projects on hepatitis treatment (see Chapter 7), as well as the *psychotherapy group at the Wassermanngasse integrative addiction advisory centre*, which was started in October 2013. The latter addresses socially integrated clients with great willingness to exercise self-reflection, who join the group in addition to individual counselling or following group counselling in the context of withdrawal and treatment. The psychotherapy group provides a protected setting for an exchange among clients. It has a three-trimester structure: after each trimester, clients can leave or join the group. The group shows great diversity with regard to both age and social factors, as well as substance use.

As various reports and the data from treatment and support centres indicate an increase in methamphetamine use in Upper Austria at least (see sections 4.3, 5.3 and 9.2), the question arises whether the relevant support and treatment services should be adapted accordingly. The majority of services – except specialised services for persons addicted to alcohol – are, as a rule, open to users of any psychoactive substances. In the case of methamphetamine users, flexible, uncomplicated, low-threshold approaches seem to be particularly important (Institut Suchtprävention 2013). For example, when incidents of (partly) massive use of mephedrone were recorded in Graz a few years ago, the approaches of the low-threshold services, in particular, were modified to provide appropriate services to these clients (see GÖG/ÖBIG 2011b).

As far as **quality assurance** is concerned, a Viennese working group focusing on mothers and children is worthy of mention: it is preparing quality standards for cooperation when mothers, together with their children, are admitted to opioid substitution treatment at Department 4a of the General Hospital Vienna, in order to ensure adequate support during the inpatient stage, as well as afterwards (SDW 2014). *ANS-Ost*, a working group for the provinces of Burgenland, Lower Austria and Vienna, is drawing up a curriculum for addiction experts and other advisory staff, based on the new guidelines for services for relatives, which were presented at this year's expert meeting (Hörhan, personal communication).

During the reporting period, many **events** were again held to promote the discussion of relevant themes and the exchange among experts. It is not possible to describe them all in the context of the present report. They include annual events such as the substitution forum held at Mondsee (April 2014), the symposium on addiction disease at Grundlsee (March 2014), the annual expert meeting of the *Anton Proksch Institute* on developments regarding treatment goals (January

2014), as well as the 7th Tyrolean addiction conference that took place in Innsbruck (June 2014)[31].

5.3 Access to treatment

5.3.1 Characteristics of treated clients

The client year 2013 is the eighth year for which data of the DOKLI nationwide documentation system of clients of Austrian drug services have been available (see also Table A25 to Table A30). In accordance with the EMCDDA's TDI standard protocol 3.0[32], as of this year, the first treatment episode of the year has been reported rather than the last one, as under the former protocol. This has led to changes in the time series, and comparisons with previous years cannot easily be made.

The drug support and treatment centres in Austria that are covered by the DOKLI system communicated data on a total of 2 976 people who had started **long-term outpatient treatment** in 2013.[33] For 1 549 of them, this was the first drug treatment they had ever had in their lives. 655 clients started long-term **inpatient/residential treatment**, and for 237 of them this was their first long-term drug-related treatment. Apart from these persons undergoing conventional drug-related medical treatment, DOKLI also registered 1 908 people turning to low-threshold services, and 4 684 people requiring drug-related services in the form of **short-term contacts**.

17% of clients receiving long-term outpatient treatment and 9% of clients in inpatient treatment were under 20 years old (low-threshold services: 5%; short-term contacts: 20%). Between 40% (low-threshold services) and 52% (long-term inpatient treatment) of the clients are between 20 and 29 years old (see Figure 5.8 and Table A25).

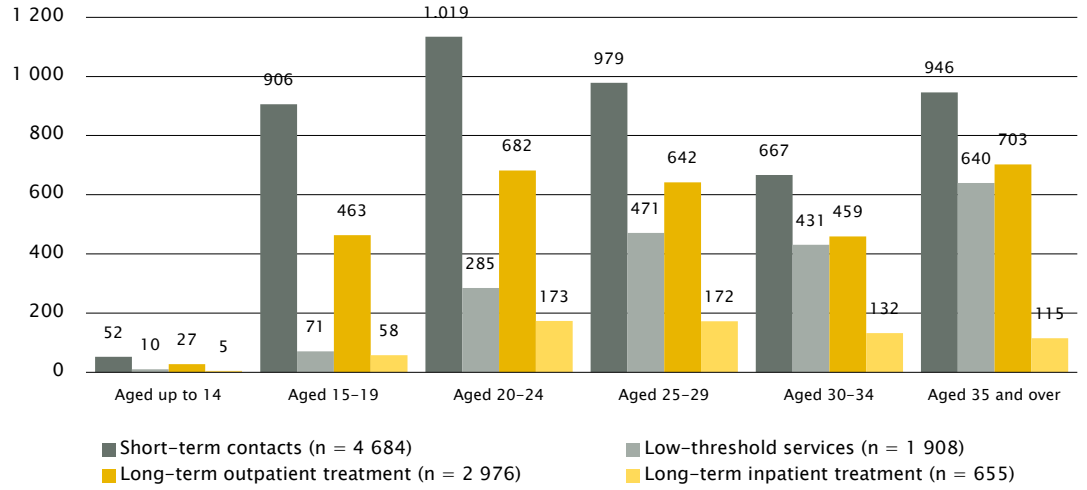
In all settings studied, the percentage of women clients was between 19% and 26%.

31
For further information please visit http://www.kontaktco.at/suchttagung/ (23 June 2014; in German).

32
http://www.emcdda.europa.eu/publications/manuals/tdi-protocol-3.0.

33
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 2013 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 2012). 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 5.8:
Number of persons starting drug-related treatment or service uptake in Austria in 2013; by age and type of service

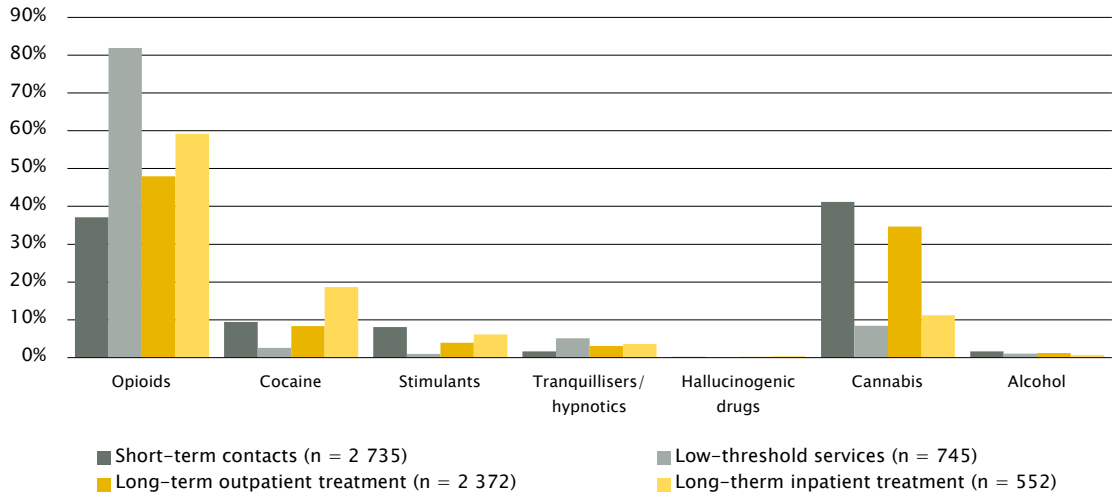


Source: DOKLI analysis of client year 2013; calculation and graphic representation: GÖG/ÖBIG

In the traditional treatment settings (long-term outpatient and inpatient/residential treatment), opioids predominate as primary drugs[34]. Cocaine continues to play an insignificant role in this respect (see Figure 5.9 and Table A29). 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).

34
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 2013d).

Figure 5.9:
Primary drug(s) used by persons starting drug-related treatment or service uptake in Austria in 2013; by type of service



Note: Multiple answers were permitted.

Source: DOKLI analysis of client year 2013; calculation and graphic representation: GÖG/ÖBIG

The proportion of users indicating cannabis as their primary drug is between 8% and 41%, 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 by the health authorities (see also GÖG/ÖBIG 2013d).

In view of information from other drug monitoring sources (see sections 4.3, 9.2 and Table A14), the DOKLI data were analysed in more detail with regard to the use of stimulants (excluding cocaine, MDMA and amphetamine) requiring treatment. For this purpose, all data in the drug categories 'other stimulants' and 'other drugs' were used. Methamphetamine, other stimulants (not specified in more detail) and mephedrone are the stimulants that have been indicated most frequently in the above drug categories (see Table A32).

Table 5.2:
Selected details regarding primary and secondary drugs in the categories 'other stimulants' and 'other drugs' for all 9 043 clients receiving inpatient or outpatient support and treatment in centres covered by DOKLI; in 2013

Province	Methamphetamine			Mephedrone			Other stimulants not specified in more detail**		
	PD*	SD*	T*	PD*	SD*	T*	PD*	SD*	T*
Burgenland	0	0	0	0	0	0	0	1	1
Carinthia	0	11	11	16	78	94	2	3	5
Lower Austria	2	3	5	6	1	7	1	4	5
Upper Austria	40	36	76	0	2	2	5	23	28
Salzburg	3	0	3	0	1	1	0	5	5
Styria	2	6	8	11	22	33	14	9	23
Tyrol	1	6	7	2	12	14	1	4	5
Vorarlberg	1	3	4	0	1	1	0	0	0
Vienna	0	13	13	1	21	22	25	157	182

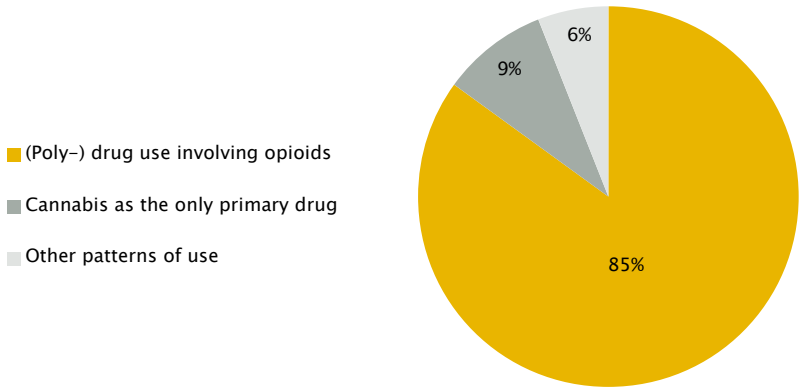
Note:
* PD = primary drug; SD = secondary drug; T = PD + SD total
**Other stimulants not specified in more detail: the category 'other stimulants' has been ticked but no further information on the type of stimulant has been provided. The category 'other stimulants' excludes cocaine, crack cocaine, amphetamine and MDMA.
Multiple answers were permitted.

Source: DOKLI analysis of client year 2013; calculation and graphic representation: GÖG/ÖBIG

Table 5.2 shows that methamphetamine plays a relevant role as a primary or secondary drug almost exclusively in Upper Austria. In sum, 76 persons in Upper Austria (i.e. 9% of all clients taking up services in Upper Austria) indicated methamphetamine as a primary or secondary drug. In Carinthia, 7% of the clients covered by DOKLI said that mephedrone was their primary or secondary drug, compared to 3% of clients in Styria. In view of these figures, local scenes seem to exist with regard to these two substances. The indication of a methamphetamine scene in Upper Austria is confirmed by other drug monitoring data sources as well. The scene seems to consist of more than 100 persons (see sections 4.3, 9.2 and Table A14). In Vienna, too, 7% of clients indicated 'other stimulants' as their primary or secondary drugs. It cannot be specified, however, which specific stimulants they had used.

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 proportion of people undergoing OST are registered in the DOKLI system. According to the 2014 epidemiology report (Busch et al. under preparation), a total of approximately 22 000 persons have received drug-related services in 2013: this figure is an extrapolation taking into account overlapping data of the pseudonymised substitution registry with those of DOKLI, possible double counts in DOKLI and DOKLI's coverage. A proportion of 85% of these clients suffer from (polydrug) addiction disorders involving opioids (see Figure 5.10; Busch et al. under preparation).

Figure 5.10:
Distribution of patterns of use of clients receiving drug-related services in Austria; estimate, in 2013



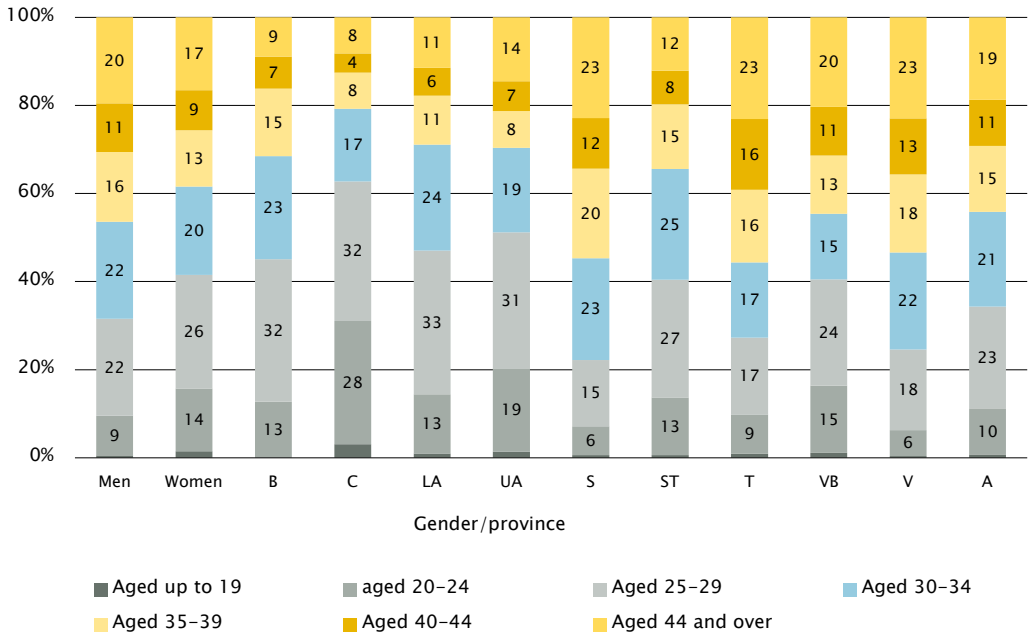
Sources: DOKLI analysis of client year 2013, eSuchtmittel; calculation and graphic representation: GÖG/ÖBIG

Approximately 20% clients in inpatient treatment, and 32% of those undergoing long-term outpatient treatment, are in OST when entering treatment (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 87%.

According to DOKLI, 37% of clients in outpatient settings and 50% of DOKLI clients in inpatient treatment indicate experience of injecting drug use. These percentages have slightly declined in the long term, and they are considerably smaller among clients undergoing long-term drug-related treatment for the first time in their lives (see Busch et al. under preparation). The DOKLI data of 2013 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 16 989 people registered as OST patients in 2013 are men, and 27% are women. The gender ratio is similar among the total 1 061 people registered as entering opioid substitution treatment for the first time in 2013 (76% men, 24% women).

Figure 5.11:
Age structure of clients registered as undergoing opioid substitution treatment in Austria; by gender and province, percentages, in 2013



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

Figure 5.11 shows the age structure of clients registered as undergoing opioid substitution treatment in 2013, by gender and province. Regarding the nationwide situation, 11% of clients undergoing OST are younger than 25, 23% are in the age group from 25 to 29, 36% are aged 30 to 39, and 30% are 40 or older. Female clients tend to be younger than male clients. Differences are also found at the regional level. For instance, in Carinthia 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.

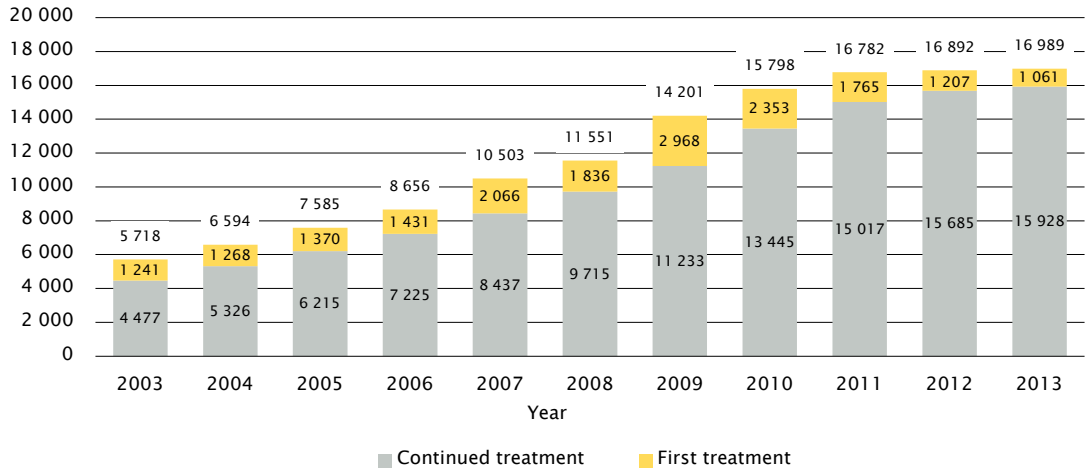
5.3.2 Trends of treated population and treatment provision

As DOKLI has only been available since 2006, few statements on trends can be given (see section 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).[35]

35
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

The growing acceptance of, and readiness to undergo, opioid substitution treatment is reflected in the annually rising number of persons reported as currently receiving OST (see Figure 5.12). The slower increase in persons registered as undergoing opioid substitution treatment is probably due to a saturation effect (i.e. the majority of persons for whom OST is an option have already started treatment). 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 risky patterns of drug use (opioid use) has gone up by only 50% since 1999, and has shown a slight decline in recent years, the number of persons currently in OST is almost five times as high as then (see Figure 5.13). In sum, a proportion of 59% to 61% of the estimated total of 28 000 to 29 000 high-risk opioid users have meanwhile been in opioid substitution treatment, and between 66% and 68% are receiving other types of services (Busch et al. under preparation). This is obviously a very favourable development.

Figure 5.12:
Development of annual reports of the number of persons currently undergoing OST in Austria by first treatment and continued treatment; from 2003 to 2013

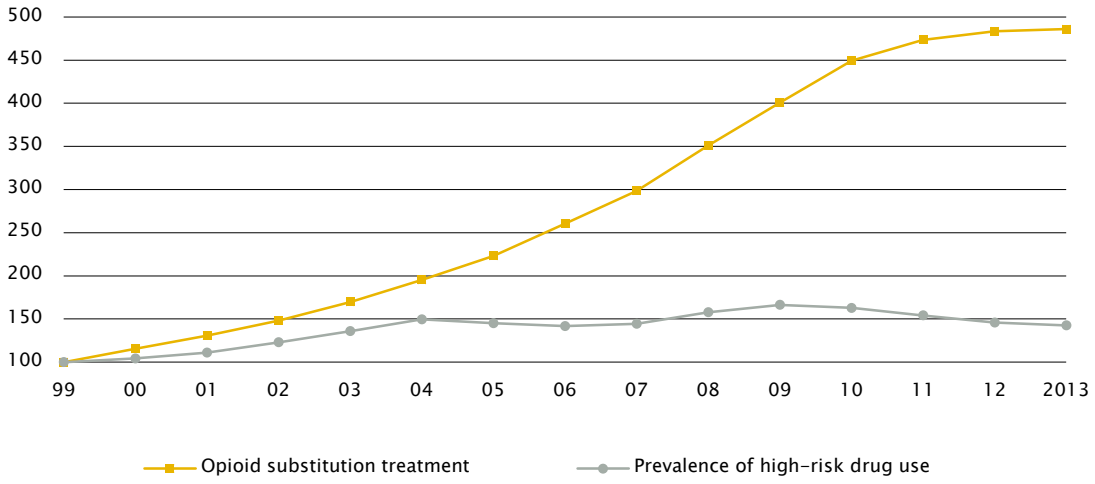


Note: **Continued treatment** means treatment started before the respective year or repeated treatment of persons already having undergone opioid substitution treatment in the past.
First treatment means treatment of persons who have never been in opioid substitution treatment before.

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

implementation of the *eSuchtmittel* data collection system, 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 the context of *eSuchtmittel* have significantly improved the validity of the time series data, particularly with regard to the last few years (elimination of ghost cases; see GÖG/ÖBIG 2013d). 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 5.13:
Developments in the number of persons in opioid substitution treatment and estimated number of high-risk drug users (index – 1999 = 100%)



Sources: 2014 prevalence estimates, GÖG/ÖBIG 2013d, eSuchtmittel; calculation and graphic representation: GÖG/ÖBIG

Section 5.3.1 provides data on persons in OST broken down by age, gender and region, and Table A24 gives figures on reports of OST treatments by province.

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). At present, the most important information on the HIV epidemic in Austria comes from the Austrian HIV cohort study (AHIVCOS), which currently includes data from seven treatment centres. The cohort is assumed to include around two out of three persons with HIV infections currently living in Austria (AHIVCOS 2014).

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 or low-threshold services, as well as the statistics on drug-related deaths. 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 Viennese low-threshold centre *ambulatorium suchthilfe wien*. In both cases, not all clients are tested, and one has to take into account that the motivation for testing depends on the status of infection of the client in question (e.g. a person who already knows that they 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 this group of drug users are likely to have followed high-risk patterns of use. The lack of a reliable monitoring system for drug-related infectious diseases is a considerable shortcoming and makes it very difficult to provide statements on trends.

Psychiatric comorbidity in the context of drug addiction continues to be a focal theme in Austria. Although no routine data have been collected in this field, data and reports from treatment centres are available.

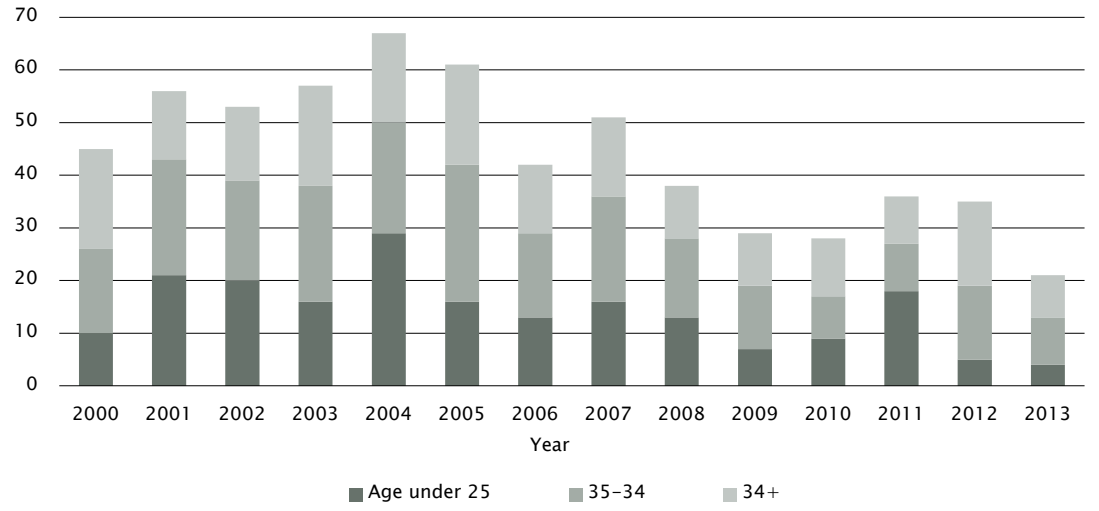
In Austria, the Ministry of Health has been collecting data on drug-related deaths (DRDs) since 1989. In the case of directly drug-related deaths, a causal connection between death and drug use may safely be assumed, i.e. the persons in question died as a result of acute drug poisoning (overdoses). Data 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 (2013: 0% to 11%; see Table 6.1), with the largest numbers recorded among drug-related deaths. Here, slightly elevated figures have repeatedly been registered in recent years (e.g. 2012: 5% to 12%; see GÖG/ÖBIG 2013c). 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[36] has gone down in recent years. However, in 2011 we see an increase for the first time since 2007, especially in the group aged under 25. As of 2012, the figures have not continued to rise, and in 2013 a marked decline has been recorded.

36
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 January 2014, a total of 7 919 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 2 000 people are estimated to have HIV infections that have not been diagnosed. The cohort thus includes around two out of three people with HIV infections in Austria. The study analyses both the most likely mode of transmission and the sociodemographic characteristics of clients, and numerous medical parameters (AHIVCOS 2014).

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

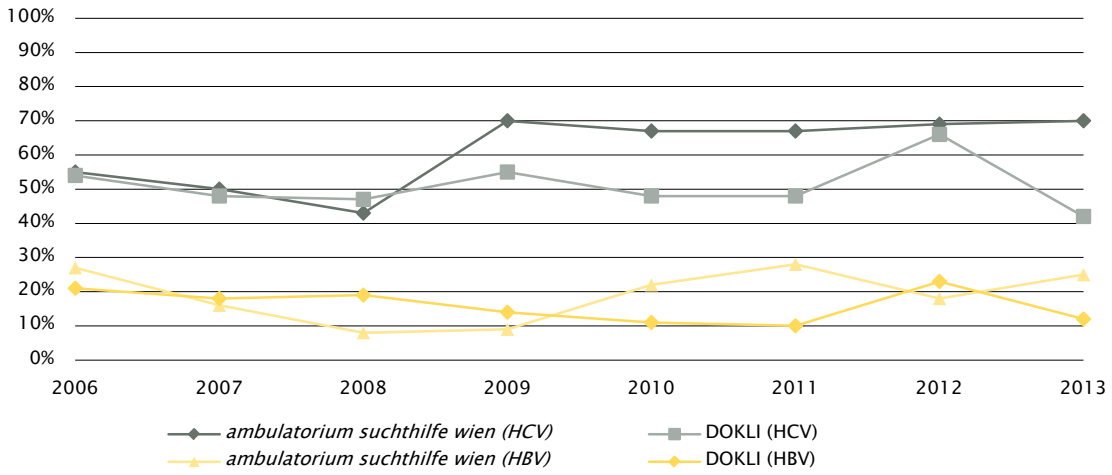


Sources: AHIVCOS 2014 and Zangerle, personal communication; calculation and graphic representation: GÖG/ÖBIG

In the available sources of data, the hepatitis B prevalence rates range from 5% to 25% 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 over 50% for several years in the past. It lay between 20% and 69% in 2012, and between 13% and 70% in 2013. 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, it would be very important to improve the national monitoring routines (e.g. conducting a representative seroprevalence study).

Figure 6.2:
HCV and HBV infection rates covered by DOKLI and the Vienna *ambulatorium* (former *ganslwirt* data), from 2006 to 2013



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

Source: ST9; calculation and 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 (e.g. Marienambulanz: 65%, Vienna *ambulatorium:* 61%).

Table 6.1:
Data on hepatitis B, hepatitis C-Ab and HIV infection rates among injecting drug users in Austria; in 2013

Source of data	HBV rate	HCV-Ab rate	HIV rate
Lukasfeld treatment unit	5% (5/100)[1]	67% (67/100)	1% (1/100)
Vienna ambulatorium	25% (34/139)[2]	70% (119/171)	1% (1/145)
Caritas Marienambulanz	8% (8/85)[3]	67% (57/85)	0% (0/85)
DOKLI	12% (5/43)	42% (19/45)	0% (0/44)
Drug-related deaths (poisoning) in 2013	not available	13% (15/119)[4] 31% (15/48)[4]	4% (5/119)[4] 11% (5/47)[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. Persons who tested positive only for anti-HBVs were not counted because this results from HBV vaccination.
4 Out of a total number of 119 forensic reports on directly drug-related deaths, only 47 and 48, 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

The reports on the long-term national statistics on AIDS diseases show that injecting drug use ranks second regarding risk situations (10 cases, i.e. 29%), after heterosexual contacts (n = 14; homosexual contacts: n = 9) (BMG 2014; see Table A8). Data on other drug-related infections are available only for tuberculosis (TB). Only one of the 108 persons for whom tuberculosis entries exist in the corresponding DOKLI data set (see Section 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 327 people. The data of the reporting year again confirm the small vaccination coverage for TB (1%; Busch et al. under preparation).

The DOKLI data set on hepatitis A vaccinations includes 435 people, and regarding hepatitis B vaccinations, 433 people. The **vaccination coverage** of 25% for hepatitis A and 26% 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 (Busch et al. under preparation)[37]. 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 on problems addressed in advice sessions at the Vienna *ambulatorium*, the issue of mental distress was raised in 28% out of a total of 6 672 talks, and physical problems were discussed in 29% of cases (SHW 2014b; see Chapter 9). In Vienna, mental or physical health was discussed in approximately one third of *streetwork's* advice and support sessions (SHW 2014c).

Apart from psychiatric comorbidity and the health consequences of the infectious diseases 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 organ damage among drug users (Busch et al. under preparation).

37
Hepatitis B vaccination has been included in the children's vaccination schedule since 1998.

In the majority of indirectly drug-related deaths[38] (52 persons), the cause of death was a disease such as myocarditis, cirrhosis (mostly resulting from hepatitis C) or cancer. One person died of AIDS. In 14 cases, other causes of death were recorded (e.g. suicides or accidents).

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.

6.4 Drug-related deaths and mortality of drug users

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.

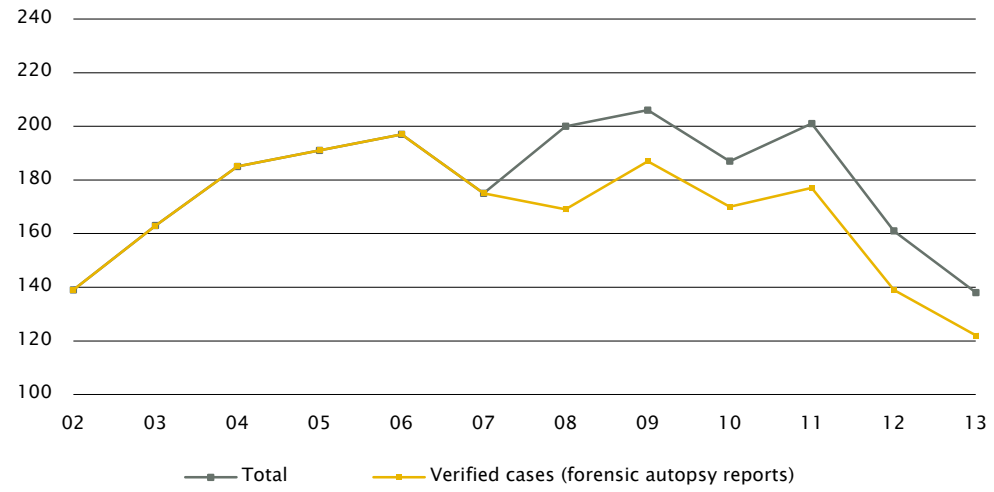
The classification of causes of death is based on the results of (forensic) autopsies including chemical/toxicological testing. In cases in which no autopsies have been carried out, a list compiled by Statistics Austria on cases recorded as drug deaths in the general cause-of-death statistics, as well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

In 2013, a total of 122 fatal overdoses were verified in the context of autopsies. An additional 16 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 after external post-mortem examination)[39]. A total number of 138 deaths directly related to overdoses is therefore assumed for 2013. A decline in drug-related deaths has become apparent in recent years (see Figure 6 3). Figures for individual provinces and age groups are given in Tables A3 to A7.

38
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).

39
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).

Figure 6.3:
Directly drug-related deaths in Austria, verified by forensic autopsy reports; total figures from 2002 to 2013



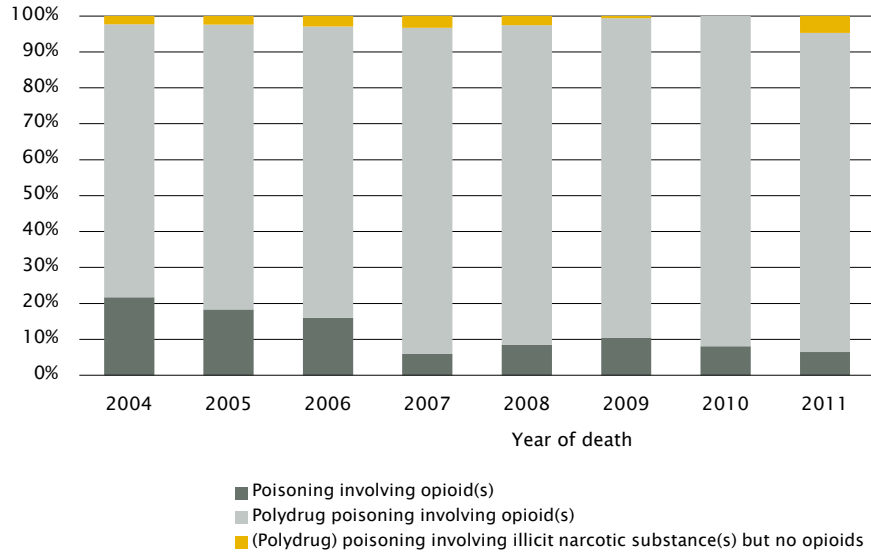
Source: statistics on drug-related deaths; graphic representation: GÖG/ÖBIG

In 13% 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 61% of cases, psychopharmaceuticals were detected as well, in 6% alcohol was found in addition to illicit drugs, and in 20%, both substances, i.e. alcohol as well as psychopharmaceuticals. As in previous years, fatal polydrug overdoses involving opioids clearly predominate (see Figure 6.4). Patterns of polydrug 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.

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 the presence of 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 eight 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 seven in a total of 78 cases relating to morphine poisoning have been attributed to exclusive morphine use (without the involvement of any other narcotic drugs, alcohol or psychopharmaceuticals).

In 2013 no death due to NPS use without narcotic drugs involved was recorded. In three cases, the blood tests revealed NPS (GBL or MDPV, 4-fluoroamphetamine) combined with narcotic drugs (methamphetamine, morphine).

Figure 6.4:
Percentage of directly drug-related deaths in Austria; by cause of death; from 2004 to 2013



Source: statistics on drug-related deaths; graphic representation: GÖG/ÖBIG

The grouped median[40] of the age at death was 29[41] years in 2013, i.e. at a level similar to previous years (2010: 29; 2011: 30; 2012: 30). The proportion of persons aged under 20 was 5%[42], which is slightly below the percentages for the past 10 years (2010: 7%; 2011: 13%; 2012: 7%; 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[43], which corresponds to the long-term average.

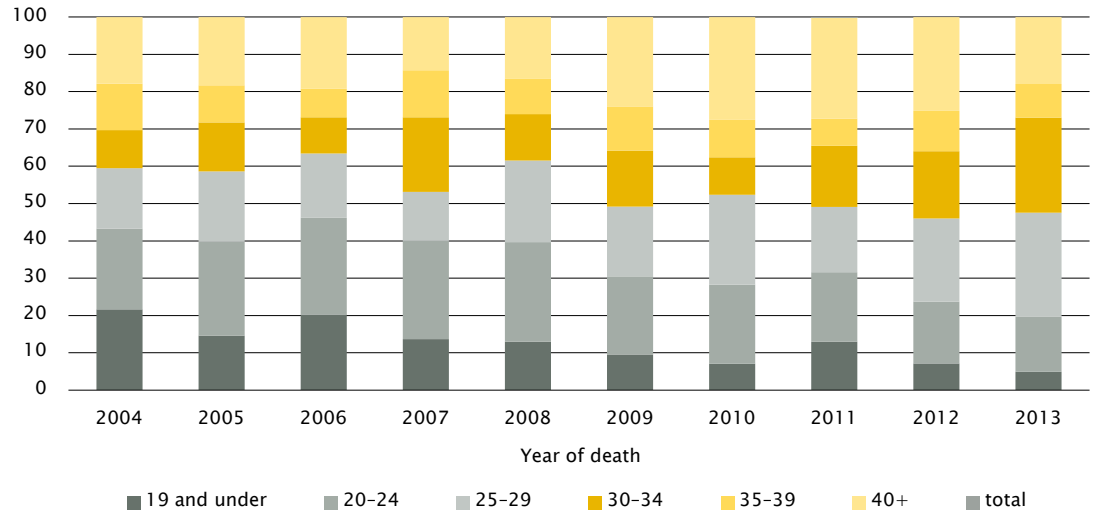
40
Grouped median means that 50% of cases lie above this figure and 50% is below this figure.

41
If the drug-related deaths for which no autopsies were performed are included, the median age is 30.

42
If the drug-related deaths for which no autopsies were performed are included, the corresponding proportion is 4%.

43
If the drug-related deaths for which no autopsies were performed are included, the corresponding proportion is 18%.

Figure 6.5:
Age distribution of verified directly drug-related deaths in Austria; percentages, from 2004 to 2013



Source: statistics on drug-related deaths; graphic representation: GÖG/ÖBIG

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 general practitioners/medical 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 (see also SQ 23/29). For an overview of the locations of specialised harm reduction services for drug users in Austria, broken down by municipality, see Map 7.1.

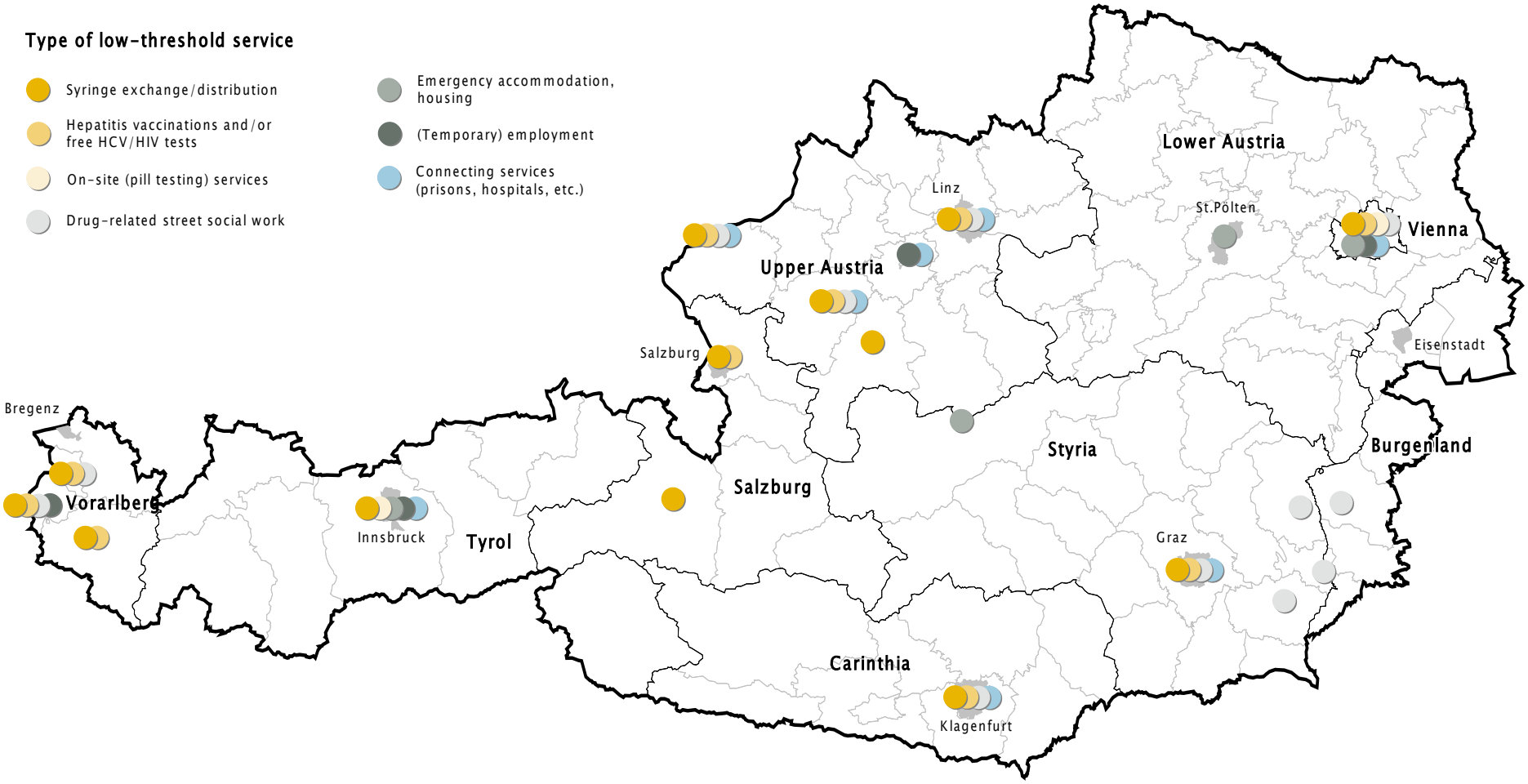
7.2 Prevention of drug-related emergencies and reduction of drug-related deaths

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 GÖG 2013c).

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 2014g). Specific first-aid courses for drug users and staff of drug assistance services have again been organised in low-threshold centres (see SQ 23/29). Data on drug-induced emergency admissions to hospital are not available for Austria.

Naloxone is a prescription-only substance in Austria, and is only dispensed through doctors, and it is part of the standard equipment of emergency physicians and ambulances. It is not directly dispensed to drug users in emergencies involving overdoses, however. The use of naloxone in low-threshold support services was discussed at a REITOX Academy organised by GÖG in December 2013. After an introductory presentation of Denmark's naloxone project and a

Map 7.1:
Specialised low-threshold harm reduction services for drug users in Austria; in 2014



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

comprehensive review drawn up by GÖG (GÖG/ÖBIG 2013b), the participants – mainly doctors, social workers in low-threshold services, as well as representatives of the Ministry of Health and several Provinces – discussed this approach on reducing drug-related deaths.

A study on the administration of buprenorphine combined with naloxone in the context of opioid substitution treatment (see section 5.2) concludes that this combination can contribute to treatment safety, particularly in low-threshold settings. In open treatment settings, injecting use is likely to be more frequent, and adding naloxone can prevent overdoses (Jagsch et al. 2013).

Drug checking, for instance the services offered by *checkit!* in Vienna, continues to be important for **preventing and reducing emergencies in party settings.** In 2013, a total of 1 022 samples were analysed. 19% of the samples contained especially hazardous ingredients or combinations of substances so that users had to be warned. In the context of the European Union's NEWIP project, *checkit!* cooperated with other European party projects to build a comprehensive database for the findings of the drug analyses[44] (see section 10.4; SHW 2014d). *In January 2014 MDA basecamp* started a pilot project funded by the Province of Tyrol, in cooperation with the Innsbruck Department of Forensic Medicine. In addition to advisory services at events (2013: 21 events with a total of 2 876 contacts), drug-testing is now offered at the headquarters as well (MDA basecamp 2014). Both services report their results to the *Austrian information and early warning system on specific health hazards in the context of illicit substance use*.

Drug consumption rooms continue to be discussed among experts and by the media in Austria. In a study on harm reduction interventions in support and treatment services conducted on behalf of the European Commission, drug consumption rooms are recommended as a relevant intervention (see GÖG/ÖBIG 2013a).

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 rates for used syringes are very high (97%) (see Caritas Diözese Graz-Seckau 2014b). In addition to syringe exchange, it is possible to buy syringe sets at vending machines in five provinces. The sets also include accessories such as alcohol pads, as well as information on safer use (see Figure 7.1 and Figure 7.2, as well as Table A31).

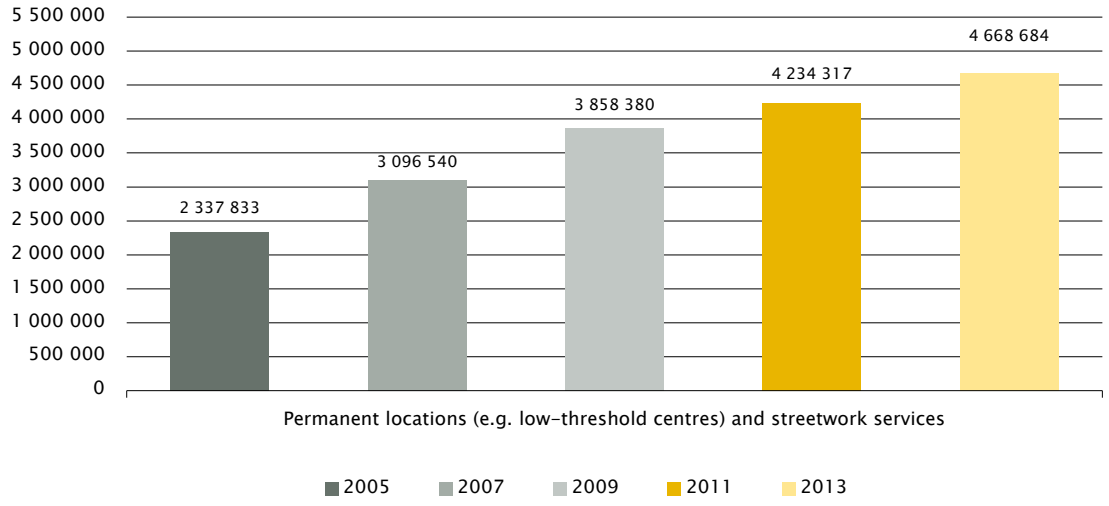
In addition to the established programmes for the exchange and sale of syringes that are run at the provincial level, in Austria it is also possible to buy syringes and needles at pharmacies.

44
http://www.safernightlife.org/newip-news (3 July 2014)

The number of syringes that have been returned or sold in the individual provinces has further risen. In 2013 a total of 4 762 999 syringes or needles were issued to drug users throughout Austria (2012: 4 625 121). Assuming that there are between 11 000 and 15 000 injecting drug users in Austria, an average of approximately 360 sterile syringes per year have been issued per injecting drug user in the context of syringe exchange. Austria thus continues to rank top in Europe and also meets the goal defined by the WHO to a great extent[45] (see GÖG/ÖBIG 2013a). The number of permanent locations where syringes can be exchanged or bought has not changed. In Carinthia, one streetwork service is no longer available, whereas in Upper Austria an additional syringe vending machine was installed in the reporting period (see Table A31 and ST10).

In 2013, Vienna recorded 210 021 contacts with clients in the context of syringe exchange. Even though this represents an increase as against the previous two years, it is lower than the figures for the period from 2007 to 2009 (245 000 to 279 000 contacts). The number of syringes that were exchanged in the reporting period has also gone up slightly (2012: 2 924 487; 2013: 2 940 457) (see SHW 2014a; Table A31). The *streetwork* service at Karlsplatz in Vienna only dispenses emergency syringe sets. In 2013, a daily average of 24 emergency sets were provided (2012: 54), and 13 sets were issued on an average day in the context of street social work (2012: 10) (SHW 2014a, SHW 2014c).

Figure 7.1:
Number of syringes exchanged and sold in Austria – permanent locations and streetwork



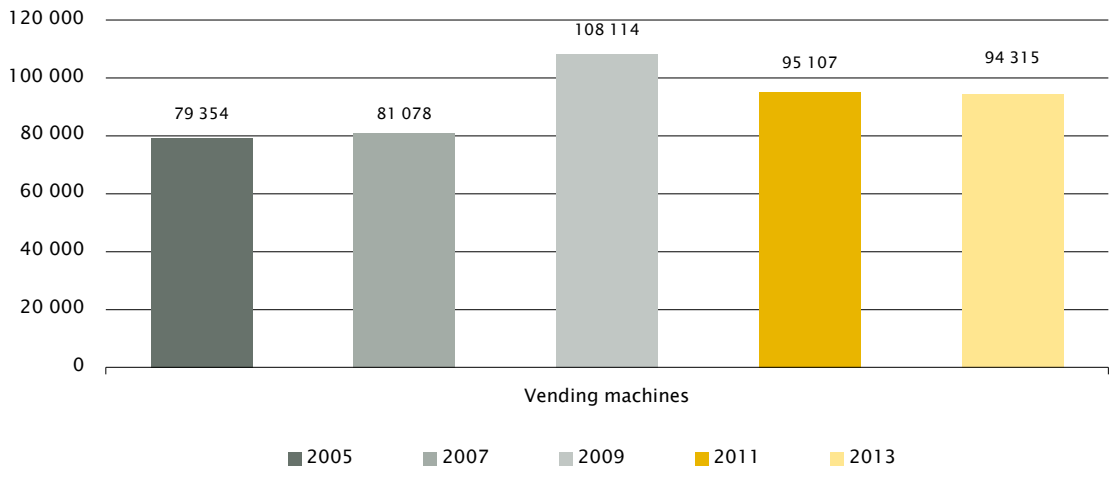
Source: Standard Table 10; calculation and graphic representation: GÖG/ÖBIG

45
Low = ≤100 per IDU/year; medium = >100-≤200; high = >200. These figures relate to the prevention of HIV infections. For preventing HCV, a higher number of syringes/IDU/year is assumed.

Figure 7.1 shows that the figures have risen particularly with regard to syringe exchange in low-threshold centres, including streetwork services. In 2013, 4 668 684 syringes were issued in this context. On the other hand, the number of sets bought at vending machines has decreased slightly, as is apparent in Figure 7.2. A general interpretation of this decline cannot be given as not all services have provided data for the reporting year (2013: 13/19; 2012: 17/18). The relevance, particularly for the prevention of HCV infections, of providing injection accessories in addition to exchanging syringes is underlined in the ECDC/EMCDDA recommendations (ECDC 2011). In Austria, the number and type of accessories issued is not recorded systematically.

Graz reports a downward trend in sales of syringe sets at the two prevention vending machines (2011: 25 972; 2012: 23 756; 2013: 21 168), whereas the number of sets exchanged at *Kontaktladen* has continued to increase. A shift towards the *Kontaktladen* centre is apparent (see ST10, Table A31). Here, users can also exchange specific injection paraphernalia such as spoons (n = 3 296). Since October it has also been possible to exchange microfilters in order to adequately filter the substances each time before use. During the first three months, as many as 2 343 filters were exchanged (Diözese Graz-Seckau 2014b).

Figure 7.2:
Number of syringes exchanged and sold in Austria – vending machines



Source: Standard Table 10; calculation and graphic representation: GÖG/ÖBIG

Syringes sold to drug users by pharmacies are not documented systematically, therefore no figures can be given (see ST10).

Safer use and **safer sex** continue to be relevant aspects of low-threshold services, which are often, though not exclusively, combined with syringe exchange opportunities. In Vienna, the *jedmayer* centre offers safer-use advice in the context of syringe exchange 365 days a year, around the clock. Several low threshold services also organised safer-use training for users as well as staff of addiction services (see SHW 2014b; SHW 2014c). Furthermore, many low-

threshold centres issue condoms as part of their regular services (e.g. Institut Suchtprävention 2014). Safer use, safer sex, preventing infections, and 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.

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 low-threshold centres. In particular, Vienna and Graz have endeavoured in recent years to offer comprehensive hepatitis treatment services to drug users. After free HIV and viral hepatitis testing, low-threshold access to **treatment of hepatitis infections** is offered in close cooperation with hospitals.

In April 2013 the Vienna *ambulatorium* started to establish a hepatitis outpatient clinic. In close cooperation with the 4th Medical Department of the Vienna Wilhelminen Hospital, patients diagnosed with HCV or HBV are offered further examination and treatment at the *ambulatorium* (SDW 2014; SHW 2014g). Since 2012, hepatitis treatment has also been offered by the Dialog association (Verein Dialog 2014). The two services were presented at the 17th substitution forum held by the Austrian Society of Pharmacologically Assisted Treatment of Addiction (ÖGABS; see Chapter 4)[46]. An aspect underlined in this context is that it is difficult for drug-using patients to undergo the current standard treatment, with regard to compliance and complications (e.g. cirrhosis). The new HCV medicines can be of great benefit specifically to this group of patients, as hardly any side effects and contraindications or interactions have been recorded, and the curing rate is at almost 100% (Gschwantler 2014).

Hepatitis consulting hours have been a regular service of the *Kontaktladen* centre for many years. As of autumn 2013, a free shuttle service from the Graz Kontaktladen to the Hörgas-Enzenbach Provincial Hospital has been organised every two weeks in order to make it easier for clients to have further examinations carried out, or to start HCV treatment (Caritas Diözese Graz Seckau 2014b).

According to the current report of the Austrian HIV/AIDS cohort study (see section 6.2), 4 260 persons testing positive for HIV (with 619 indicating transmission due to IDU) had contacted a treatment centre in the previous 12 months (follow-up). Even though persons (particularly women) whose HIV infections result from injecting drug use do not have an elevated risk for a HIV diagnosis at a later point in time, the risk for treatment drop-out is higher in this group (AHIVCOS 2014).

46
http://www.oegabs.at/17_substitutionsforum.php (3 July 2014; 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 2013c). Psychiatric comorbidity was the main subject of the focus group on risky drug use among young people, which GÖG had organised for already the second time (see section 5.2). In the discussion, the experts agreed that good networks and cooperation among the providers of specific services, as well as other relevant settings (such as schools or youth work in recreational settings) are of key relevance for addressing this target group, which cannot easily be reached. The well-established services for young people offered by Dialog (Vienna) were presented (CORE 2011; see GÖG/ÖBIG 2012), as well as the pilot project started in March 2014 for a youth psychiatric contact point at an emergency accommodation in Klagenfurt (Carinthia). The goal here is to close the supply gap regarding early detection and early intervention in response to severe psychiatric and substance-associated disorders among young people, as well as to increase motivation to start treatment among young people (aged up to 21) with risky patterns of use. Having health insurance is no prerequisite for service uptake. The pilot project corresponds to the recommendations for interventions listed in the national child and youth psychiatry strategy (goal 15) to improve the supply of child and youth psychiatry services in Austria (see BMG 2013). The staff of the service providers concerned can also attend further training programmes on the identification of disorders in the field of child and youth psychiatry (see Drogenkoordination des Landes Kärnten 2014; Wladika 2014).

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 2014b, Caritas Tirol 2014; see section 6.3). For instance, *streetwork* (Vienna) recorded a total of 1 783 advice and support sessions, with the issue of (physical and mental) health addressed in more than 30% of talks (see SHW 2014c; section 9.3).

In addition to the long-standing *marienambulanz* centre run by Caritas of the Diocese of Graz-Seckau (Styria), low-threshold medical services have been made available in Innsbruck as well. *Medcare* is a cooperation project of Caritas and Red Cross in Tyrol focusing on persons without health insurance, who can thus get access to basic health-care services provided at the centre, as well as in a mobile setting through a bus[47] (Gstrein, personal communication). Both services are frequented by drug users, primarily from the street scene.

Women continue to be a relevant target group of services addressing drug users. The majority of centres have separate opening hours for women, and/or separate rooms for women, which has

47 http://www.roteskreuz.at/nocache/berichten/news/datum/2013/11/18/medcare-ein-projekt-von-caritas-und-rotem-kreuz/ (23 July 2014; in German).

constantly met with acceptance. The focuses of **services specifically for women** are on social work interventions and exchange of experience with other women. Several low-threshold centres also offer gynaecological treatment: the most recent development here is the new gynaecological outpatient clinic at the Vienna *ambulatorium*. The themes addressed include safer use and safer work, motherhood as well as custody problems, experience of violence and eating disorders; and in the context of medical care, basic gynaecological examinations, birth control and pregnancy tests (see, e.g. Verein Dialog 2014, SHW 2014c, Caritas Diözese Graz-Seckau 2014, Caritas Tirol 2014).

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 cities and municipalities where the relevant services are available.

As in previous years, the most pressing social problems of drug users (particularly heavily addicted persons from the street scene) continue to be homelessness, unemployment and debt.

Interventions aimed at the social (re-)integration of (formerly) addicted persons address clients after abstinence-based treatment on the one hand and current drug users on the other. 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 persons may also take part in a range of other services that focus on unemployment, homelessness and recreational 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, one should by no means conclude from this that drug problems mainly arise among socially disadvantaged people. All it shows is that this group will more readily turn to the drug support and treatment system than people who (still) have their own social and financial resources (see section 5.3).

In 2013, according to Statistics Austria[48] around 215 000 persons were out of work in Austria (according to the international definition), which corresponds to an increase of 26 100 persons compared to the previous year, and an unemployment rate of 4.7%. The groups that are particularly affected are people with non-Austrian nationality, people with disabilities, older people and

48
http://www.statistik.at/web_de/statistiken/arbeitsmarkt/arbeitslose_arbeitssuchende/index.html (16 July 2014; in German).

young people under 25. The educational level of almost half of the unemployed does not go beyond compulsory school, and less than one third of them have completed apprenticeship[49].

If these figures are compared to the figures of the DOKLI client year 2013 (see section 5.3), it becomes apparent that the percentage of employed persons continues to be the lowest among clients receiving inpatient treatment (4%). Particularly among clients of long-term outpatient services, the percentage of women who have jobs is significantly smaller compared to men (women: 22%; men: 35%; see Table A26). In the client year 2013, only 61% 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 Busch et al. under preparation and Table A28).

In 2012, 1.2 million people living in Austria were facing poverty risks – with a rising trend – with low-income households by now having to spend as much as half of their income on housing (Verband Wiener Wohnungslosen 2014). No more recent figures on homelessness in Austria than those presented in last year's report have been made available (see GÖG/Österreich 2013c).

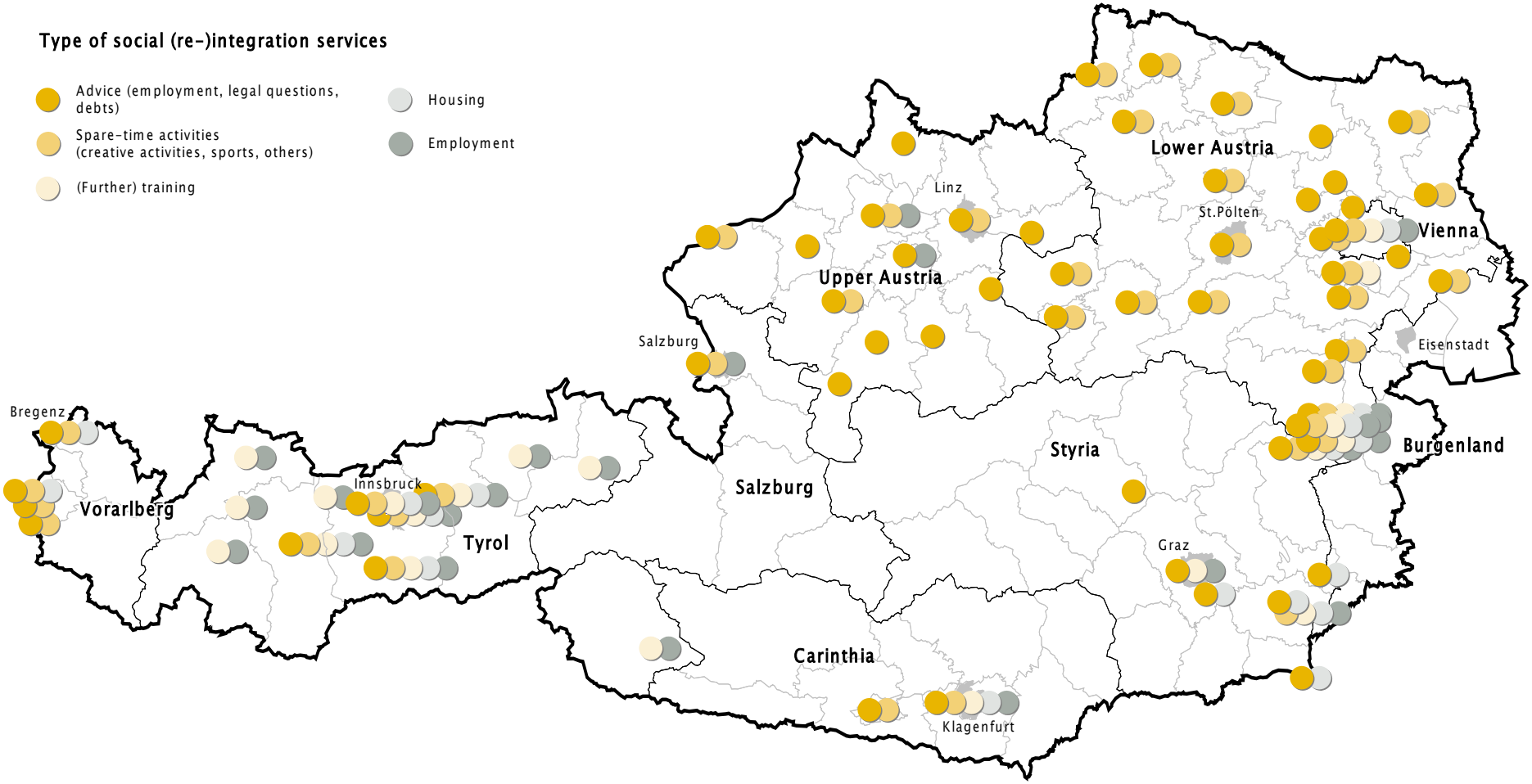
The replacement of the welfare assistance system by the means-tested minimum income scheme has had great influence on the financial situation of recipients, which could also be relevant for addicted persons (see GÖG/ÖBIG 2012, GÖG/ÖBIG 2013c). No detailed data are available on this aspect.

8.3 Social reintegration

Services aimed at social re-)integration are delivered in the areas of employment and training, housing and recreational 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.

49
http://www.ams.at/ueber-ams/medien/arbeitsmarktdaten/berichte-auswertungen (16 July 2014; in German)

Map 8.1:
Specialised providers of outpatient and inpatient drug support services focusing on social (re-)integration in Austria; in 2014



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

In view of the forthcoming changes in the ill-health pensions system[50] and the resulting changes in funding by the Public Employment Service and the pension insurance fund, Vienna started to adapt all active employment policy measures addressing addicted persons accordingly (SDW 2014).

Vienna's 2013 addiction and drug strategy (SDW 2013; see section 1.3) points out that persons with addictions can only be (re-)integrated into the labour market if their individual needs and demands are taken into account, in order to achieve positive effects on the development of their disease. Persons who cannot (yet) be integrated into the regular labour market shall have an opportunity to find temporary employment in a protective setting, e.g. social firms (SDW 2013). *fix und fertig*, a social firm owned by Suchthilfe Wien [Vienna Addiction Services] is among those social firms that have continued to be operated in 2013 (see GÖG/ÖBIG 2012, GÖG/ÖBIG 2013c). However, whereas the last few years have not seen any cases of drop-out, in 2013 one third of the temporary workers terminated their employment, and thus the reintegration phase, prematurely. This is in line with the general down-levelling development in the Viennese labour market. In 2013, due to the tight labour market, it has for the first time not been possible to refer clients to the non-subsidised labour market, even though 54% of the clients met the 'job-ready'[51] benchmark (SHW 2014f).

In the context of 'single-caseworker support', the clients at *jedmayer* (owned by Suchthilfe Wien) can take specific steps towards social integration. They receive assistance, e.g. with regard to obtaining health insurance, referral to treatment places and housing, as well as checking eligibility for financial support and contacting local authorities. Furthermore, job prospects and/or a satisfying daily structure, recreational activities and a stable social environment are developed. In 2013, this form of support was provided to approximately 300 persons (SHW 2014b).

Since 2010 the *TALON*[52] project funded by the European Social Fund (ESF) and the Province of Upper Austria and run by the FAB Association for the Promotion of Work and Employment, has become part of the regular services provided in the context of drug support and treatment in and around Wels, Upper Austria. The main goal of the employment project is to provide support to young people and young adults aged between 16 and 25 who are in active addiction. The project is open to addicted young people released from prison as well. Participation in the

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50
Persons aged under 50 on 1 January 2014 are ineligible for ill-health pensions or inability-to-work pensions unless permanent ill health or permanent inability to work are diagnosed. In the case of temporary ill health or inability to work, rehabilitation benefits or retraining benefits are granted. Persons who are eligible for, and receive, rehabilitation benefits and whose income from work is above the minor-employment limit have health insurance and pension insurance on the basis of partial social insurance. Persons undergoing retraining are integrated into the compulsory pension insurance system. This also applies to recipients of retraining benefits.
(https://www.help.gv.at/Portal.Node/hlpd/public/content/340/Seite.34060808.html; 21 July 2014; in German)

51
'Job-ready' means that the client is, in principle, able to hold a job.

52
http://www.drogensubstitution.at/index.php?id=510 (17 July 2014; in German)

project is voluntary, and regular attendance is not obligatory. Persons who, due to a court order, have to undergo 'treatment instead of punishment' (see section 9.4) can also join the project to fill in the waiting time between the court sentence and the start of treatment. *TALON*'s goal is not to integrate clients into the labour market at quickly as possible: the primary aim rather is to help them regain mental and physical health and to offer appropriate activities and tasks to this end. The focus is on enhancing life skills and reducing stress. From Monday to Thursday, 12 places are available for a maximum of three hours a day. The clients' wages are paid daily. In the production area, trash-design products are made, and sold in *TALON*'s own shop. The work that the clients do ranges from easy assignments for persons who are using the daily structure offered to test their stress tolerance at work, to tasks that require craft skills and high levels of concentration, as well as stamina. In 2013, 53 persons took part in *TALON* (20 women and 33 men). Some of them were subsequently able to find employment (apprenticeship) in the regular labour market again or decided to enter opioid substitution treatment or withdrawal treatment. For five homeless young people, housing was found. (Schröder 2014).

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. The services described in prior reports have been continued (some of them in a modified way or at other locations, however, e.g. *jedmayer*) (see GÖG/ÖBIG 2010a, GÖG/ÖBIG 2011b, GÖG/ÖBIG 2012, GÖG/ÖBIG 2013c).

In the Salzburg region of Pinzgau, the new *Landeplatz* [landing pad] accommodation project has been started: the Pimuma private initiative established a mobile emergency sleeping network for young people aged 18 to 22. *Landeplatz* provides free accommodation for one night (and sometimes two nights) to young adults who, for one reason or another, have no place to spend the night. They are served an evening snack and breakfast as well. Those in need of accommodation can either use a phone hotline or go to the police and are then taken to the next *Landeplatz* by taxi. At present, accommodation is provided by 10 voluntary hosts, who are offered reimbursement of their expenses (EUR 35), but most of whom do not take up on the offer. Young people with addiction problems are not turned down, but attempts are made to refer them to the specialised services provided by the district or provincial authorities (Herr, personal communication).

The assisted housing service run by Suchthilfe Wien has been integrated into the service structure of the *jedmayer* social medicine centre. The flats rented by Suchthilfe Wien on the private housing market (for 15 persons) for this purpose were occupied throughout 2013 (SDW 2014).

Many drug and addiction service providers also organise **recreational** activities with low-threshold and one-off events, as well as activities extending over longer periods, and some of them require participants to sign in and sign out. These activities usually focus on sports, art/culture/creativity and sharing experience. 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, GÖG/ÖBIG 2013c). A wide range of recreational activities are organised as an integral part of the services offered.

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 recreational programmes, as well as outdoor activities. In 2013, 34 outdoor recreational activities were organised (e.g. horse-riding or boat trips) for 127 participants. The 30 indoor recreational activities (e.g. creativity workshops, gardening in the yard) at *jedmayer* were attended by 130 persons (SHW 2014c).

The project *LOGINCLUSION*[53] is based on experience gathered in the *LOGIN* project (see GÖG/ÖBIG 2010a) and is aimed at addressing people through meaningful recreational activities and at contributing to the building of stable social networks. Its target group includes people looking for work, as well as people in unstable jobs who are facing poverty risks or who are living in poverty. Another target group is people in qualification programmes organised by the Public Employment Service or in social firms. *LOGINCLUSION* organises more than 15 regular sports and exercise activities, as well as cultural and creativity opportunities every week, it runs an internet café; and in addition, sports and recreational events in public parks in and around Vienna take place several times a year. Every week the events are attended by around 80 persons on average, and since the start of the project in July 2011, *LOGINCLUSION* has registered more than 300 participants.

During the Tyrolean addiction conference in June 2013, a workshop on experience-based group work with young drug users was held. Its goal was to present and communicate the fundamentals of experience-based approaches using the proven programme of the *Walk About* service as an example (see GÖG/ÖBIG 2013c). The workshop was also aimed at discussing appropriate implementation strategies for experience-based approaches (Drogenberatung Z6 2014).

53
http://www.sozialmarie.org/projekte/loginclusion_-_gesundheitsforderung_bei_arbeitslosigkeit_armut_und_isolation.2710.html (21 July 2014; in German)

http://www.sozialmarie.org/projekte/loginclusion__begegnung_in_bewegung.2222.html (21 July 2014; in German)

http://www.wig.or.at/LOGINCLUSION.181.0.html (21 July 2014; 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 publications, the annual reports of drug support and treatment services and information by the Addiction and Drug Coordination Offices in the provinces. 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 violation 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. In 2012, data on violation of the Act on *New Psychotropic Substances* were made available for the first time.

As explained in previous years and underlined by the Federal Ministry of the Interior (BMI 2014), the statistics on reports to the police primarily reflect the intensity and focuses of police activities in this field.

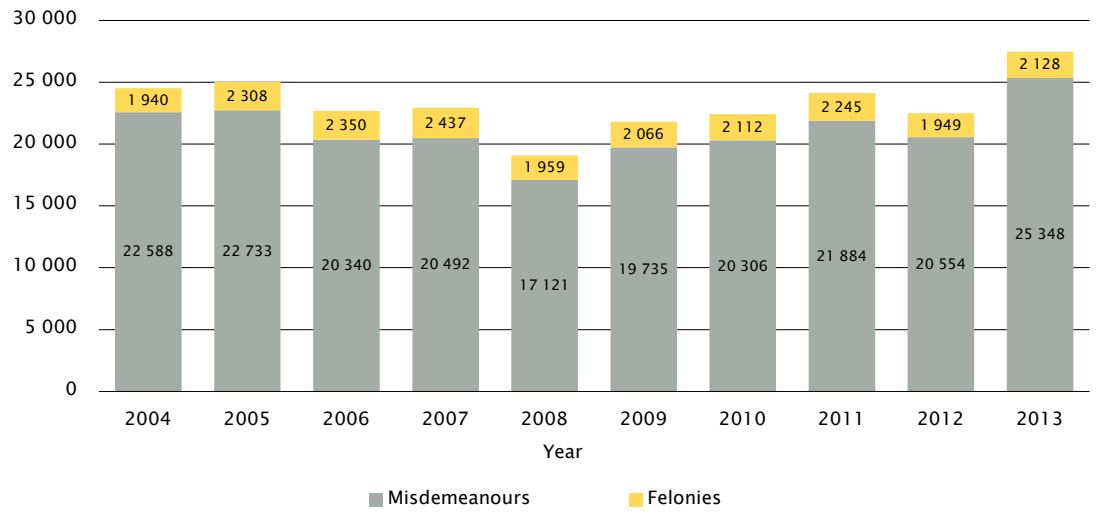
Compared to previous years, 2013 saw a massive increase in reports to the police relating to violation of the Narcotic Substances Act; in fact, a 10-year peak has been reached. The majority of reports concerns cannabis. According to the Ministry of the Interior, the disproportionately high increase in cannabis seizures results from a small number of large seizures. Another reason for the increase in the number of seizures is a greater intensity of activities in this area in 2013 (BMI 2014). The proportion of convictions under the SMG due to felonies (SMG Section 28) continues to be significantly lower than the number of convictions based on misdemeanours (SMG Section 27).

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 2013, the number of reports to the police due to violation of the SMG (28 227) saw a massive rise compared to 2012 (23 797; see also Table A9 and Table A10), and constitutes the maximum within the period of observation.

A total of 27 476 reports related to narcotic drugs (2012: 22 503). The remaining 471 reports (2012: 1 294) mostly concerned psychotropic substances, which, however, represents a decline of 43% compared to the previous year. Only 10 reports related to precursor substances (see Table A10 and Table A11). Regarding type of report (see Figure 9.1), 2013 saw a considerable increase in reports due to both felonies (+9%; preparation for drug trafficking – SMG Section 28, or drug trafficking – SMG Section 28a) and misdemeanours (+23%; 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; from 2004 to 2013



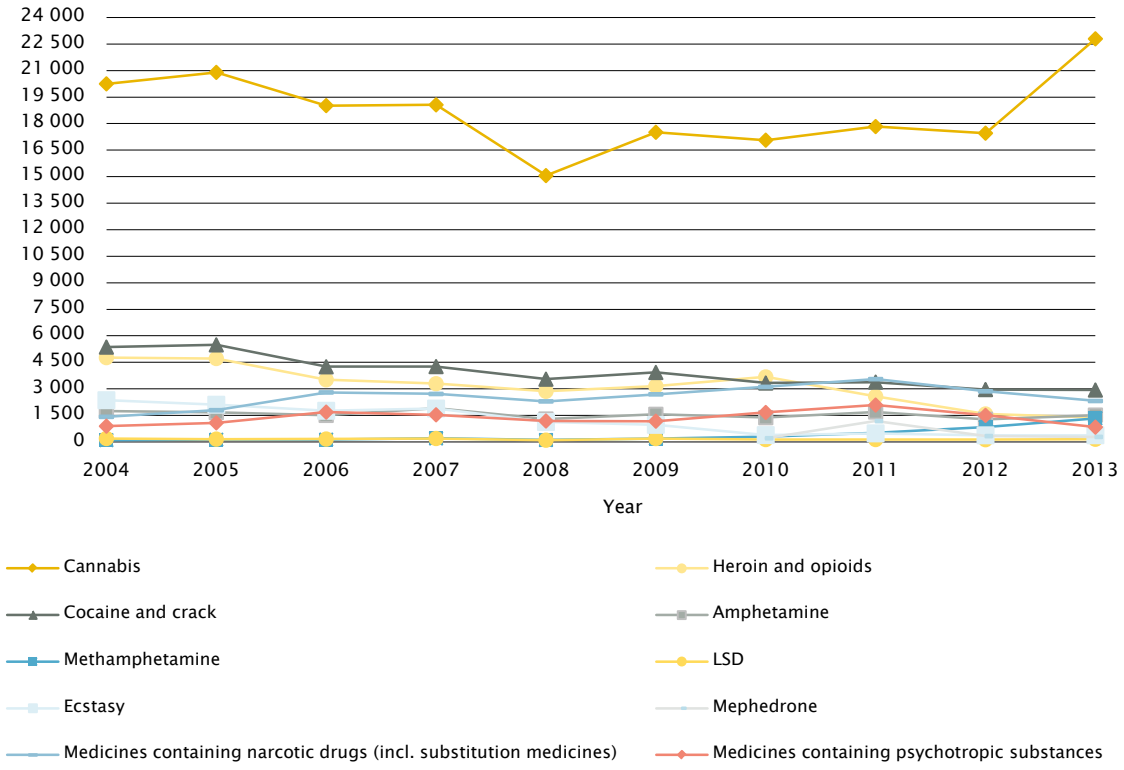
Source: BMI/.BK; graphic representation: GÖG/ÖBIG

If the reports are analysed by substances involved (see Table A13 and Figure 9.2), increases compared to the previous year are apparent for many substances. In the case of methamphetamine, the rise is as high as 60%, and in the case of cannabis it is 31%. A downward trend, which is pronounced in some respects, has become apparent with regard to reports relating to medicines containing narcotic drugs (–19%, including substitution medicines), medicines containing psychotropic substances (–44%), heroin and opioids (–12%), as well as mephedrone (–14%). In 2013, the total number of reports relating to heroin, opioids and medicines containing narcotic drugs was the lowest in the past 10 years, while the number of reports concerning cannabis was the highest, and accounted for two out of three reports (see Table A13). The development of reports at the provincial level has been similar to the development at the federal level (see Table

A14). The situation regarding methamphetamine use in Upper Austria, which has been described in sections 4.3 and 5.3, is reflected in the number of the corresponding reports in Upper Austria (see Table A14).

This year, figures on reports relating to violation of the Act on *New Psychotropic Substances* have been included in the tables for the first time. Compared to 2012 (93 reports), a rise of almost 40% (2013: 128 reports) has become apparent (see Table A12). Still, compared to other substances, NPS play an insignificant role.

Figure 9.2:
Development of reports relating to violation of the Narcotic Substances Act in Austria by type of substance; from 2004 to 2013



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

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

In 2013, a total of 28 227 reports to the police led to 1 297 arrests (2012: 1 569) in connection with the Narcotic Substances Act. 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 and 2013 data are comparable with the former figures only to a limited extent, and as in previous years, in 2013 the number of convictions for misdemeanours (SMG Section 27) have been considerably higher than convictions for felonies (SMG Section 28): 2 933 v. 1 289 cases. The proportion of convictions for violation of the SMG, out of the total number of convictions in Austria, showed a slight rise as against the previous years and was 12.4% in 2013 (see also Table A15).

Figure 9.3:
Number of convictions in Austria under SMG Sections 27, 28 and 28a; from 2004 to 2013*

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 have no longer been compiled by Statistics Austria but by the courts.

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

As of 2012, data on all offences[54] of which a defendant has been found guilty are available. In 2013, 4 252 defendants were found guilty of a total of 7 368 drug-related offences and thus

54
As of the reporting year 2012, **all** offences leading to final convictions have been included in the statistics of the corresponding year.

convicted by Austrian courts. Convictions in which psychotropic substances (SMG Sections 30, 31 and 31a) were decisive in terms of punishment played a minor role (2013: 30 convictions). In 2013, a total of 116 (2012: 195) offences connected to psychotropic substances as either the only or one of several drugs resulted in convictions (Statistics Austria, judicial criminal statistics).

Table 9.1 gives the number of final convictions that are based on SMG offences. As of 2012, the available figures have included all SMG-related offences of which a defendant has been found guilty: they show that offences relating to SMG Sections 27 and 28 have been much more 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 (see Table 9.1 and Table A16) show that a large part of convictions under the SMG concerns several SMG violations. This particularly applies to offences under SMG Section 27, which led to 5 379 convictions, and 4 889 of those concerned men.

Table 9.1:
Final convictions under the Narcotic Substances Act (SMG) in Austria, by basis of conviction, gender and age group, in 2013*

Basis of conviction		Aged 14-19	Aged 20-24	Aged 25-29	Aged 30-34	34+	Total
SMG total	Men	791	2.087	1.494	933	1.368	6.673
	Women	62	209	191	84	149	695
SMG Section 28 or 28a	Men	110	380	361	262	572	1.685
	Women	10	45	48	25	59	187
SMG Section 27	Men	679	1.692	1.111	646	761	4.889
	Women	52	159	139	56	84	490

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 2013, as in 2012, just over 70% of all persons convicted for SMG offences were punished by imprisonment, with prison sentences suspended on probation going down from 43% in all prison sentences in 2012 to 40% in 2013. The percentage of young people punished by imprisonment was 2.6%, and for 2% the prison sentence was suspended on probation (see Table A17).

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. Section 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.

Information on **other forms of drug-related crime** – specifically, offences committed to support drug habits – is given in the analyses provided on the occasion of the 15-year anniversary of the Schweizer Haus Hadersdorf (SHH) centre for inpatient, decentralised and outpatient drug treat-

ment. They show that approximately 90% of the patients undergoing outpatient (outp.) or inpatient (inp.) treatment at SHH in 2013 had prison experience, with some of them having served several or rather long prison sentences. The most frequent reason for the prison sentence was violations of the Narcotic Substances Act (outp. 42%; inp. 54%), followed by theft (outp. 8%; inp. 15%), robbery (outp. 15%; inp. 9%), as well as breaking and entering (outp. 8%; inp. 7%): property offences are typical offences committed to support drug addiction (SHH 2014).

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.

For instance, the steps taken by the Vienna Addiction and Drug Coordination (see section 1.3) in the focal area of public spaces and security aim at enhancing access to support services for marginalised people (integration), establishing a high level of socially acceptable coexistence in public spaces, and raising people's feeling of security in public spaces. This is underlined in Vienna's new 2013 addiction and drug strategy as well, which also states that removing persons or groups of persons from public spaces – unless they have committed an offence – is illegal and stigmatising and no sustainable solution. Rather, low threshold services and support oriented towards specific needs are offered, which, in addition to public relations activities and participative approaches, are intended to enhance de-stigmatisation (SDW 2014; SDW 2013).

In this context, the (German) glossary on social work in public spaces (Krisch et al. 2013) was presented in 2013, as an example of the cooperation between the *FH Campus Wien* University of Applied Sciences, practitioners and politicians in Vienna. The glossary was compiled by the Social Work Competence Centre at *FH Campus Wien* on behalf of the City of Vienna, and defines the position of social work in public spaces. It includes comprehensive definitions of relevant terms and aims at delineating social work in public spaces on the one hand and police and security interventions on the other. It thus provides guidance at expert level for social workers, and addresses fields of activity in the following five policy areas (of the Vienna City Administration): education, youth, information and sports; health and social services; integration and women's issues; consumer protection and personnel; urban planning, traffic and transport; as well as housing, housing construction and urban renewal. These areas are linked through the interdepartmental advisory group on social work in public spaces. For instance, the glossary describes different dimensions of the concept of target group, and explains that definitions of the term 'target group' are developing from specific situational contexts, and that an accepting position towards a target group, including orientation towards their resources, is maintained (SDW 2014).

In addition, representatives of the above areas have drawn up a mission statement on social work in public spaces, which expresses the position of the City of Vienna with regard to social

work in public spaces. The statement underlines that Vienna pursues a policy of tolerance in which integration, inclusion and prevention play key roles (Stadt Wien 2013).

The services in Vienna's public spaces that have been described in prior reports (see GÖG/ÖBIG 2013, GÖG/ÖBIG 2012, GÖG/ÖBIG 2011b) have been continued and, in some cases, expanded: for instance, *help U* now provides its services along Vienna's entire underground network, wherever need for intervention arises. *sam 9* changed its name to *sam nordwest* as its area of activity has been expanded from Vienna's 9th district to include the Josefstädter Straße U6 underground station and its neighbourhood. As of 2013, *sam flex* has provided services not only around the Wien Mitte underground station but, on behalf of the district administration, in the entire 3rd district, depending on need. While the number of contacts to clients has remained at the same level as in the previous year, the number of interventions requiring intensive advisory services has risen. *sam 2* – for the area at and around the Praterstern underground station – also recorded a greater number of both interventions (+67%) and client contacts (+42%) as against the previous year. In the case of *streetwork*, the proportion of clients aged over 50 (8%) was the same as the proportion of clients aged up to 24 in 2013, which is rather high compared to past years. The main subjects addressed in the context of advisory talks include financial issues, necessary documents, housing/sleeping facilities, health and substance use (see also section 6.3, SDW 2014, SHW 2014c, SHW 2014e, SHW 2014h, SHW 2014i, SHW 2014j).

In the other provinces, the services provided in public spaces have been continued as well. In view of the highly frequented meeting places of the scene in Feldkirch (Vorarlberg), the outreach social work hours were increased (2012: 255 hours; 2013: 319 hours), and the contacts with clients also rose as against the year before (2012: 2 800 contacts; 2013: 3 723 contacts) (Caritas Vorarlberg 2014).

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.[55] 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 section 9.3), Figure 9.4 and Table A18 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).

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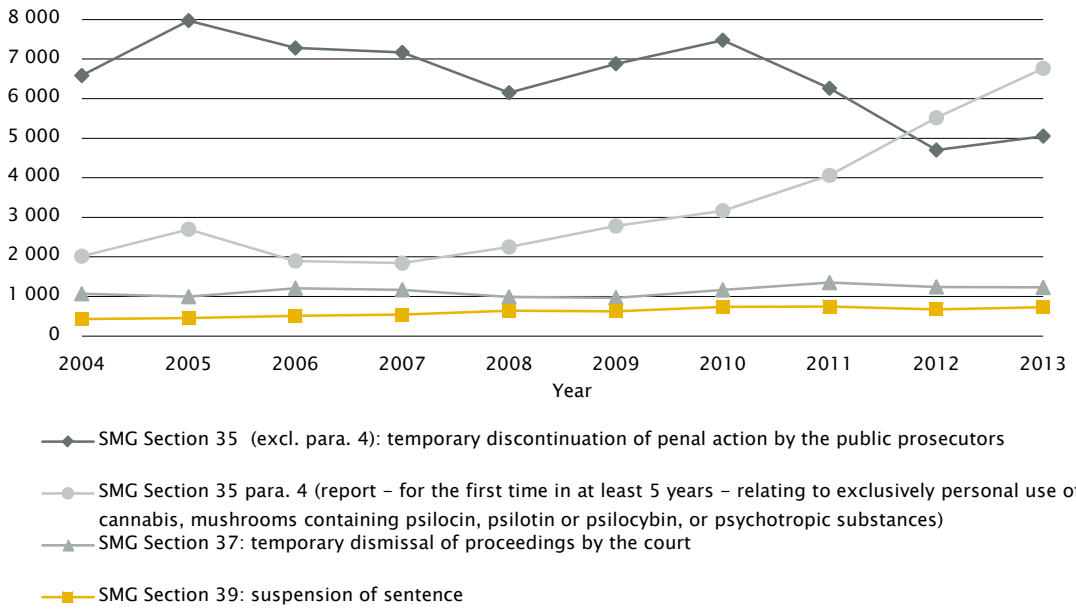
The principle of treatment instead of punishment relates to criminal policy, health policy and social policy measures that are taken in order to reduce drug abuse. Besides settlement by diversion, the measures include a special form of suspension of sentence, which may be granted to persons convicted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

As Figure 9.4 shows, the considerable increase in temporary discontinuations of penal action by the public prosecutors has continued in those cases in which the proceedings related to exclusively personal use of cannabis, mushrooms containing psilocin, psilotin or psilocybin, or psychotropic substances, and in which the health authorities had not been involved because no investigations relating to drug offences had been instituted against the person in question for at least five years (SMG Section 35 para. 4). These cases already exceeded the total number of other cases of temporary discontinuation of penal action under SMG Section 35 (excl. para. 4) in 2012. This development may also have been influenced by the rise in cannabis-related reports to the police. Table A16 provides additional information concerning final convictions under the SMG in 2013, broken down by basis of conviction, gender and age group.

With regard to suspension of sentence under the principle of treatment instead of punishment (SMG Section 39), Figure 9.4 and Table A18 show that the slight decline in these cases has been limited to the year 2012; in 2013 a rise in the relevant figures has again become apparent. The expenditure by the Austrian Federal Ministry of Justice (BMJ) for inpatient treatment in the context of treatment instead of punishment has nevertheless decreased further in 2013, which is probably due to the recent limitation of cost coverage by the BMJ for health-related measures in accordance SMG Section 41 (see Table 9.2 and GÖG/ÖBIG 2012).

Figure 9.4:
Development of statutory alternatives to punishment applied in Austria; from 2004 to 2013



Until 2007: SMG Section 35 = temporary waiving of reports by the public prosecutors.
As of 2008: SMG Section 35 = temporary discontinuation of penal action by the public prosecutors.
The data on SMG Sections 35 and 37 have been reported to the BMG by the public prosecutors and the courts.

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

As already discussed in GÖG/ÖBIG 2012, as of 2011 the maximum period of inpatient treatment in the context of treatment instead of punishment has been limited (to six months), and access to treatment instead of punishment has been generally restricted for repeat offenders. According to experts, this has led to a situation where expert opinions are issued stating that six months of treatment are insufficient for a person, and as a consequence, this person has to serve a prison sentence immediately – which runs counter to the intentions of the relevant provision. On the other hand, in certain cases for which a need for treatment or money beyond the limited resources granted by the court administration was identified, the provinces were willing to fund longer inpatient treatment (SHH 2014).

Table 9.2:
Expenditure by the Austrian Federal Ministry of Justice for inpatient treatment in the context of treatment instead of punishment; from 2004 to 2013

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Expenditure in EUR mill.	3,20	4,61	4,85	5,86	6,48	7,03	8,54	8,77	8,46	7,71

Source: BMJ 2014; graphic representation: GÖG/ÖBIG

An important goal 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 (Rast 2013).

In 2013, the number of diversion offers (2013: 14 147) under SMG Section 35 (temporary discontinuation of penal action by the public prosecutors) and Section 37 (temporary dismissal of proceedings by the court) increased by 13% as against the previous year. The majority of diversion offers (86%) was initiated by the public prosecutors, with diversion under SMG Section 35 for adolescents and young adults playing the most important role (44% and 42%, respectively, of all settlements by diversion. A total of 81% of all diversion proceedings were settled successfully and penal action was discontinued permanently. Regarding SMG Sections 35 and 37, the corresponding percentage is 77% (women: 80%, men 76%; adolescents: 77%, young adults: 77%) (BMJ 2014).

For an academic article[56] by Köchl et al (2014), structured medical, psychological, and legal data on the implementation of the Narcotic Substances Act with regard to health-related measures and legal interventions were collected. The authors noticed that the Austrian courts tended to grant the option of health-related measures to addicted patients who had committed minor

56
For the survey on which the article is based, 96 persons with opioid addictions – 10% of them female – were selected, who had undergone outpatient or inpatient health-related measures in the context of treatment instead of punishment. The control group consisted of 228 persons imprisoned on grounds of drug-related offences who were in substitution treatment; 15% of them were women.

offences (e.g. possession of narcotic substances and/or trafficking), while addicted persons convicted of severer offences (property offences or violent offences, combined with drug possession and/or trafficking) were sentenced to imprisonment. The majority of either group had previous convictions, particularly the group of imprisoned persons. This led to the conclusion that standardised, multi-professional and holistic diagnosing processes at an early stage were needed, performed by trained experts, and that treatment should be started as early as possible (on first contact with the court system). According to the authors, it is also necessary to increase the quality and precision of the recommendations for health-related measures by experts in order to ensure a more appropriate referral of patients to the available measures (Köchl et al 2014).

In 2013 Hellmair, in the context of job-related basic training for staff in the penal system, conducted a catamnestic survey[57] on withdrawal treatment in Austrian prisons, specifically at the prisons of Innsbruck and Favoriten, Vienna[58]. The evaluation was carried out on the occasion of the 20th anniversary of the department of non-punitive custody at the Innsbruck prison, and focused on recidivism among (former) prisoners. The study shows that 51% of the prisoners treated in Innsbruck, and 61% of the prisoners treated in Vienna, subsequently committed further offences. In both prisons, a relevant factor for recidivism was whether the treatment had been terminated prematurely, by the prisoners themselves or the provider of treatment (recidivism rate: 59%) or had been completed as planned and the patient was prepared for the end of treatment (recidivism rate: 45%). If the recidivism rate is compared to the duration of treatment, it is apparent in both prisons that the reoffence rates were significantly smaller among prisoners who had received withdrawal treatment in prison for more than one year. It has been confirmed for both prisons that prisoners who have been 'sentenced' to treatment by the court (Innsbruck: 59%; Vienna: 68%) tended to commit further offences significantly more often than prisoners who were undergoing treatment voluntarily (Innsbruck: 50%; Vienna: 60%) (Hellmair 2013). [59]

A comparison of trends regarding reported offences, convictions and the application of alternatives to punishment reveals interesting results. Figure 9.5 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

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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.

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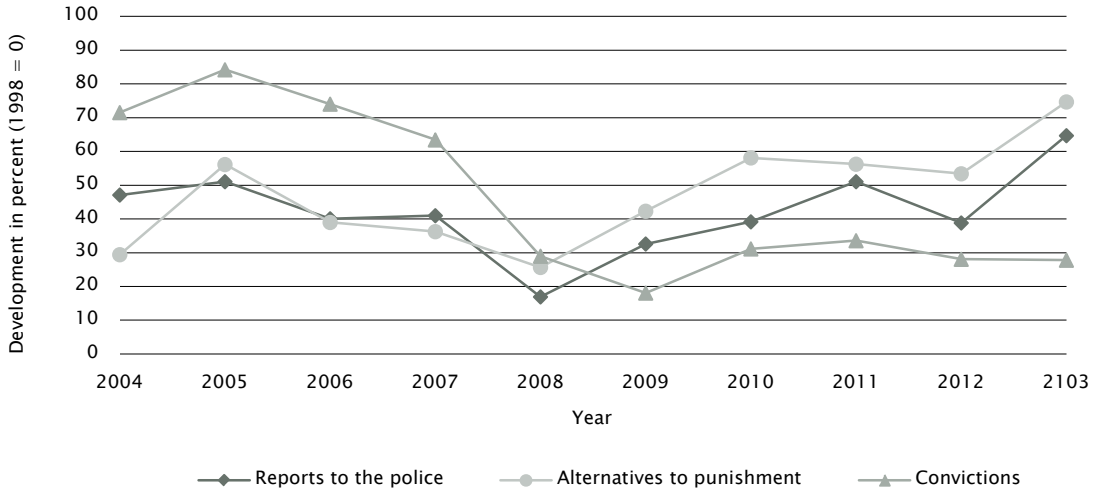
The catamnestic survey included 287 (former) prisoners who had undergone withdrawal treatment between 1 January 1996 and 1 March 2013 at the department of non-punitive custody at the Innsbruck prison. The control group consisted of 215 randomly selected prisoners at the prison of Favoriten/Vienna, who had been imprisoned during the same period. The sample was selected independent of the prisoners' type of addiction (misuse of a single drug, polydrug use, or addiction to alcohol). The prisoners in the department of non-punitive custody in Innsbruck, on average, were 10 years older, they had two prior convictions less than those in the Viennese control group, and their treatment period was significantly shorter (4.7 months v. 24.7 months).
The study does not specify whether all (former) prisoners surveyed were men or whether no distinction between male and female prisoners had been made.

up to 2005 the percentages of convictions went up most significantly. As of 2007, reports to the police and convictions have decreased 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 section 9.2 has to be taken into account.

Figure 9.5:
Comparison of index-linked developments of reported drug offences, convictions and application of statutory alternatives to punishment in Austria; from 2004 to 2013*



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 of conviction have 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 (High-risk) drug use in prison

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 made available.

9.6 Responses to drug-related health issues in prison

In Austria, interventions regarding drug-related health issues in prison are primarily oriented towards substitution treatment, drug-free zones in prisons and, to a smaller extent, harm reduction measures. However, no specific measures with regard to infectious diseases exist (see section6.2).

Information on OST in Austrian prisons is provided in Chapter 11 of the 2011 report on the drug situation (GÖG/ÖBIG 2011b). For details on health-related measures during imprisonment see section 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).

The figures on opioid substitution treatment show that in October 2013, 783 persons in Austrian prisons were undergoing OST, which corresponds to approximately nine percent of all prisoners in Austrian prisons (including affiliated institutions) (Macheiner, personal communication).

The completion of the project described in the report of the previous year (GÖG/ÖBIG 2013c) to develop standards for advice, support and treatment services for persons in regular prisons or non-punitive custody centres is scheduled for 2014 (SDW 2014).

A recommendation in the report on harm reduction in Europe drawn up on behalf of the European Commission is to implement syringe exchange programmes in prisons as well (GÖG/ÖBIG 2013a, GÖG/ÖBIG 2013b).

9.7 Reintegration of drug users after release from prison

The majority of reintegration measures for drug users are 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 drug production and trafficking, as well as supply routes and seizures, come from the Austrian Federal Ministry of the Interior/Federal Criminal Agency (BMI/.BK), and the data on ingredients and purity have been provided by *checkit!*[60], BMI/.BK (see ST13, ST14, ST15) and the Austrian Federal Office for Safety in Health Care/AGES Medicines and Medical Devices Agency[61]. The information on prices has been communicated by BMI/.BK (ST16).

10.2 Supply to and within the country

Austria is a country of drug transit and drug use. As a country where illicit drugs are produced, Austria plays an insignificant role – with the exception of an increase in cannabis production (BMI 2014). The relevant transit routes have already been described in detail in the 2012 report (GÖG/ÖBIG 2012), and have hardly changed since then. Heroin and opioids are primarily smuggled to Austria on the route over the Balkans. Meanwhile, this route has also been used for cocaine that has been transported to Africa or Europe by sea. In addition, Vienna International Airport plays a certain role as a transit point. Anonymous platforms of the 'darknet' on the internet seem to be becoming increasingly important as trading places for illicit drug transactions.

According to the Ministry of the Interior, cannabis products continue to be transported to Austria primarily from the Netherlands, Switzerland and Morocco. In addition, there are small-scale dealers from the Czech Republic who are smuggling marijuana to Austria. Cannabis grown in Austria is mainly intended for personal use or for small-scale trafficking. Professional indoor cultivation with up to 1 000 cannabis plants or more is the exception in Austria. Outdoor growing of cannabis plays a minor role, probably also due to climatic reasons.

Synthetic drugs such as ecstasy and MDMA in powder form are primarily smuggled to Austria from the Netherlands, via Germany. Furthermore, some of the amphetamines are brought to

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checkit! is a cooperation project run jointly by *Suchthilfe Wien* 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.).

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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.

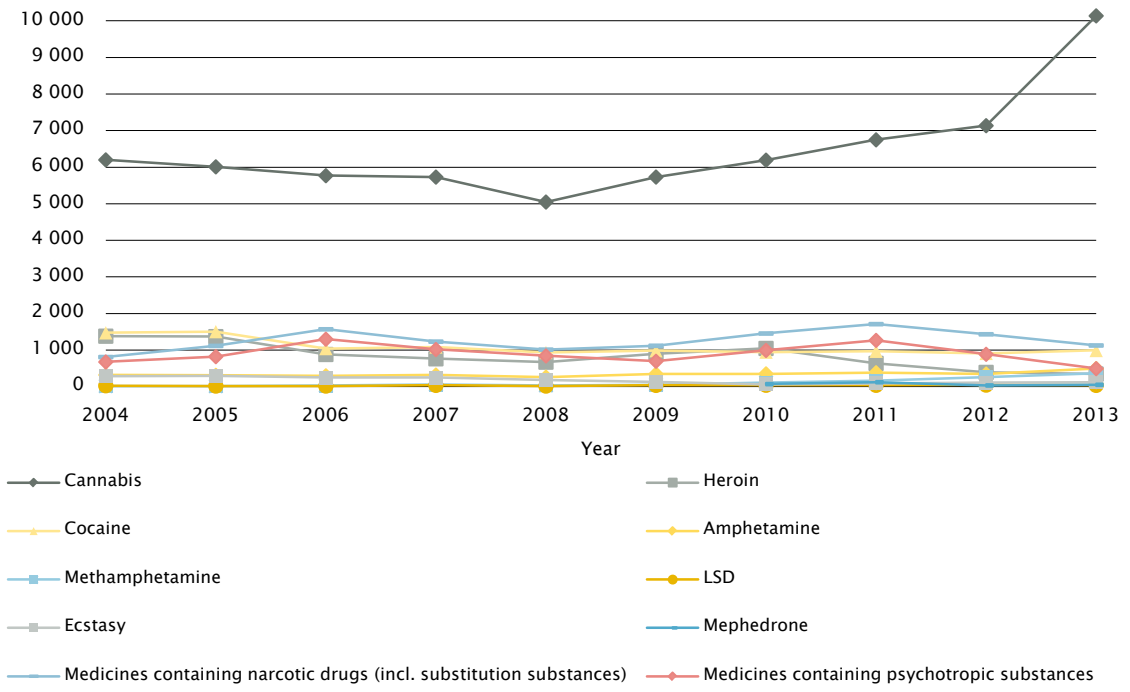
Austria from Poland. Methamphetamine, which is relevant primarily in Upper Austria (see section 4.3) is transported to Austria from the Czech Republic, and partly from Slovakia.

According to the BMI, the new psychoactive substances that are used in Austria definitely come from China; they are mostly ordered on the internet and mailed to Austria. The (advance) payment is effected through money transfer to banks in China and Hong Kong.

10.3 Seizures

Compared to 2012, the quantities seized have decreased in the case of heroin, medicines containing narcotic drugs and medicines containing psychotropic substances. Increases have been recorded with regard to amphetamine and methamphetamine, and massive increases in the case of cannabis (see Figure 10.1 and Table A19). The quantities seized have shown considerable variations in the course of time (see Table A20). One has to bear in mind here that individual seizures of large amounts, which are not necessarily intended for Austria (transit), distort the general picture.

Figure 10.1:
Number of seizures of narcotic drugs and medicines containing psychotropic substances in Austria; from 2004 to 2013



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

10.4 Availability

While 99% and 98%, respectively, of the 501 Austrian young people interviewed in the context of Eurobarometer[62] (European Commission 2014b; see also section 2.3) said it would be easy or very easy to obtain alcohol and tobacco within 24 hours, the corresponding percentages relating to illicit drugs are 53% for cannabis, 23% for ecstasy, 18% for cocaine, and 21% for new psychoactive substances. According to the survey, a higher proportion of Austrian young people than the European average think it would be harder to access illicit substances (including NPS). On the other hand, a greater proportion than the European average indicated that it was easy to obtain the legal substances alcohol and tobacco. However, this is likely to reflect different legal frameworks in the individual countries as well.

Information from the Ministry of the Interior on the purity and prices of various drugs sold at street level is given in Table 10.1 (see also ST14 and ST16). As in previous years, a considerable variation in the potency of drugs sold at 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 2013

		Herbal cannabis*	Cannabis resin*	Brown heroin*	White heroin*	Cocaine*	Ampheta-mine*	Meth-ampheta-mine*	Ecstasy**
Purity	Minimum	0.06%	0.3%	0.2%	-	0.8%	0.6%	0.2%	19.4 mg
	Maximum	43.5%	30.7%	55.1%	-	74.8%	59.8%	80.3%	83.2 mg
	Median	9.9%	8.5%	6.9%	-	22.7%	7.5%	69.8%	40.3 mg
Price	Minimum	5	6	30	-	50	6	40	4
	Maximum	12	12	100	-	130	60	120	12
	Typical	8.5	9	60	-	75	45	75	6

* 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.

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

In the context of the *checkit!* project (see section 2.4), a total of 1 023 samples bought as psychoactive substances were analysed at 15 music events of the party and clubbing scenes in the provinces of Vienna and Lower Austria in 2013. A proportion of 26% of the samples analysed contained the expected ingredients in the expected dose. Another 21% did contain the expected ingredients but users had to be warned because the doses were very high. 34% of the samples

62
In June 2014, a representative sample of 13 128 persons aged between 15 and 24 in all 28 EU Member States were interviewed for Eurobarometer. The Austrian sample comprised 501 persons.

contained unexpected ingredients, and in the case of 19% of the samples, it was necessary to issue warnings due to highly hazardous ingredients (SHW 2014d).

Approximately 63% of the total of 108 samples sold as ecstasy did not contain pharmacologically active substances other than the expected ingredient of MDMA[63] (or MDE/MDA), which has been the highest percentage since 2008 (see Table A21). As in the previous year, the number of pills that contained high doses of MDMA was remarkably high: in around one in four pills tested, between 100 mg and 200 mg of the expected ingredient was detected (v. 3% in 2011) – and in four pills, even more than 200 mg. If men take MDMA doses over 1.5 mg per kg of body mass, and women, doses of more than 1.3 mg per kg of body mass, the negative effects of MDMA predominate, and neurotoxic effects are more likely to occur. While the number of samples containing PMA[64] decreased from 14 last year to 2 in the reporting year, more users had to be warned because pills bought as ecstasy contained the new synthetic substance methoxetamine. Methoxetamine has a chemical structure similar to ketamine and PCP, but according to users, its effects are more intensive and last longer. Combining this substance with other drugs seems to be particularly risky: several deaths in connection with methoxetamine have already been recorded in Europe. As methoxetamine is a new psychoactive substance, few scientific findings regarding risks and possible long-term effects have so far been made available.

In the case of the 290 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 previous years: 78.3% of the samples only contained the expected ingredient (see Table A22). In approximately 16% of samples, substances from the NPS group were detected (2012: 9.9%).

18% of the 321 samples bought as speed and analysed by *checkit!* contained only amphetamine as their sole pharmacologically active component (2012: 7%). Another 57%, apart from amphetamine, also contained caffeine (see Table A23). In 8 samples (2012: 19 samples), in addition to amphetamine, 4-methylamphetamine (4-MA) was identified. 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 bought as speed in which NPS were found has further decreased as against 2012 (from 4.0% to 2.0%). Only 0.9% of the samples bought as speed were found to contain methamphetamine. Around one in four speed samples was regarded as posing considerable health risks.

63
3,4 methylenedioxy-N-methylamphetamine.

64
Para-methoxyamphetamine (PMA) and para-methoxymethamphetamine (PMMA), a substance related to PMA, have repeatedly led to the death of users in Europe and also in Austria.

Only around 19% of a total of 110 samples bought as cocaine and analysed by *checkit!* actually contained cocaine without any other pharmacologically active substance. Many samples contained several unexpected ingredients. Levamisole and/or phenacetin are the most frequent adulterants, a phenomenon which has also been registered 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. Based on the results provided by *checkit!*, Hofmaier et al (2013) discovered that the effects on the neurotransmitter system of aminorex, a metabolite of levamisole, might be the reason why levamisole is added to cocaine. 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. 58% of the samples bought as cocaine and submitted for analyses were regarded as posing considerable health risks.

Regarding NPS, a further decline has become apparent in 2013 as well. While in 2011 a proportion of 18% of samples handed in contained new psychoactive substances as (expected or unexpected) ingredients (and 13% in 2012), this applied to only 11% in 2013. New psychoactive substances have also declined in importance as additives to typical recreational drugs (from 13.3% in 2011 to 8.9% in 2013). The percentage of samples bought as new psychoactive substances and handed over for testing has gone down to approximately 2%.

During the reporting period, the Austrian Agency for Health and Food Safety (AGES) analysed 33 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. In powders and pills, substances such as 5FUR-144 (= XLR-11), 2C-C-NBOMe and 2H-NBOMe were detected.

In 2013, a total of 123 samples were analysed by BMI/.BK in connection with suspected violation of the New Psychoactive Substances Act, and the results were reported to the Austrian information and early warning system on specific health hazards in the context of illicit substance use, to enable monitoring. The substance that has been found most frequently is PVP (pyrrolidinovalerophenone), detected in 13% of samples, followed by 4-MEC (8.9%) and pentedrone (6.5%). 5.7% of samples contained 4-methylamphetamine.

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LGBl 2013/81 v. 14. 5. 2013 über den Schutz und die Förderung von Kindern und Jugendlichen (Steiermärkisches Jugendgesetz – StJG 2013)

Personal communications (alphabetic order)

Name	Institution or function
Bayer, Raphael	Federal Ministry of Health
Ederer, Klaus Peter	Addiction Coordinator, Styria
Gstrein, Christof	Addiction Coordinator, Tyrol
Herr, Christina	Head of Landeplatz project; Pinzgau region, Salzburg
Hörhan, Ursula	Addiction Coordinator, Lower Austria
Klein, Jean-Paul	Federal Ministry of Health
Macheiner, Franz	Prisons Directorate
Prehslauer, Brigitte	Drug Coordinator, Carinthia
Schabus-Eder, Franz	Addiction Coordinator, Salzburg
Schopper, Johanna	Federal Ministry of Health, Federal Drug Coordinator
Schwarzenbrunner, Thomas	Addiction and Drug Coordinator, Upper Austria
Zangerle, Robert	Innsbruck University Hospital, Department of Dermatology and Venereology

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.

Below, all accessible academic studies which have been published by Austrian (co-)authors in 2013, and until spring 2014 (and which have been identified) 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 Bibliographic references.[65]

Beer, B., Erb, R., Pavlic, M., Ulmer, H., Giacomuzzi, S., Riemer, Y., and Oberacher, H. (2013). Association of polymorphisms in pharmacogenetic candidate genes (OPRD1, GAL, ABCB1, OPRM1) with opioid dependence in European population: a case-control study. PLoS One 8/9:e75359

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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, primarily 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.

Hofmaier, T., Luf, A., Seddik, A., Stockner, T., Holy, M., Freissmuth, M., Ecker, G. F., Schmid, R., Sitte, H. H., and Kudlacek, O. (2013). Aminorex, a metabolite of the cocaine adulterant levamisole, exerts amphetamine like actions at monoamine transporters. Neurochemistry International 73, 32–41

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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. 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 Bibliographic references.

Bayer, K. M. (2013). Die Stressantwort bei Suchtkranken: Aggression und selektive neuroendokrine Parameter im Vergleich zwischen männlichen polytoxikomanen Suchtkranken und einer gesunden Kontrollgruppe. Medizinische Universität Graz. Unpublished doctoral thesis.

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At the European Level, the EMCDDA provides a lot of data and information on its website, e.g. the Statistical Bulletin (http://www.emcdda.europa.eu/stats12) as well as the Best Practice Portal (http://www.emcdda.europa.eu/best-practice). The Best Practice Portal includes information on standards and guidelines as well as the Evaluation Instruments Bank (EIB) and **examples for evaluated interventions** (EDDRA = Exchange on Drug Demand Reduction Action). Below, EDDRA database entries on Austrian projects/programmes or centres are listed (as at August 2014[66]).

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)

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)

66
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)

Being a parent can be difficult
(Fachstelle für Suchtprävention NÖ)

Employment Programme WALD [forest]
(H.I.O.B. – Anlauf- und Beratungsstelle für Drogenabhängige, Vorarlberg)

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

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)

FITCARD – health promotion for apprentices; SUPRO subprogramme
(SUPRO – Werkstatt für Suchtprophylaxe, Vorarlberg)

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

Grenzwert
(Landesstelle für Suchtprävention Kärnten)

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)

H.I.O.B.: Help, information, orientation and counselling for drug addicts
(H.I.O.B. – Anlauf- und Beratungsstelle für Drogenabhängige, Vorarlberg)

High enough? Practical kit for addiction prevention in the field of youth social work
(VIVID Fachstelle für Suchtprävention, Styria)

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)

Kinder stark machen mit Sport
(SUPRO – Werkstatt für Suchtprophylaxe, Vorarlberg)

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 facility CARINA
(Stiftung Maria Ebene, Vorarlberg)

Long-term treatment, Anton Proksch-Institute, Mödling
(Anton Proksch Institute, Lower Austria)

Lukasfeld: A short-term therapy for young illegal drug addicts
(Stiftung Maria Ebene hospital, 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: Occupational reintegration of (former) drug addicts
(Beratungsstelle DIALOG, 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)

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)

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

Step by Step Graz: 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: occupational integration of persons addicted to drugs, medicine or alcohol
(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
(blue|monday gesundheitsmanagement, Steiermark)

Websites

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

For a comprehensive list of European and international websites on drugs and addiction please consult http://www.goeg.at/en/Area/Links.html.

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

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

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

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, OÖ
http://www.praevention.at

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

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

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 covered)	Target group (sample)	Drug types surveyed	Percentage of respondents with drug experience, by age	
				Age	%
Bevölkerungsbefragung Österreich/ general population survey, Austria (Uhl et al. 2005)	Austria 2004 (lifetime)	General population aged 14 and over (n = 4 547)	Cannabis	14+	20.1
			Ecstasy	14+	3.0
			Amphetamine	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
			Amphetamine	14+	2
			Cocaine	14+	2
			Opioids	14+	1
			Biogenic drugs	14+	2
			LSD	14+	2
			Solvents and inhalants	14+	2
Wiener Suchtmittelstudie/ drug survey, Vienna (IFES 2009)	Vienna 2009 (lifetime)	General population aged 15 and over (n = 600)	Cannabis	15+	16
			Ecstasy	15+	3
			Amphetamine	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
			Amphetamine	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 2011a)	Vienna 2011 (lifetime)	General population aged 15 and over (n = 600)	Cannabis	15+	21
			Ecstasy	15+	3
			Amphetamine	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
			Amphetamine	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 2014

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	%
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
			Amphetamine	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
			Amphetamine	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
			Amphetamine	15–24	12.3
			Cocaine	15–24	10.0
			LSD	15–24	9.0
			Solvents and inhalants	15–24	16.5
			Biogenic drugs	15–24	13.0
Schulstudie Burgenland/ school 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

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	%
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
			Amphetamine	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
			Amphetamine	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
Flash Eurobarometer Young people and drugs (European Commission 2014a and b)	Austria 2014 (lifetime)	Young people aged 15 to 24 (n = 501)	Cannabis	15–24	38
			NPS	15–24	7

Summary and graphic representation: GÖG/ÖBIG

Table A3:
Number of directly drug-related deaths in Austria, by cause of death; from 2004 to 2013

Cause of death	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Opioid poisoning	38	31	27	9	13	18	13	11	11	10
Polydrug poisoning involving opioid(s)	133	134	137	138	136	153	148	151	111	103
(Polydrug) poisoning involving narcotic drug(s) or NPS[1] without opioid(s)	4	4	5	5	4	1	0	8	8	6
Fatal poisoning of unknown type	10	22	28	23	16	15	9	7	9	3
Verified directly drug-related deaths, total	185	191	197	175	169	187	170	177	139	122
Drug-related deaths without verification by autopsy[2]	–	–	–	–	32	19	17	24	22	16
Drug-related deaths, total					201	206	187	201	161	138

1: NPS = new psychoactive substance(s)
2: See GÖG/ÖBIG 2011b

Source: statistics on drug-related deaths; calculation and graphic representation: GÖG/ÖBIG

Table A4:
Number of verified directly drug-related deaths in Austria, by province; from 2004 to 2013

Province	2004	2005	2006	2007	2008[1]	2009[2]	2010[3]	2011[4]	2012[5]	2013[6]	2004–2013
Burgenland	5	3	3	5	1	1	3	3	2	1	27
Carinthia	4	6	7	4	6	5	6	3	6	7	54
Lower Austria	31	29	38	27	34	26	30	28	20	18	281
Upper Austria	15	13	14	12	20	21	10	12	18	13	148
Salzburg	7	8	6	3	11	13	17	6	9	4	84
Styria	12	17	12	16	21	10	11	15	7	6	127
Tyrol	15	17	16	11	18	15	18	23	14	14	161
Vorarlberg	8	6	6	7	2	14	10	8	7	8	76
Vienna	88	92	95	90	55	82	65	79	56	51	753
Unknown	0	0	0	0	1	0	0	0	0	0	1
Total	185	191	197	175	169	187	170	177	139	122	1 712

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.
6: Plus 16 drug-related deaths without verification by autopsy.

Source: statistics on drug-related deaths; calculation and graphic representation: GÖG/ÖBIG

Table A5:
Number of verified directly drug-related deaths in Austria, by age group, total and by gender; from 2004 to 2013

Age group	2004		2005		2006		2007		2008[1]		2009[2]		2010[3]		2011[4]		2012[5]		2013[6]	
	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%
19 and under	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	6	4.9
20–24	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	18	14.8
25–29	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	34	27.9
30–34	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	31	25.4
35–39	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	11	9.0
40 and over	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	22	18.0
Total	185	100	191	100	197	100	175	100	169	100	187	100	170	100	177	100	139	100	122	100.0
Men	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	98	80.3
Women	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	24	19.7

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.
6: Plus 16 drug-related deaths without verification by autopsy.

Source: statistics on drug-related deaths; calculation and graphic representation: GÖG/ÖBIG

Table A6:
Distribution of verified directly drug-related deaths in Austria, by cause of death and age; in 2013

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	0	1	3	3	1	0	0	0	8
		Several opioids	0	1	0	0	0	1	0	0	0	2
		+ alcohol	0	0	3	0	1	0	0	0	0	4
		+ psychopharmaceuticals	0	4	6	15	10	5	4	2	4	50
		+ alcohol & psychopharmaceuticals	0	0	2	2	4	4	2	3	1	18
	Opioids and other narcotic drugs	Narcotic drugs only	0	0	0	1	3	0	0	0	0	4
		ND + alcohol	0	0	1	0	0	0	0	0	0	1
		ND + psychopharmaceuticals	0	1	4	6	7	0	1	0	1	20
		ND + alcohol & psychopharmaceuticals	0	0	1	2	1	0	1	0	1	6
	Narcotic drugs without opioids	Narcotic drugs only	0	0	0	1	1	0	0	0	0	2
		ND + alcohol	0	0	0	2	0	0	0	0	0	2
		ND + psychopharmaceuticals	0	0	0	1	1	0	0	0	0	2
		ND + alcohol & psychopharmaceuticals	0	0	0	0	0	0	0	0	0	0
	Fatal poisoning/ unknown type		0	0	0	1	0	0	2	0	0	122
	Verified directly drug-related deaths, total		0	6	18	34	31	11	10	5	7	98
	of these: men		0	4	13	29	27	9	8	3	5	24

ND = narcotic drug(s) or *new psychoactive substance(s)*

Source: statistics on drug-related deaths; calculation and graphic representation: GÖG/ÖBIG

Table A7:
Distribution of verified directly drug-related deaths in Austria, by cause of death and province; in 2013

Cause of death			Province									
			B	C	LA[1]	UA[2]	S	St	T	VB[3]	V[4]	A[5]
Fatal poisonings	Opioids	One opioid	0	2	0	2	0	1	0	0	3	8
		Several opioids	0	0	0	0	0	0	0	1	1	2
		+ alcohol	1	0	1	0	0	0	0	0	2	4
		+ psychopharmaceuticals	0	2	9	4	2	3	10	2	18	50
		+ alcohol & psycho-pharmaceuticals	0	1	3	1	1	1	1	1	9	18
	Opioids and other narcotic drugs	Narcotic drugs only	0	0	0	0	0	0	0	0	4	4
		ND + alcohol	0	0	0	0	1	0	0	0	0	1
		ND + psycho-pharmaceuticals	0	1	5	3	0	1	2	2	6	20
		ND + alcohol & psycho-pharmaceuticals	0	1	0	0	0	0	1	1	3	6
	ND without opioids	Narcotic drugs only	0	0	0	1	0	0	0	0	1	2
		ND + alcohol	0	0	0	0	0	0	0	0	2	2
		ND + psycho pharmaceuticals	0	0	0	1	0	0	0	1	0	2
		ND + alcohol & psycho-pharmaceuticals	0	0	0	0	0	0	0	0	0	0
	Fatal poisoning/unknown type		0	0	0	1	0	0	0	0	2	3
	Verified directly drug-related deaths, total		1	7	18	13	4	6	14	8	51	122
Verified directly drug-related deaths per 100 000 inhabitants aged 15 to 64			0.5	1.9	1.7	1.4	1.1	0.7	2.9	3.2	4.3	2.1
Directly drug-related deaths **per 100 000 inhabitants** aged 15 to 64			0.5	1.9	1.8	1.5	1.1	0.7	2.9	4.0	5.3	2.4

ND = narcotic drug(s) or *new psychoactive substance(s)*

1: Plus 1 drug-related death without verification by autopsy.
2: Plus 1 drug-related death without verification by autopsy.
3: Plus 2 drug-related deaths without verification by autopsy
4: Plus 12 drug-related deaths without verification by autopsy
5: Plus 16 drug-related deaths without verification by autopsy.

Source: statistics on drug-related deaths; calculation and graphic representation: GÖG/ÖBIG

Table A8:
Development of AIDS cases in Austria by risk situation; from 2004 to 2013

Risk situation	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Homo-/bisexual contact	23	28	33	39	28	28	25	20	18	9
Injecting drug use	18	22	21	26	27	16	11	11	14	10
Heterosexual contact	51	45	47	42	38	45	37	21	22	14
Other cause/unknown	14	22	17	22	17	13	21	12	12	2
Total	106	117	118	129	110	102	94	64	66	35

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

Table A9:
Distribution of reported violations of the Narcotic Substances Act in Austria, by first offenders and repeat offenders as well as development of total reports; from 2004 to 2013

Reports	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total number of reports	25 215	25 892	24 008	24 166	20 043	22 729	23 853	25 892	23 797	28 227
First offenders	14 346	15 569	15 808	16 053	13 634	14 893	19 409	21 828	19 683	22 979
Repeat offenders	9 990	9 520	7 636	7 569	5 990	7 258	3 681	3 247	3 107	3 688

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; from 2004 to 2013

Province	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Burgenland	967	923	1 033	1 008	871	953	716	801	687	844
Carinthia	1 464	1 529	1 190	1 408	1 153	1 372	1 522	1 422	1 165	1 460
Lower Austria	3 531	3 632	3 050	3 464	2 583	3 165	2 978	2 917	2 683	3 134
Upper Austria	3 521	3 769	3 209	3 786	3 245	3 908	3 660	3 590	3 547	4 446
Salzburg	1 077	1 092	1 001	1 116	1 015	1 096	1 099	1 431	1 145	1 350
Styria	1 705	1 516	1 435	1 929	1 372	1 669	1 607	1 878	1 879	2 465
Tyrol	2 695	2 775	2 607	2 454	1 982	2 555	2 692	3 095	2 570	3 929
Vorarlberg	1 044	1 008	1 240	1 153	976	1 027	1 143	1 092	1 392	1 251
Vienna	8 524	8 797	7 925	6 611	5 883	6 056	7 001	7 903	7 435	8 597
Total number of reports	24 528	25 041	22 690	22 929	19 080	21 801	22 418	24 129	22 503	27 476

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 violations of the Narcotic Substances Act in Austria (psychotropic substances only) by province; from 2010 to 2013

Province	2010	2011	2012	2013
Burgenland	19	30	14	3
Carinthia	25	44	29	36
Lower Austria	97	124	88	71
Upper Austria	180	249	229	98
Salzburg	31	31	22	23
Styria	41	49	54	26
Tyrol	99	80	75	58
Vorarlberg	39	61	25	20
Vienna	904	1 095	758	406
Total number of reports	1 435	1 763	1 294	741

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

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

Table A12:
Distribution of reports relating to violations of the New Psychoactive Substances Act in Austria, by province, from 2012 to 2013

Province	2012	2013
Burgenland	5	4
Carinthia	3	5
Lower Austria	25	32
Upper Austria	10	9
Salzburg	9	3
Styria	15	35
Tyrol	12	19
Vorarlberg	2	6
Vienna	12	15
Total number of reports	93	128

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

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

Table A13:
Distribution of reports relating to violation of the Narcotic Substances Act in Austria by drug type; from 2004 to 2013

Drug type	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Cannabis	20 252	20 900	19 021	19 063	15 063	17 513	17 066	17 836	17 461	22 798
Heroin and opioids	4 770	4 720	3 516	3 294	2 865	3 157	3677	2 575	1 582	1 390
Cocaine and crack	5 365	5 491	4 252	4 263	3 551	3 930	3332	3 383	2 963	2 936
Amphetamine	1 741	1 664	1 503	1 914	1 296	1 562	1 375	1 696	1 283	1 517
Methamphetamine	102	131	136	198	109	187	294	510	837	1 337
LSD	196	160	164	196	101	193	137	138	129	155
Ecstasy	2 362	2 106	1 763	1 889	1 127	966	388	485	375	378
Mephedrone							209	1 179	331	285
Medicines containing narcotic drugs (incl. substitution medicines)	1 420	1 795	2 800	2 714	2 294	2 693	3 113	3 552	2 864	2 317
Other narcotic drugs*	304	427	355	323	263	363	185	160	143	164
Psychotropic substances	11	4	14	20	13	16	37	58	35	59
Psychotropic medicines	892	1 081	1 687	1 535	1 185	1 174	1 666	2 086	1 502	837
Precursor substances	0	4	8	2	12	1	3	4	8	18

– = No data available.
Note: As the figures are broken down by type of drug, multiple counts in individual reports cannot be ruled out. 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 A14:
Distribution of reports relating to violation of the Narcotic Substances Act in Austria by drug type and province; in 2013

Drug type	B	C	LA	UA	S	St	T	VB	V	Total
Cannabis	771	1 282	2 641	3 710	1 224	2 307	4 034	1 143	5 686	22 798
Heroin and opioids	20	172	175	182	29	17	36	79	680	1 390
Cocaine and crack	64	167	193	281	94	92	340	185	1 520	2 936
Amphetamine	65	46	192	444	130	112	183	128	217	1 517
Methamphetamine	63	25	174	733	29	24	75	26	188	1 337
LSD	7	6	14	56	9	7	17	21	18	155
Ecstasy	13	32	39	88	34	36	78	30	28	378
Mephedrone	8	12	65	4	4	114	13	0	65	285
Medicines containing narcotic drugs (incl. substitution medicines)	21	93	232	543	83	108	82	36	1 119	2 317
Other narcotic drugs*	5	22	28	36	12	14	27	10	10	164
Psychotropic substances	1	4	13	10	2	2	10	3	14	59
Medicines containing psychotropic substances	4	54	80	107	26	33	60	24	449	837
Precursor substances	5	0	0	9	0	0	0	0	4	18

Note: As the figures are broken down by type of drug, multiple counts in individual reports cannot be ruled out. 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 A15:
Convictions under the Narcotic Substances Act (SMG) and total number of convictions in Austria; from 2004 to 2013

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)
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
2013	4 252	1 289	2 933	34 424	12.4

Until 2007:
SMG Section 28 = trafficking in, possession, etc. of, large quantities of narcotic drugs (commercial trafficking).
SMG Section 27 = trafficking in, possession, etc. of, small quantities of narcotic drugs.
As of 2008:
SMG Section 27 = illicit handling of narcotic 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. Since that year, information on the offence that has been decisive for the punishment imposed has been provided by the courts. Until then, Statistics Austria had 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. Due to 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:
Final convictions under the Narcotic Substances Act (SMG) in Austria by basis of conviction, gender and age group; in 2013*

Basis of conviction		Aged 14–19	Aged 20–24	Aged 25–29	Aged 30–34	34+	Total
SMG total	Men	468	1 226	874	518	753	3 839
	Women	34	127	106	55	91	413
SMG Section 28 or 28a	Men	84	267	244	170	385	1 150
	Women	8	35	34	17	45	139
SMG Section 27	Men	384	956	626	344	352	2 662
	Women	26	90	71	38	46	271

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. Since that year, information on the offence that has been decisive for the punishment imposed has been provided by the courts. Until then, Statistics Austria had 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. Due to 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 A17:
Final convictions under the Narcotic Substances Act (SMG): young people and adults, basis of conviction and type of punishment; in 2013*

Basis of conviction		Fine	Prison sentence			Other punishment[1]	Total
			Probation	No probation	Partial probation		
SMG total	Young people	74	72	26	14	10	196
	Adults	935	1 161	1 135	663	162	4 056
SMG Section 28 or 28a (felonies)	Young people	5	6	5	7	1	24
	Adults	37	318	504	328	78	1 265
SMG Section 27 (misde-meanours)	Young people	69	66	21	7	9	172
	Adults	892	834	616	335	84	2 761

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), i.e. combination of fine plus a prison sentence on probation; referral to institution (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. Since that year, information on the offence that has been decisive for the punishment imposed has been provided by the courts. Until then, Statistics Austria had 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. Due to 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 A18:
Development of statutory alternatives to punishment applied in Austria; from 2004 to 2013

Temporary discontinuation of penal action/ dismissal of proceedings	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total	9 666	11 660	10 379	10 175	9 384	10 627	11 807	11 667	11 455	13 044
SMG Section 35: temporary discontinuation of penal action by the public prosecutors*	8 599	10 668	9 173	9 008	8 399	9 661	10 643	10 319	10 215	11 818
SMG Section 35 para 4 (first report after at least 5 years, exclusively personal use of cannabis, mushrooms containing psilocin, psilotin or psilocybin, or psychotropic substances)*	2 016	2 697	1 895	1 841	2 249	2 780	3 166	4 059	5 515	6 766
SMG Section 37: temporary dismissal of proceedings by the court*	1 067	992	1 206	1 167	985	966	1 164	1 348	1 240	1 226
SMG Section 39 (suspension of sentence)	427	452	507	540	638	624	733	741	673	728

* 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 waiving of reports 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; graphic representation: GÖG/ÖBIG

Table A19:
Number of seizures of narcotic drugs/substances in Austria; from 2004 to 2013

Drug type	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Cannabis	6 202	6 012	5 770	5 732	5 050	5 733	6 195	6 750	7 137	10 139
Heroin	1 383	1 371	883	765	673	901	1 048	640	393	346
Cocaine	1 475	1 507	1 044	1 087	936	984	946	970	912	992
Amphetamine	324	312	299	319	262	347	352	383	348	496
Methamphetamine	18	16	35	61	37	53	114	162	259	363
LSD	29	20	20	39	20	39	43	41	47	39
Ecstasy	286	295	248	250	181	131	63	90	113	119
Mephedrone							73	125	36	54
Medicines containing narcotic drugs (incl. substitution medicines)	812	1 117	1 571	1 234	1 015	1 121	1 456	1 712	1 435	1 129
Other narcotic drugs*	87	97	84	92	58	79	72	67	65	88
Psychotropic substances	5	2	2	10	1	2	13	23	22	30
Medicines containing psychotropic substances	678	823	1 300	1 019	843	697	993	1 268	888	495
Precursor substances	0	2	7	1	12	0	1	0	8	9
Substances under the NPSG**										424

* Since 2008, mushrooms containing psilocin, psilotin or psilocybin have also been included.
** NPSG: Act on New Psychoactive Substances.

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

Table A20:
Seizures of narcotic drugs/substances in Austria by quantity; from 2004 to 2013

Narcotic drug/substance	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Cannabis (kg)	1 680.9	819.9	1 880.4	1 276.0	873.6	1 139.3	1 292.3	915.6	1 158.6	1 757.8
Heroin (kg)	235.0	282.2	34.3	117.0	104.0	189.6	96	64.9	222.1	80.2
Cocaine (kg)	75.5	244.9	61.8	78.1	78.38	53.2	241	139	64.6	24.7
Amphetamine (kg)	25.7	8.9	38.2	17.5	12.9	63.9	22.0	13.4	32.1	21.4
Methamphetamine (kg)	1.9	0.7	0.7	1.9	0.1	1.1	1.4	2.4	3.2	7.6
LSD (no. of trips)	2 227.5	2 108.5	10 831.5	1 058	225.50	1 581	533.5	1 588	276	618
Ecstasy (no. of pills)	122 663	114 104	30 855	66 167	45 335	5 847.5	7 275	45 780	8 998	5 768
Mephedrone (kg)	–	–	–	–	–	–	2.9	14.2	2.4	4.0
Medicines containing narcotic drugs (incl. substitution medicines)	9 031	9 057	12 253	10 376	7 180	8 233.5	11 630.5	12 504	11 039.5	8 196
Other narcotic drugs (kg)*	21.4	5.0	2.4	3.6	2.9	5.3	5.5	0.5	1.1	2.2
Psychotropic substances (kg)	0.05	0.00	0.03	0.20	0.00	0.01	2.6	4.3	2.9	0.6
Medicines containing psychotropic substances (no. of pills)	21 119	27 105	44 416	26 289	24 675	36 624.5	28 178	157 910	18 042	8 423
Precursor substances (kg)	0.00	0.10	9.85	0.17	22.16	0	1	0	2.8	149.7
Substances under the NPSG** (kg)										31.6

* Since 2008, mushrooms containing psilocin, psilotin or psilocybin have also been included.
** NPSG: Act on New Psychoactive Substances.

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

Table A21:
Ingredients of samples bought as ecstasy and analysed by *checkit!* at parties and clubbing; from 2004 to 2013

Ingredients	Samples bought as ecstasy (percentages)									
	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)	2012 (n=108)
MDMA	72.0	67.9	74.6	60.7	61.6	15.2	21.1	29.6	56.6	63.0
MDMA + MDE	9.7	0.0	1.5	0.0	0.0	0.0	0.0	0.0	2.1	0.0
MDMA + MDA	0.0	0.0	0.7	0.0	0.0	0.0	0.0	0.0	0.0	0.9
MDE and/or MDA	7.5	0.0	0.0	0.0	1.4	1.0	0.0	0.0	0.0	0.0
MDMA + caffeine	1.1	5.7	5.2	0.9	0.7	1.0	0.0	5.9	2.1	0.9
MDMA + amphetamine	0.0	1.9	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.9
MDMA + various combinations*	1.1	13.2	0.0	6.0	7.5	1.9	5.3	18.5	6.2	12.0
PMA/PMMA	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	9.7	1.9
Amphetamine	0.0	1.9	4.5	0.0	0.7	1.0	1.3	0.0	0.0	0.0
Methamphetamine	0.0	0.0	0.7	0.0	0.0	1.0	0.0	0.0	0.0	0.0
Caffeine	1.1	0.0	0.7	1.7	0.0	0.0	6.6	0.7	0.0	0.9
Piperazine/piperazine + various combinations**	0.0	0.0	1.5	16.2	17.8	52.4	47.4	19.3	–[3]	–[3]
Various combinations*	7.5	9.4	9.0	14.5	10.3	25.7	11.8	3.0	9.7	5.6
New psychoactive substances[1] / NPS[2] + various combinations***	–	–	–	–	–	0.0	6.6	23.0	13.8	13.9

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

** mCPP + various combinations: mCPP and one or more additional substances.

*** *New psychoactive substances*/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:
Ingredients of samples bought as ecstasy or MDMA in powder or crystalline form or as capsules and analysed by *checkit!* at parties and clubbing; from 2005 to 2013

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)	2012 (n=290)
MDMA	100.0	100.0	81.5	87.1	69.6	51.6	82.2	80.2	78.3
MDMA + MDE	0.0	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	0.0
MDE and/or MDA	0.0	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	1.4
MDMA + amphetamine	0.0	0.0	0.0	3.2	0.0	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	1.0
PMA/PMMA	0.0	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	0.0
Methamphetamine	0.0	0.0	0.0	0.0	0.0	1.1	0.0	0.0	0.3
Caffeine	0.0	0.0	0.0	0.0	0.0	1.1	1.2	0.0	0.3
Piperazine/piperazine + various combinations**	0.0	0.0	0.0	3.2	21.7	0.0	1.2	–[3]	–[3]
Various combinations*	0.0	0.0	7.4	6.5	4.3	3.3	1.2	5.0	2.4
New psychoactive substances[1] / NPS[2]+ various combinations***	–	–	–	–	8.7	35.2	8.0	9.9	16.2

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

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

*** *New psychoactive substances*/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 A23:
Ingredients of samples bought as speed and analysed by *checkit!* at parties and clubbing; from 2004 to 2013

Ingredients	Samples bought as speed (percentages)									
	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)	2012 (n=321)
Amphetamine	22.0	33.3	24.0	22.5	15.2	9.7	14.5	5.4	7.0	18.1
Amphetamine + caffeine	19.5	6.1	29.3	10.1	27.3	50.4	61.3	55.7	55.7	56.7
Amphetamine and methamphetamine	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.5	0.4	0.0
Amphetamine + various combinations	39.0	24.2	24.0	31.8	34.3	15.0	10.5	18.2	24.9	19.3
Methamphetamine	2.4	3.0	0.0	10.1	1.0	0.9	1.6	0.5	2.2	0.9
Caffeine	4.9	9.1	1.3	1.6	3.0	8.8	1.6	7.9	0.4	0.6
MDMA	0.0	6.1	4.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0
Various combinations*	12.2	18.2	17	23.3	14.1	14.2	7.3	5.4	5.5	2.5
Piperazine/piperazine + various combinations**	0.0	0.0	0.0	0.8	2.0	0.9	0.8	1.0	–[3]	–[3]
New psychoactive substances[1] / NPS[2] + various combinations***	–	–	–	–	–	0.0	2.4	5.4	4.0	1.9

* 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.

*** *New psychoactive substances*/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 A24:
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 2013

Treatment	B	C	LA	UA	S	St	T	VB	V	A
Continued treatment	217	576	2 255	1 629	448	1 204	1 057	594	7 948	15 928
First treatment	18	132	147	165	29	68	102	41	359	1 061
Total	235	708	2 402	1 794	477	1 272	1 159	635	8 307	16 989

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 A25:
Persons starting drug treatment or requiring addiction services in 2013, 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	2	0
5 to 9	0	0	0	0	0	0	0	0	0	0	1	0
10 to 14	1	2	1	0	1	1	1	1	1	0	0	0
15 to 19	19	21	19	3	7	4	15	16	16	6	19	9
20 to 24	25	21	24	13	21	15	23	24	23	26	28	26
25 to 29	20	23	21	24	26	25	21	23	22	28	17	26
30 to 34	14	15	14	24	19	23	16	15	15	20	21	20
35 to 39	8	8	8	15	10	14	10	6	9	8	6	8
40 to 44	6	4	5	11	7	10	6	6	6	6	2	5
45 to 49	4	4	4	6	4	5	4	5	5	2	2	2
50 to 54	2	2	2	3	3	3	2	2	2	2	2	2
55 to 59	1	1	1	2	0	1	1	1	1	1	1	1
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	3 670	1 014	4 023	1 407	501	1 908	2 264	712	2 976	529	126	655
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 2013; graphic representation: GÖG/ÖBIG

Table A26:
Persons starting drug treatment or taking up support services in 2013, 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
Gainful employment	–	–	–	15	11	14	35	22	32	3	8	4
Unemployed	–	–	–	52	43	50	37	36	37	36	38	37
Means-tested minimum income	–	–	–	14	26	17	9	18	11	7	10	7
Child, (school) student (='persons for whom support obligations exist')	–	–	–	1	3	1	3	6	4	0	2	1
Military service, alternative civilian service, parenthood leave, retired	–	–	–	8	13	10	7	15	9	15	18	15
Household, retraining, other source	–	–	–	6	6	6	7	8	8	41	34	40
No gainful employment and other source unknown	–	–	–	21	21	21	14	16	15	31	33	32
Number of persons with valid indications	–	–	–	1 147	403	1 550	2 054	662	2 716	503	124	627
Unknown	–	–	–	236	85	321	152	32	184	13	2	15
Missing	–	–	–	24	13	37	58	18	76	13	0	13

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 2013; graphic representation: GÖG/ÖBIG

Table A27:
Persons starting drug treatment or taking up support services in 2013, 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	–	–	–	–	–	–	1	1	1	2	0	1
Carinthia	–	–	–	–	–	–	15	16	15	3	5	3
Lower Austria	–	–	–	–	–	–	9	8	9	17	22	18
Upper Austria	–	–	–	–	–	–	1	1	1	15	16	15
Salzburg	–	–	–	–	–	–	5	6	6	7	5	6
Styria	–	–	–	–	–	–	9	12	10	6	7	6
Tyrol	–	–	–	–	–	–	3	3	3	8	7	8
Vorarlberg	–	–	–	–	–	–	15	10	14	10	11	11
Vienna	–	–	–	–	–	–	39	42	40	33	25	32
Abroad	–	–	–	–	–	–	2	1	1	0	1	0
Valid indications	–	–	–	–	–	–	2 151	684	2 835	509	122	631
Unknown	–	–	–	–	–	–	31	12	43	1	0	1
Missing	–	–	–	–	–	–	82	16	98	19	4	23

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 2013; graphic representation: GÖG/ÖBIG

Table A28:
Persons starting drug treatment or taking up support services in 2013, 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)	–	–	–	61	63	61	86	88	87	84	80	83
Unstable (e.g. homelessness)	–	–	–	33	32	33	7	7	7	9	11	9
Institution (e.g. hospital, treatment centre) plus additional stable housing (e.g. flat)	–	–	–	0	0	0	2	1	1	5	7	5
Institution (e.g. hospital, treatment centre), no additional stable housing	–	–	–	6	5	5	1	1	1	2	1	2
Assisted housing, plus additional stable housing (e.g. flat)	–	–	–	0	0	0	1	1	1	0	1	0
Assisted housing, no additional stable housing	–	–	–	0	0	0	2	2	2	0	1	0
Prison	–	–	–	0	0	0	1	0	1	0	0	0
Valid indications	–	–	–	1 146	395	1 541	2 129	677	2 806	499	122	621
Unknown	–	–	–	237	94	331	110	29	139	6	0	6
Missing	–	–	–	24	12	36	25	6	31	24	4	28

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 2013; graphic representation: GÖG/ÖBIG

Table A29:
Persons starting drug treatment or taking up support services in 2013, 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	**36**	**43**	**37**	**82**	**80**	**82**	**45**	**58**	**48**	**60**	**55**	**59**
Heroin	25	26	25	59	59	59	39	48	41	43	38	42
Methadone	4	3	4	44	40	43	4	7	5	13	17	14
Buprenorphine	4	3	4	40	37	39	5	8	6	3	6	4
Slow-release morphine	9	16	11	61	60	61	14	20	15	14	22	16
Other opioid	5	7	6	42	39	41	3	5	4	23	22	23
Cocaine group	**12**	**8**	**12**	**7**	**6**	**7**	**13**	**10**	**12**	**38**	**28**	**36**
Cocaine	12	8	11	7	6	7	13	10	12	37	28	35
Crack	0	0	0	1	1	1	0	0	0	1	1	1
Other cocaine	0	0	0	0	0	0	0	0	0	0	1	0
Stimulants total	**10**	**12**	**11**	**1**	**1**	**1**	**6**	**7**	**6**	**21**	**23**	**21**
Amphetamine (e.g. speed)	6	6	6	1	1	1	5	5	5	15	17	15
MDMA (ecstasy) and derivatives	2	2	2	0	0	0	3	2	3	16	16	16
Other stimulant	4	6	4	1	0	0	1	2	1	0	2	1
Tranquillisers/hypnotics total	**8**	**7**	**8**	**21**	**22**	**22**	**10**	**15**	**11**	**18**	**36**	**22**
Benzodiazepines	8	7	7	21	21	21	10	15	11	18	36	22
Barbiturates	0	0	0	4	4	4	0	0	0	1	2	1
Other hypnotics/tranquillisers	0	0	0	11	12	11	0	0	0	1	2	1
Hallucinogenic drugs total	**1**	**1**	**1**	**0**	**0**	**0**	**1**	**1**	**1**	**5**	**0**	**4**
LSD	1	0	1	0	0	0	1	0	1	5	0	4
Other hallucinogenic drug	0	0	0	0	0	0	0	0	0	0	0	0
Cannabis	**57**	**45**	**55**	**11**	**13**	**11**	**49**	**38**	**46**	**58**	**50**	**56**
Solvents and inhalants	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Alcohol	**8**	**9**	**8**	**5**	**9**	**6**	**6**	**6**	**6**	**17**	**25**	**18**
Other drugs	**5**	**4**	**5**	**0**	**0**	**0**	**1**	**2**	**2**	**1**	**6**	**2**
Primary drug (indications)	3 355	779	4 134	1 742	548	2 290	2 809	968	3 777	1 185	315	1 500
Primary drug indicated (persons)	2 191	549	2 740	563	182	745	1 803	569	2 372	445	109	554
Only legal problems (persons)	187	75	262	30	11	41	117	24	141	17	2	19
No primary drug indicated (persons)	1 276	383	1 659	814	308	1 122	303	106	409	21	6	27
Missing	16	7	23	0	0	0	41	13	54	46	9	55

Note: All lines except Primary drug (indications), Primary drug indicated (persons), Only legal problems (persons), No primary drug indicated (persons) and Missing give percentages that relate to the number of valid indications. 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 2013; graphic representation: GÖG/ÖBIG

Table A30:
Persons starting drug treatment or taking up support services in 2013, 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	75	66	73	31	33	31	65	56	63	53	36	50
Yes	25	34	27	69	67	69	35	44	37	47	64	50
Valid indications	3 385	875	4 260	1 114	392	1 506	2 108	671	2 779	463	116	579
Unknown	273	131	404	271	100	371	143	38	181	26	6	32
Missing	12	8	20	22	9	31	13	3	16	40	4	44

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 2013; graphic representation: GÖG/ÖBIG

Table A31:
Exchange and sale of syringes by number of provision points and province; in 2013

Province	Number of syringe provision points	Number of vending machines	Number of syringes provided (exchanged or sold)
Burgenland	0	0	0
Carinthia	4[2]	0	29 000
Lower Austria	0	0	0
Upper Austria	4[1]	3	355 805
Salzburg	1	2	8 615
Styria	2[1 3]	3	619 979
Tyrol	2	4	472 069
Vorarlberg	4	7	323 599
Vienna	2[1]	0	2 953 932
Total	**19**	**19**	**4 762 999**

1: Includes one streetwork service.
2: Includes two streetwork services.
3: Service restricted to Graz.

Source: ST10 Syringe availability 2014; calculation and graphic representation: GÖG/ÖBIG

Table A32:
Details regarding primary and secondary drugs in the categories 'other stimulants' and 'other drugs' for all 9 043 clients receiving inpatient or outpatient support and treatment in centres covered by DOKLI; in 2013

Substance	Primary drug	Secondary drug	Total
Nicotine	70	1 285	1 355
Methamphetamine	50	78	128
Other stimulants (not specified in more detail)	48	207	255
Mephedrone	36	138	174
Research chemicals	21	21	42
Mushrooms	14	248	262
Other	6	16	22
GHB	4	5	9
Ketamine	4	36	40
Herbal blends	2	13	15
Other natural drugs	1	21	22
4-MEC	1	0	1
Steroids	0	17	17

Note: Multiple indications.

Source: DOKLI analysis of client year 2013; 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. 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* [Become independent] is implemented in primary schools (children aged 6 to 10) over at least 10 lessons per year. It is oriented towards a holistic view of individuals, 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 course for primary school teachers.

Table A33:
Become Independent, school year 2013/14

Province	Number of completed trainings SY 2013/14	Number of training sessions for teachers[1] SY 2013/14	Number of certified teachers SY 2013/14	Percentage of primary school teachers reached	Number of primary schools reached SY 2013/14	Percentage of primary schools reached	Number of parents' meetings SY 2013/14	Number of workshops SY 2013/14	Number of primary school teachers reached by SY 2013/14	Percentage of primary school teachers reached by SY 2013/14	Number of primary schools reached by SY 2013/14	Percentage of primary schools reached by SY 2013/14
B	1	28	15	1.5	1	0.5	1	2	170	17.2	75	38.0
C	4	120	65	2.8	13	5.5	2	2	366	15.8	119	50.4
LA	6	180	87	1.2	18	2.6	0	2	711	9.9	161	22.9
UA	8	224	164	2.9	21	3.7	21	2	1 737	30.9	444	77.5
S	4	112	69	3.5	11	5.9	1	3	536	26.8	126	68.1
St	6	149	80	2.0	22	4.7	1	5	461	11.7	174	36.9
T	2	48	29	0.9	19	5.0	1	5	566	17.5	233	61.5
VB	2	52	31	2.2	4	2.3	1	4	774	55.3	100	60.0
V	4	112	69	1.3	26	6.5	n.a.	3	1 403	25.6	256	93.5

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 A34:
Programme *plus*, school year 2013/14

Province	Number of further training courses for teachers since 2008	Number of teachers with completed training SY 2013/14	Percentage of teachers reached	Number of schools reached SY 2013/14	Number of classes reached SY 2013/14	Percentage of schools reached SY 2013/14	Number of teachers reached by SY 2013/14	Percentage of school teachers reached by SY 2013/14	Number of schools reached by SY 2013/14	Percentage of schools reached by SY 2013/14	Number of classes reached by SY 2013/14
B	11	60	3.7	18	n.a.	34.0	60	3.7	18	34.0	n.a.
C	8	115	3.5	35	71	41.7	142	4.4	40	47.6	95
LA	5	13	0.1	5	6	1.7	80	0.9	14	4.7	67
UA	19	320	3.3	89	160	32.0	350	3.7	100	35.0	190
S	4[67]	42	1.2	22	41	23.9	74	2.1	24	26.1	50
St	9	203	5.0	35	105	21.6[68]	248	6.1	43	26.5[69]	130
T	7	88	2.1	34	ca. 66	30.4	145	3.1	52	46.4	125
VB	7	119	4.5	41	n.a.	60.0	119	4.5	41	62.0	n.a.
V	6	137	1.4	73	125	11.2	181	1.4	94	39.4	101

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

67
Courses only in school year 2013/14

68
Percentage relates only to lower and new secondary schools.

69
Percentage relates only to lower and new secondary schools.

Under the name *movin'* and *MOVE*, 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 A35:
movin' and *MOVE* courses, in 2013

Province	Direct/final target group (age group)	Indirect target group (advisers, multipliers)	Number of courses/course series in 2013	Number of training sessions for multipliers in 2013	Number of certified participants in 2013	Documentation yes/no	Process evaluation yes/no
C	Young people aged 12 to 21 in youth centres/social centres or in contact with street workers	Staff of open youth services, staff of youth welfare services	2	32	28	Yes	Yes
LA	Children and young people; smokers; pregnant women, mothers of new-born babies	Multipliers in prevention services, staff of youth welfare services, midwives, health promotion staff 2 reflection workshops for persons having completed *movin'* courses	4 2	80 12	33 18	Yes	Yes
UA	Young people aged 12 to 21, in youth centres, AMS labour market programmes, advisory services/social-care centres/in contact with street workers	Staff of open youth services; basic youth social work course for provincial youth officers; trainers in labour market policy programmes; staff of social-care and advisory services	3	56	47	Yes	Yes
S	Young people in youth centres and support services (work-place/apprenticeship, assisted shared housing), school students, clients of drug services, street work, etc.	Staff of youth centres and shared housing for young people and youth welfare services, guidance counsellors, apprentice instructors, street workers, police officers specialising in prevention, etc.	3	48 sessions (50 min. each)	39	Yes	Yes
St	Young people aged 12 to 21, young adults	Staff of open youth services, school social workers/advisers, social education workers, staff instructing or working with young people	3	48	45	Yes	Yes
T	Young people & young adults, aged 15 to 21	Staff of youth services, streetwork, employment projects, drug services	1	22	14	Yes	Yes
VB	Young people aged 12 to 21, clients of (addiction) support centres	Staff of (addiction) support centres and open youth services, recreational education staff	1	19	19	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	189	97	Yes	Yes

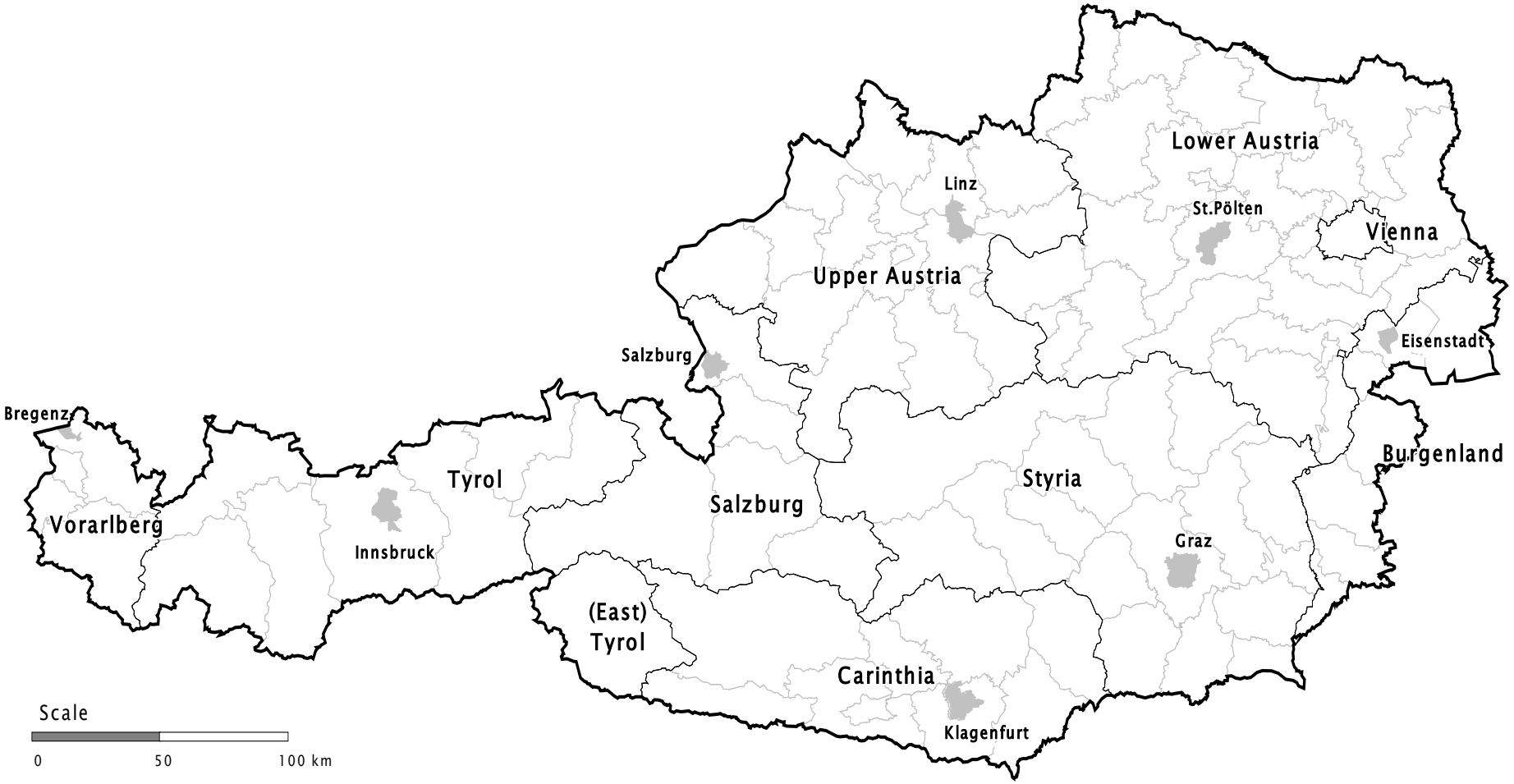
Sources: Akzente Addiction Prevention Unit Salzburg; Addiction Prevention Unit Burgenland; Addiction Prevention Unit Lower Austria; VIVID Addiction Prevention Unit Styria; Addiction Prevention Institute Upper Austria; kontakt+co; SUPRO Addiction Prevention Unit; Addiction Prevention Institute Vienna;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

Table A36:
Austrian population statistics by age group (groups of 5 and 15 years, respectively) and gender; annual average of 2012

Age group	Men	Women	Total
0 to 4	203 087	191 948	395 035
5 to 9	207 118	197 674	404 792
10 to 14	215 731	205 056	420 787
15 to 19	248 739	235 672	484 411
20 to 24	270 764	262 166	532 930
25 to 29	277 338	274 666	552 004
30 to 34	275 709	273 121	548 830
35 to 39	275 513	279 550	555 063
40 to 44	331 894	331 822	663 716
45 to 49	358 257	352 580	710 837
50 to 54	320 858	319 817	640 675
55 to 59	259 444	270 177	529 621
60 to 64	228 939	246 410	475 349
65 to 69	191 806	215 973	407 779
70 to 74	194 202	229 812	424 014
75 to 79	111 043	149 589	260 632
80 to 84	84 012	134 477	218 489
85 and over	54 977	146 370	201 347
Total	**4 109 431**	**4 316 880**	**8 426 311**
0 to 14	625 936	594 678	1 220 614
15 to 29	796 841	772 504	1 569 345
30 to 44	883 116	884 493	1 767 609
45 to 59	938 559	942 574	1 881 133
60 to 74	614 947	692 195	1 307 142
75 and over	250 032	430 436	680 468
Total	**4 109 431**	**4 316 880**	**8 426 311**
15 to 64	2 847 455	2 845 981	5 693 436

Source: Statistics Austria; 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
AC	Addiction Coordinator
AGES	Austrian Agency for Health and Food Safety
AHIVCOS	Austrian HIV Cohort Study
AIDS	acquired immune deficiency syndrome
AKB-48	N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide
AR	Addiction Representative
ART	antiretroviral treatment
B	Burgenland
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
BMBF	Federal Ministry of Education and Women's Affairs
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
BMVIT	Federal Ministry of Transport, Innovation and Technology
BMWFW	Federal Ministry of Science, Research and Economy
C	Carinthia
CND	Commission on Narcotic Drugs
COFOG	Classification of Functions of Government
CRC	capture-recapture method
DC	Drug Coordinator
DOKLI	nationwide documentation system of clients of Austrian drug services
DOKU	documentation system
DR	Drug Representative/Drug Commissioner
e.g.	for example
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
EWS_AT	Early Warning System Austria
FGÖ	Fonds Gesundes Österreich [Health Austria Fund]
FH	University of Applied Sciences
GHB	γ-hydroxybutanoic acid
GÖG	Gesundheit Österreich [Health Austria]
HAART	highly active antiretroviral 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
ICD-10	International Classification of Diseases and Related Health Problems
IDU	injecting drug use(r)
IFES	Institute for Empirical Social Studies
IHME	Institute for Health Metrics and Evaluation
incl.	including
inp.	inpatient
ISP	Addiction Prevention Institute
KAV	Vienna Hospital Association
kg	kilogram
LA	Lower Austria(n)
LGBl.	Collection of Provincial Statutes
LISA	list of doctors qualified to deliver opioid substitution treatment
LSD	d-lysergic acid diethylamide
MA	Municipal Department
mCPP	meta-chlorophenylpiperazine
MDA	3,4-methylenedioxyamphetamine
MDE	3,4-methylenedioxy-N-ethylamphetamine
MDMA	3,4-methylenedioxy-methylamphetamine
n. a.	not available
NPS	new psychoactive substance(s)
NPSG	Act on New Psychoactive Substances
ÖAKDA	Austrian Working Group for Communicative Drug Work
ÖBIG	Österreichisches Bundesinstitut für Gesundheitswesen [Austrian Health Institute]
ÖGABS	Austrian Society of Pharmacologically Assisted Treatment of Addiction
OST	opioid substitution treatment
outp.	outpatient
ÖVDF	Federation of Austrian Professionals Working in the Field of Drug Abuse
para	paragraph
PCP	phenylcyclohexylpiperidine
PMA	paramethoxyamphetamine
PMMA	para-metoxymethamphetamine
PVP	pyrrolidinovalerophenone
REITOX	European Information Network on Drugs and Drug Addiction (Réseau Européen d'Information sur les Drogues et les Toxicomanies)
S	Salzburg
SDHN	Vienna addiction and drug services network
SDW	Vienna Addiction and Drug Coordination
SHH	Schweizer Haus Hadersdorf

SHW	Suchthilfe Wien [Vienna Addiction Services]
SMG	Narcotic Substances Act
SQ	Structured Questionnaire
ST	Standard Table
St	Styria
STD	sexually transmitted disease(s)
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
XLR-11	see 5FUR-144
4-MA	4-methylamphetamine = 1-(4-methylphenyl)propan-2-amine
4-MEC	4-methylethcathinone
5FUR-144	(1-(5-fluoropentyl)-1H-indole-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone

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 collected information is used for the update of the statistical bulletin, the European report on the drug situation as well as other products of the EMCDDA.[70]

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 high-risk drug use
Standard Table 08:	Local prevalence estimates on high-risk 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 (not available for Austria); 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; not available for Austria)
Standard Table 18:	Overall mortality and causes of deaths among drug users
Standard Table 24:	Access to treatment
Standard Table 30:	Standardised results and methodology of targeted youth and/or site settings, national or local surveys on drug use (not available for Austria)
Standard Table TDI:	Characteristics of individuals starting treatment for drugs by type of treatment centre
Standard Table:	Public expenditure (not available for Austria)
Structured Questionnaire 22/25:	Universal prevention (latest update: 2013)
Structured Questionnaire 23/29:	Prevention and reduction of health-related harm associated with drug use (latest update: 2014)
Structured Questionnaire 26:	Selective prevention (latest update: 2013)

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

Structured Questionnaire 27:	Part 1: Treatment programmes; Part 2: Quality assurance (latest update: 2014)
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)