European Monitoring Centre for Drugs and Drug Addiction

REITOX FOCAL POINT AUSTRIA

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AUSTRIA

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

REITOX

Gesundheit Österreich GmbH
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Report on the Drug Situation

2009

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Summary

National reports on the drug situation in Austria are drawn up annually for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Federal Ministry responsible for health affairs. They deal with the subject of illicit drugs. This report gives an overview of current developments regarding the political and legal framework, the epidemiological situation and demand reduction interventions in the reporting period 2008/9. Every year specific issues are also highlighted; for this report, the themes of market and production of cannabis as well as treatment for older drug users have been selected.

Summary and discussion of the most important trends

In 2008 the Narcotic Substances Act (SMG) was amended in order to harmonise with EU legislation the Austrian provisions on use and handling of narcotic substances and precursors. Under the amended act it has been admissible to grow cannabis for the purpose of obtaining active substances for the production of pharmaceuticals. In addition, the legal basis has been provided for using e-government functions to maintain the central narcotic substances database, for establishing nationwide substitution monitoring and for regulating the exchange of information in the context of coordinated, comprehensive treatment and counselling routines for substitution patients. Several decrees were issued to control the substances of BZP, oripavine, Spice as well as smoking blends similar to Spice.

In the Government Policy Statement of the new Federal Government, the theme of addiction is only mentioned with regard to the further development of the national strategy to prevent addiction and suicide, with special regard to risks for children and young people, and with regard to strategies for healthy schools. According to the current political focuses, legal substances as well as forms of addiction that are not related to substances have played an increasingly important role in prevention activities as well as in the services of drug help units. This is reflected in the fact that, in addition to the Federal Drug Forum, also an Alcohol Forum was established, which has already started to prepare a national alcohol prevention strategy.

The main themes of drug policy discussions included measures to prevent drug-related deaths and, as also in previous years, opioid substitution treatment and the effects of the new decrees of 2007. Reports from the provinces, among other themes, document the structural changes that were necessary as a consequence of the new legal situation. In the reporting period, recommendations were drawn up that are to be integrated in amendments to the Narcotic Drugs Decree and the Oral Substitution Further Training Decree.

A number of recent data assessing the current drug situation are available. Approximately one out of five people used cannabis at some point in life, with the highest shares (up to 40%) found among young adults. The rates concerning other substances are considerably lower in the general population, i.e. between 2% (heroin) and 4% (ecstasy, amphetamines, cocaine) at most. Moreover, the rates covering current drug use (12-month prevalence) are even smaller, which shows that use of illicit substances is typically limited to experimental use and to a certain period in life. The prevalence rates obtained in new surveys are much smaller than in past years. Part of the results sowing strong declines with regard to lifetime

prevalence rates are in fact impossible, and methodologies should thus be discussed in more detail. In 2008, smoking of Spice was a relevant issue in the media coverage of psychoactive substance use, but it is unknown whether Spice, obtained in black markets or through the internet, is still used. According to reports on the party scene, pills sold as ecstasy increasingly often contain (also) ingredients such as mCPP or PMA, which is a considerable health risk. Only 15% of drugs sold as speed actually contained only amphetamines. In addition, instances of high-risk use of GBL, which converts into GHB in the body, were reported.

The most recent prevalence estimates on problem drug use (in Austria, this primarily concerns poly-drug use with opioids) relate to the year 2007 and indicate between 22 000 and 33 000 problem drug users.

The client year 2008 is the third year for which data from DOKLI, the nationwide documentation system of clients of Austrian drug help units, are available. In the treatment sector, opioids continue to predominate as primary drugs among problem drug users, while cocaine plays a marginal role only. Different to a number of other EU members, in Austria opioids are the substances most frequently involved in drug use relevant for treatment. People with cannabis as their primary drug are the second-largest group in the treatment system. It would be a point worth discussing whether this high share actually is the result of health problems or psychosocial problems caused by cannabis use or whether it rather reflects repressive policies regarding cannabis. Another question is whether the needs of this group of clients can always adequately be met in the existing drug help units. More detailed studies based on these results found in the context of the routine monitoring of DOKLI would be needed in order to obtain further insight.

The data quality of statistics on drug-related deaths has deteriorated because autopsies now tend to be performed less often in cases of suspected drug overdoses. This significantly reduces the epidemiological conclusiveness of the corresponding data. In order to maintain a high quality of this epidemiological key indicator, activities at several levels are imperative. Regarding prevalence rates of infectious diseases, again no data basis is available that would permit reliable statements on extents or trends. Great attention has been paid to psychiatric comorbidity; the shares of drug users who also suffer from mental or behavioural disorders continue to be high.

Recent trends in the fields of prevention and drug help services show increasing regionalisation, e.g., in the form of control bodies at district level and local intervention plans. These plans are often drawn up in the context of community prevention but in part they also relate to services by drug help units. Technical standards are taken into account in all areas: for instance, both prevention programmes to be implemented at nationwide level as well as guidelines for the treatment of benzodiazepine addiction are being prepared. The target groups of drug users with a background of immigration and their families have begun to play a more prominent role in the drug help sector, and existing services are being adapted in order to address this group. In the treatment sector, regional capacities still are insufficient, mainly due to rather high shares of clients undergoing compulsory health-related measures because of use of cannabis and also the fact that opioid substitution treatment has increasingly often been carried out at drug outpatient departments or drug counselling centres. Attempts to improve the treatment of infectious diseases among drug users focus on the cooperation between the drug help sector and the corresponding medical care institutions. Activities to facili-

tate coexistence without conflicts in public places – and thus to prevent drug-related crime – are being expanded, as are activities aimed at reintegration by means of occupation programmes.

2008 saw a decline in police reports, in particular reports relating to cannabis, which the Federal Ministry of the Interior explains with investigations of drug dealing structures in order to smash drug gangs. This does not mean that drug use has gone down, however.

Selected Issue: Market and Production of Cannabis

According to the Federal Criminal Agency at the Federal Ministry of the Interior the production of cannabis in Austria is insignificant compared to other countries. Cannabis products are primarily imported to Austria from the Netherlands, the Balkan countries, the Schengen Area, Morocco and Switzerland. Austria is of growing relevance as a country of transit for cannabis products from the Far East (India, Nepal) to Western Europe. According to BMI/.BK, cannabis products are sold all over Austria, but especially in and around cities in both public places or streets and bars known as places of drug dealing. The majority of seizures concern herbal cannabis, although pronounced variations show in individual years with regard to both number of seizures and quantities seized. In 2008 92% of reports relating to cannabis were made because of violations of Section 27 of the SMG, which regulates illegal handling of drugs, 3% of cannabis reports concerned Section 28 of the SMG (preparation of narcotic drug trafficking), and 5% related to Section 28a (narcotic drug trafficking).

Selected Issue: Treatment and Care for Older Drug Users

There are some indications that the number of drug users aged 40 or older is rising. Analyses of the DOKLI data of the client year 2008 have shown differences in patterns of use in different age groups. Regarding drug-related health problems, the situation of older clients has to be considered as substantially worse than that of younger clients. It should be taken into account that older drug users are underrepresented in the services that communicate data to DOKLI. As yet, the causes of this fact are a matter of speculation. There are no specific programmes for the target group of older drug users in the Austrian drug help system. The EU project SDD-Care is of key significance regarding the development of strategies for future assistance to, and care for, older drug users.

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Introduction

This is the 14th time that the REITOX Focal Point at GÖG/ÖBIG (Austrian Health Institute) presents its annual Report to the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) and the Austrian Federal Ministry responsible for health affairs. The REITOX Focal Point is a central link in Austria's data and information network of drug-related matters and closely cooperates with the relevant federal and provincial agencies in this field as well as addiction and drug help centres.

This report deals with illicit drugs and serves both as a national report on the situation in Austria and as Austria's contribution to describing the drug situation in the European Union (EU). Similar reports are submitted by the REITOX Focal Points in all EU member states and by the EU candidates, according to guidelines issued by the EMCDDA. These reports are essential as a basis of the EMCDDA's Annual report on the state of the drug problem in the European Union (latest publication: EMCDDA 2008).

Part A of this report deals with new developments and trends with regard to the drug policy framework, the epidemiological situation and health-policy interventions aiming at demand reduction. It is based on previous reports (latest report: GÖG/ÖBIG 2008c) and refers to the reporting period from summer 2008 to summer 2009, while routine statistics refer to the year 2007. In Part B of the report two selected issues are presented in more detail. In the present report the corresponding chapters deal with cannabis markets and production as well as treatment for older drug users. The Annex includes a number of additional tables with detailed information and data.

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

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

We are especially indebted to the members of the advisory working group of the REITOX Focal Point Austria, Mr Michael Dressel (Drug Coordinator of the City of Vienna and Provincial Representative), Ms Irmgard Eisenbach-Stangl (member of the Scientific Committee of the EMCDDA), Mr Thomas Neubacher (Drug Coordinator of Vorarlberg and Provincial Representative), Mr Franz Pietsch (Federal Drug Coordinator and head of the Federal Drug Coordination, BMG), Mr Robert Scharinger (BMG) and Ms Johanna Schopper (head of the Department of Drugs and Narcotic Substances at the BMG) for their helpful comments and invaluable input.

Part A

New Developments and Trends

1 Drug Policy: Legislation, Strategies and Economic Analysis

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

Drug policy measures are financed primarily by the Provincial Governments, the social insurance funds and the Federal Government. The COFOG classification[1], which is promoted by the EU, has not fully been implemented in Austria, and in the individual budgets expenditure related to drugs or addiction is hardly specified (see GÖG/ÖBIG 2007b). Therefore, no definite statements regarding expenditure in this field can be given for Austria.

1.1 Legal framework

In the reporting period, as announced last year (GÖG/ÖBIG 2008c), the Narcotic Substances Act (SMG) was amended. The primary aim of the amendment was to harmonise with EU legislation the Austrian provisions on use and handling of narcotic substances and precursors, to permit growing cannabis for the purpose of obtaining active substances for the production of pharmaceuticals, to provide a legal basis for using e-government functions for maintaining the central narcotic substances database and to adopt provisions regulating nationwide opioid substitution monitoring and exchange of information in the context of coordinated, comprehensive treatment and counselling routines for substitution patients. The 2008 amendment to the SMG (BGBl I 2008/143 v. 19.12.2008) includes the following provisions:

- Section 6a of the SMG permits the growing of cannabis plants by the Austrian Agency for Health and Food Safety (AGES) in order to obtain a narcotic substance for the production of pharmaceuticals as well as for scientific purposes related to this field. The substances produced may only be made available to enterprises that are authorised to produce pharmaceutical products and act as wholesalers to distribute them.

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

- Under Section 8a of the SMG, physicians are obliged to report without delay to the district authorities, in their functions as health authorities, the beginning and end of opioid substitution treatment. In the case of individual prescriptions of substitution substances, also the substance in question has to be specified. Any observations made in connection with the treatment, care or counselling of substitution patients may only be communicated to others if the patient in question has expressly given their permission or if this is absolutely necessary in order to protect the patient's health. If the patient's prior permission cannot be obtained, the reasons for this have to be documented.
- Section 24 of the SMG provides that the Ministry of Health maintain a narcotic substances registry to document violations of the SMG, and a substitution registry in order to prevent multiple treatment with substitution substances. In addition, all deaths that are causally linked to drug use have to be documented and analysed. This Section also includes detailed regulations regarding who has to provide which kind of information. The facts that have to be reported and entered in the narcotic substances registry (Section 24a of the SMG) include the corresponding offence and its legal basis, substances or precursors seized as well as information on temporary discontinuation of penal action, dismissal of proceedings or convictions. In addition, also persons whose examination according to Section 12 of the SMG showed misuse of narcotic substances have to be registered. Data that are relevant for the substitution registry (Section 24b of the SMG) include the data specified in Section 8a as well as data on physicians providing treatment and the referring authority, the substitution substance of the first long-term prescription including dosage and any change of substance. Regarding drug-related deaths (Section 24c of the SMG) the day and place of death as well as when and where the deceased was found have to be reported, also the findings of the post-mortem examination, indications of drug overdose or other substances used, other evidence concerning the cause of death as well as the type and quantity of narcotic or other substances found. All data communicated may be used for statistical and scientific purposes but not for analyses related to individual persons.
- Section 25 of the SMG deals with the organisation and maintenance of the narcotic substances registry and the substitution registry in the form of electronic registries of the Ministry of Health, as well as administration and use of the data of these registries. According to these provisions data, when used for statistical or scientific purposes, have to be transferred to a statistics registry and any direct or indirect link to individual persons has to be deleted. Online access to the data is only possible if certain conditions are met, and prior authorisation by decree by the Ministries of Health and Justice is required. It is also specified in which cases data of the narcotic substances registry have to be deleted immediately (e.g., after dismissal of proceedings), after one year (in cases of examination under Section 12 of the SMG) or after five years, at the latest. Data entered in the substitution registry have to be deleted immediately in case of death, or no later than six months after the end of treatment.

In correspondence with the amendment to the SMG of 2008, also the Narcotic Drugs Decree and the Psychotropic Substances Decree had to be amended as they are related to the SMG (BGBl II 2008/480 v. 19. 12. 2008 and BGBl II 2008/481 v. 19. 12. 2008, respectively).

An amendment to the Oral Substitution Further Training Decree (BGBl II 2009/5 v. 2. 1. 2009) extends the transition period before these provisions will enter into force (see GÖG/ÖBIG 2006). Physicians who are on the list of doctors entitled to carry out opioid substitution treatment on grounds of professional practice have to be deleted from the list unless they furnish the required proof of qualification by 31 December 2009.

Changes in the legal framework during the reporting period also concern the control of new substances. After the psychoactive effect of the active substance of Spice became known, a Decree was adopted that prohibits putting into circulation, importing and delivering herbal smoking blends that contain JWH-018 (BGBl II 2009/6 v. 7. 1. 2009). Subsequently, also other psychoactive substances were detected in Spice and products similar to Spice, therefore it was necessary to expand the prohibition to include other substances with cannabinomimetic effects[2] as well (BGBl II 58/2009 v. 3.3.2009). Further legal steps are being considered.

The amendments to the Narcotic Drugs Decree (BGBl II 2009/173 v. 15. 06. 2009) and the Narcotic Substances Limit Quantities Decree (BGBl II 2009/174 v. 16. 06. 2009) aim at including also oripavine and BZP in the control structure of the SMG and consequently implementing the corresponding decisions adopted at international level. As measuring methods have become more sensitive and also very small residual quantities of alkaloids may be detected in decocainated extracts of coca leaves used as flavourings, the amendment to the Narcotic Drugs Decree also defines more precise maximum admissible residual amounts (a total of 1.25 ppm or 1.25 mg/l or mg/kg).

As a consequence of the changes in the legal framework regarding opioid substitution treatment (OST), which entered into force in March 2007 (see GÖG/ÖBIG 2007b), in spring 2008 activities were started to give an overview, and to assess the effects, of this development (see Chapter 5.3). The resulting recommendations serve as a basis for modifications of the corresponding legal provisions. This matter has been under assessment since August 2009.

1.2 National action plan, strategy, evaluation and coordination

The main political and administrative framework has not changed in the reporting period (see SQ32). Autumn 2008 saw federal elections, and on 2 December 2008 the new Government was inaugurated. In the Government Policy Statement 2008–13 (Bundeskanzleramt 2008) the theme of addiction is only mentioned in the chapter on health. Under the heading of health promotion and prevention, a plan is outlined that aims at an advancement of the national strategy to prevent addiction and suicide, with special regard to risks for children and young people. This is an expansion of the national addiction and alcohol strategy planned so far, preparations for which were started in the reporting period in the context of the Alcohol Forum. The strategy for healthy schools will be further developed in line with the focus on

[2] Synthetic substances that imitate the effects of cannabis

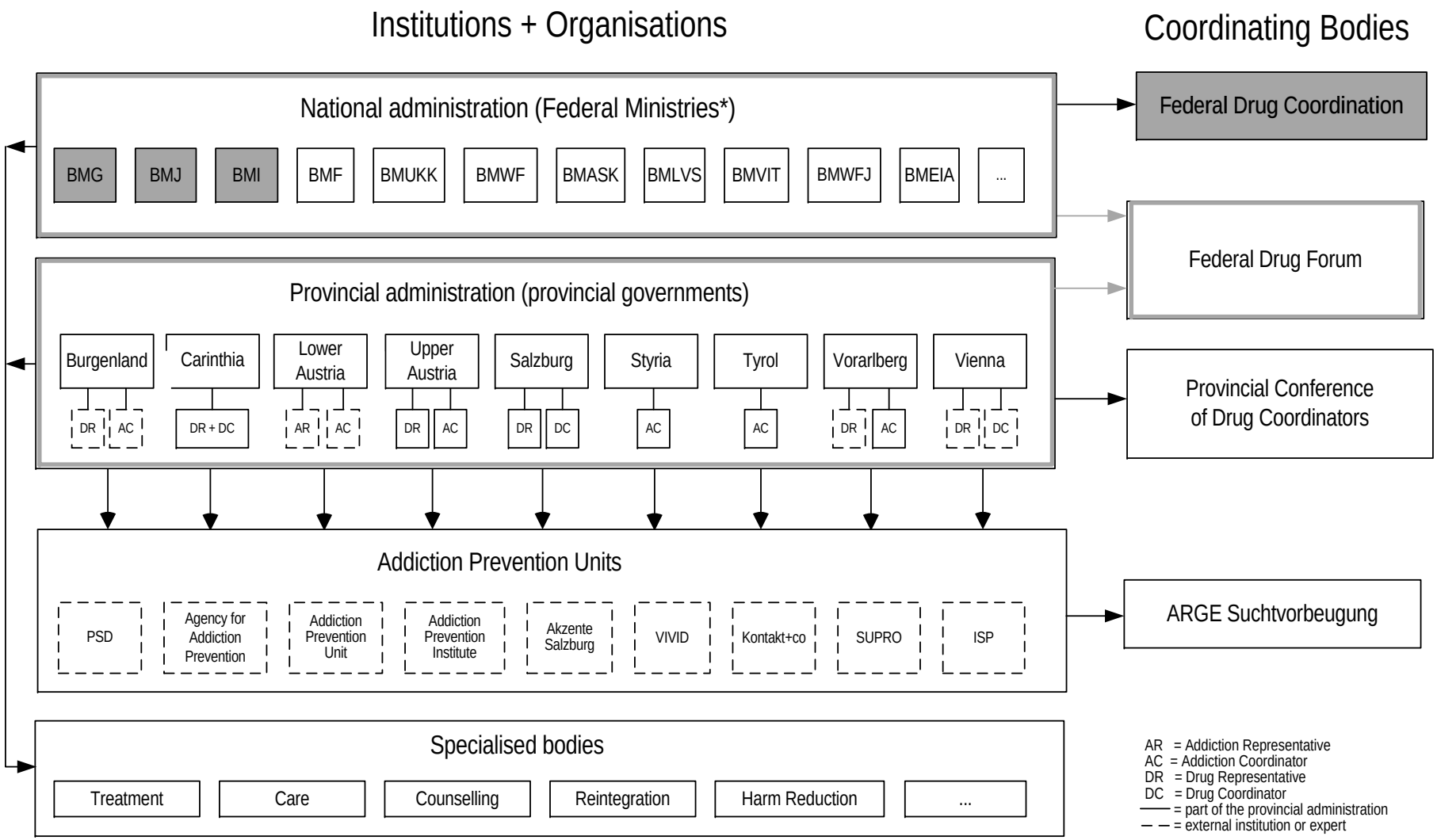
children's and young people's health. This also includes the issues of psychological health and addiction.

The Federal Drug Forum (see Figure 1.1) held two regular meetings in the reporting period (November 2008, April 2009). Among other themes, their agenda included legal questions relevant for the field of drugs (see Chapter 1.1), possible minimum standards for autopsy reports as well as harm reduction measures, procedures regarding the national addiction and suicide prevention strategy as well as establishing cofinancing structures between federal and provincial authorities (see GÖG/ÖBIG 2008c). The working groups convoked by the Federal Drug Forum to draw up guidelines for a nationwide uniform implementation of Section 12 of the SMG (see GÖG/ÖBIG 2008c) and to evaluate the legal framework of opioid substitution treatment (see Chapter 5) continued their activities in the reporting period. The new working group on annual reporting on activities regarding the Addiction Help Compass modified the Addiction Help Compass to meet the requirements connected with reporting. In addition, a new steering group was established, which deals with ways to reduce drug-related deaths (see Chapter 7.1).

In the provinces, the legal framework did not change in the reporting period, but new developments are to be expected. For instance, Upper Austria, based on the addiction strategy in force, is drawing up an addiction plan aimed at pointing out existing services and giving guidelines for medium-term developments in the field of addiction. In Styria a drug strategy was prepared, which will be adopted by the Provincial Government in autumn 2009. In the Tyrol, an analysis of social environments is carried out which, combined with past evaluations of the current drug strategy, will form the basis for drawing up a new drug strategy, which will also take into account regional developments and special regional characteristics that have been identified as of summer 2009 in the context of information events at district level (Kern, personal communication). In Carinthia, a body of experts of the Addiction Advisory Board of Carinthia prepared a list of demands that include an expansion of the provincial Addiction Prevention Unit and youth welfare agencies, the establishment of a coordination office focusing on children of addicted parents, an expansion of professional addiction-oriented services by increasing the staff of the Drug Coordination Office, the creation of specific occupational rehabilitation services and a drug department for inpatient acute treatment primarily of opioid addicts, as well as better involvement of the Addiction Advisory Board in discussions on addiction policy matters.

In Lower Austria, drug advisory boards at local level have been established since 2008 (see GÖG/ÖBIG 2008c) to promote discussions of the theme of addiction. In the town of Mödling, as a result of these activities, a local action plan on addiction was drawn up (Hörhan, personal communication). A similar approach is pursued in the district of Vöcklabruck (Upper Austria), where a plan of measures to be taken was prepared (see Chapter 3.1). Although its main focus is placed on steps to prevent addiction, the theme of opioid substitution treatment is also included.

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



* see List of Abbreviations

Quelle: GÖG/ÖBIG; representation by GÖG/ÖBIG

In order to expand universal and selective prevention in the province of Burgenland, a strategy paper was drawn up (Hausleitner 2008). It lists the necessity to expand structures, cooperation and networks as well as to increase resources, as prevalence rates of risky patterns of behaviour such as drug use have risen. Therefore, it has been recommended to establish a special prevention institute that is in charge of all prevention measures, from planning and defining interventions to coordinating them with cooperation partners. The corresponding measures will be carried out by several service providers. The strategy will be implemented over the next few years.

1.3 Economic analysis

The financial regulations in the field of drugs did not see changes in the reporting period. For an overview of the present situation please consult SQ32. A point worth mentioning might be that after the change in substitution treatment regulations a number of provinces entered into negotiations, or concluded agreements, with the social insurance funds (see GÖG/ÖBIG 2008c) in order to obtain remuneration for physicians providing opioid substitution treatment. The problem of remuneration in cases of patients referred to compulsory treatment has been a matter debated for several years already and has been an important issue also in the reporting period (see Chapter 1.2). However, solutions to this problem are not likely to be found in the near future.

Regarding budgets, no detailed information is available, therefore no overview can be given.

2 Drug Use in the General Population and Specific Targeted Groups

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

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

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

2.1 Drug use in the general population

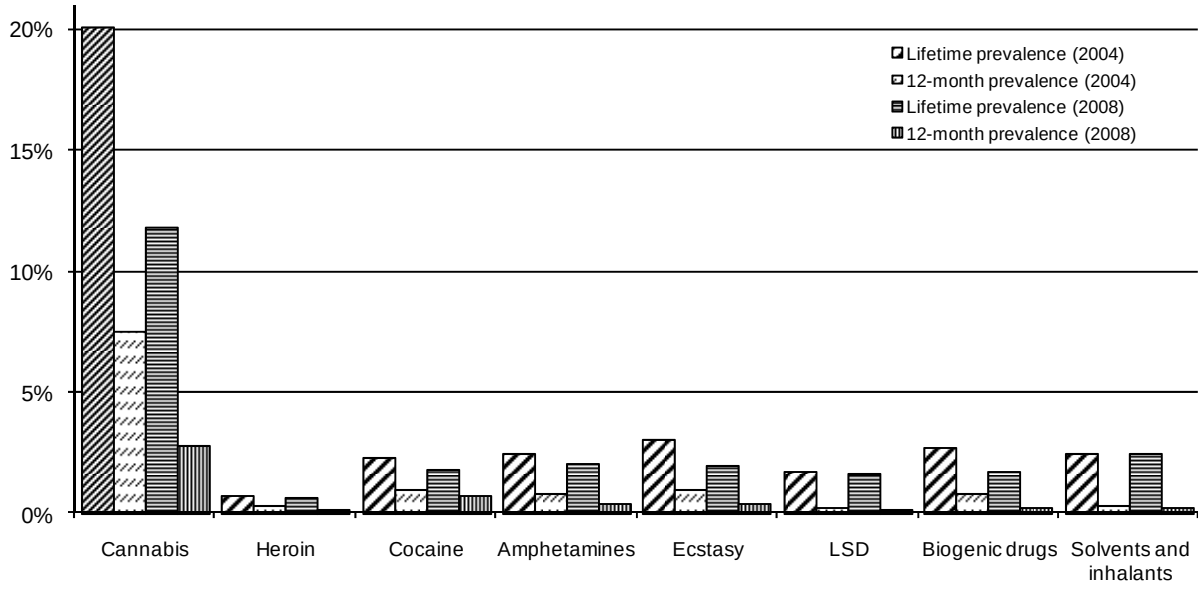
2008 was the second time that a representative survey[3] on prevalence and patterns of use of legal and illicit narcotic substances was carried out on behalf of the Federal Ministry of

[3] The questionnaire was prepared by the Ludwig Boltzmann Institute of Addiction Research and GÖG/ÖBIG, and the survey was conducted by the market research institute *market* by means of face-to-face interviews. After a briefing of the interviewers, the persons to be interviewed were selected by means of random sampling. The corresponding addresses were communicated to the 593 interviewers involved in this project, who contacted the respondents and interviewed them. Different to the previous survey, in this research project two subsamples of the same size were distinguished: persons aged 15 to 24 and persons over 24 years. In the target group of people aged 25 or older, according to the last-birthday method, the person in the household chosen for the interview was the one aged 25 or older with the most recent birthday. When choosing addresses for the sample subgroup aged 15 to 24, the first step was to verify if a person of this age group lived in the household. As a second step (in households with more than one person of this age group) the method described above was used to schedule a meeting. Each address was contacted at least three times (exceptions: no person in the required age group in the household; interview already concluded or refusal to be interviewed). The participation rate was 34.4%, which is significantly higher than in 2004. The field stage took place between 27 October and 1 December 2008. For 46% of interviews, phone checks were made. 73 questionnaires had to be eliminated, and 4 196 questionnaires could be analysed. Analysing and reporting will be carried out by the Ludwig Boltzmann Institute for Addiction Research at the end of 2009.

Health (BMG). The final report on this study and detailed analyses will not be available before the end of 2009 (Uhl et al. 2009, under preparation), but preliminary results can already be given (see Table A1 in Annex A resp. ST1). In the context of the survey on use, a total of 4 196 people over 14 were interviewed with regard to their experience of use of legal as well as illicit psychoactive substances. 50% of respondents were in the age group from 15 to 24 (oversampling of young people / young adults). In the analyses regarding overall population, this oversampling was balanced by means of weighting.

In sum, the prevalence rates found in the 2008 survey were lower for almost all drugs compared to the survey of 2004 (see Figure 2.1). Regarding cannabis, lifetime prevalence went down to nearly half the percentage of 2004. Such a decline in lifetime prevalence rates within a period of only four years is impossible. Other factors, e.g., stronger tendencies to deny use of illicit drugs or possibly methodological problems, must have been essential reasons for the low rates indicated. These results should be discussed in detail by the Austrian group of experts on population surveys of drug use.

Figure 2.1: Lifetime and 12-month prevalence rates of illicit drug use among the general population, 2004 and 2008 (percentages)



Source: Uhl et al. 2005a and 2009, under preparation; representation by GÖG/ÖBIG

The share of respondents indicating experience of alcohol (95%) or tobacco (67%) is markedly higher than people admitting illicit drug use.

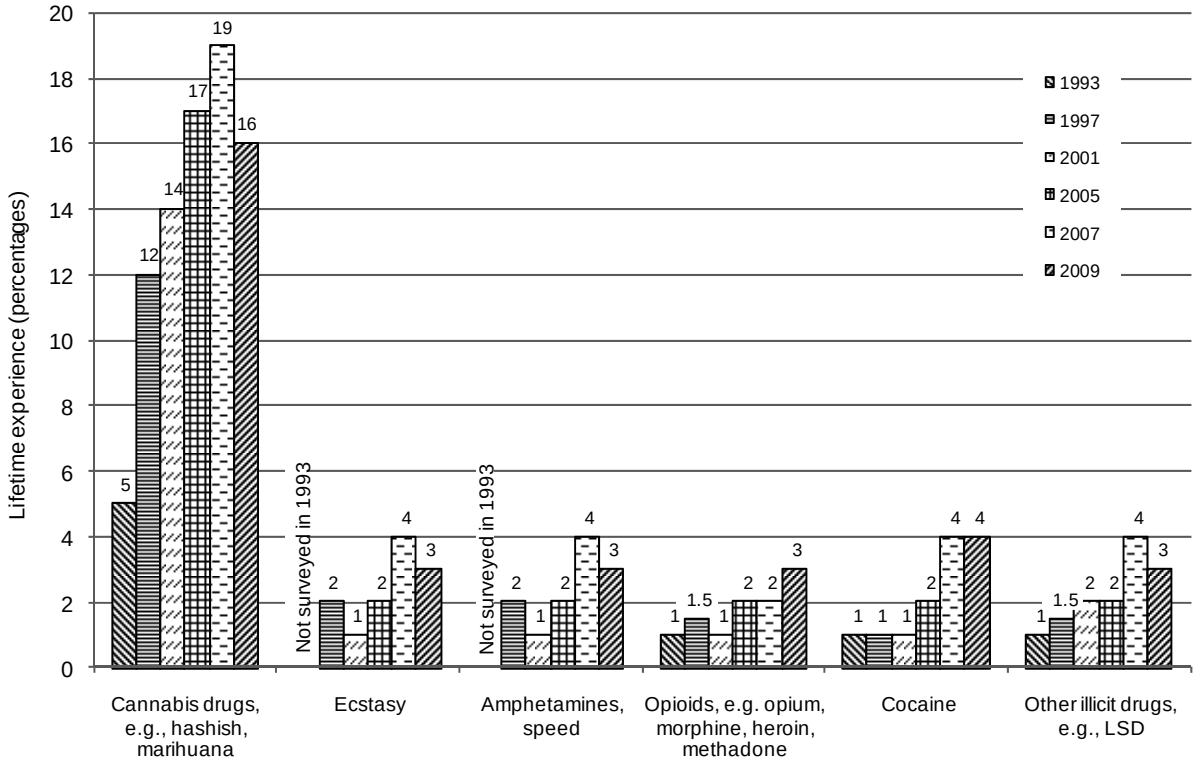
The prevalence rates covering the past year (12-month prevalence) have gone down considerably. They are above one percent only in the case of cannabis (2.8 %; 2004: 7.5 %) and under one percent regarding all other substances (see Figure 2.1). This confirms the assumption that use of illicit drugs tends to be limited to a certain period in life or to experimental use. However, the strong decrease in 12-month prevalence rates for illicit substances compared to 2004 should be assessed critically.

Recent data are again available from the Vienna drug survey[4], which permits an analysis of long-term trends since 1993 (IFES 2009; see also Table A1 in Annex A and ST1).

Compared to previous surveys, indications of drug use went down or remained at levels similar to the past, with the exception of opioids (see Figure 2.2). Regarding cannabis, after a continuous rise, rates of use went down again. Although the decline is considerably smaller here, this result shows an interesting parallel to the development of prevalence rates in the aforementioned nationwide population surveys, and should be discussed.

In the age groups under 30 and between 30 and 40, a share of 20% reported experience of cannabis, compared to 22% in the group aged 40 to 50 and 25% in the group between 50 and 60. In the group older than 60, only 3% indicated experience of cannabis. As a rule, lifetime prevalence rates are higher among men than among women (e.g., cannabis: 22% v. 11%). To obtain a more comprehensive picture, also use in the past three years and in the past 30 days was studied: here the resulting prevalence rates are considerably lower compared to lifetime use (e.g., cannabis: 5% v. 3%).

Figure 2.2: Lifetime experience of illicit drugs among the population of Vienna from 1993 to 2009 (percentages)



Source: IFES 2009; representation by GÖG/ÖBIG

[4] The Vienna drug survey (IFES 2009) was conducted in February 2009 among a representative random sample of 600 people aged 15 or older, in the form of oral interviews. Such surveys of experience of use have been carried out with similar methodologies every two years since 1993, on behalf of the Vienna Addiction and Drug Coordination.

Smoking of Spice (see Chapter 10.3) was a relevant issue in the media coverage of psychoactive substance use for some time in 2008. Spice has meanwhile been prohibited (see Chapter 1), and it is unknown whether Spice, obtained in black markets or through the internet, is still used.

2.2 Drug use in the school and youth population

In 2007 a school survey was carried out in Austria for the second time in the context of the ESPAD project[5] (see ST2). A comprehensive analysis is not yet available and will be completed late in 2009. A few results on experience of use have already been communicated in the report of last year (GÖG/ÖBIG 2008c).

2.3 Drug use among targeted groups

In 2008 MDA basecamp, a secondary prevention project run in the Tyrol (see Chapters 3.2 and 7.3), continued its survey[6] on combined drug use in party settings, the primary area of activity of MDA basecamp (MDA basecamp 2008 and 2009). The lifetime prevalence rates found (cannabis: 94%; ecstasy: 72%; speed: 69%; cocaine: 66%; magic mushrooms: 64%; LSD: 45%) are very high in particular regarding the typical party drugs of speed, ecstasy and cocaine. The prevalence rates are higher among men than among women. 30% of respondents said that they always took illicit substances at parties, and another 27% indicated frequent drug use. 88% stated that a few or almost all of their friends used illicit substances at parties, and 71% said that they had already used two or more illicit substances, or alcohol and party drugs, simultaneously or within a short time. The most frequent combination is alcohol and cannabis, and if only illicit substances are considered, the combination of speed and ecstasy is named most often (among men, cannabis combined with ecstasy is found almost as frequently). This study shows that combined drug use is of great relevance among the audience of electronic music events, and highly significant correlations also show between a person's own drug use and drug use among their friends, as well as illicit drug use at parties and combined drug use.

The drugs mentioned in the context of the event services[7] offered by ChEck iT! (see Chapter 10.3) show that cannabis predominates in party settings, followed by ecstasy, speed and cocaine. Cannabis was discussed in 47% of the talks, with ecstasy (36%) ranking second, and cocaine was an issue in 19% of the talks (VWS 2009a).

[5] In 2007 Austria (Strizek et al. 2009, under preparation) took part in the ESPAD study (European School Survey Project on Alcohol and other Drugs) the second time after 2003 (see Uhl et al. 2005b). In the 2007 survey a total of 277 classes with 5 959 school students in the 9th and 10th grades were asked to complete questionnaires on experience of use. The results presented relate to 4 574 respondents of the age group between 15 and 16 years. The Austrian ESPAD study was funded by the Federal Ministry of Health, Family and Youth.

[6] In the context of this survey carried out as of 2007 with hardcopy and online questionnaires, a total of 565 people aged between 14 and 45 (24% of them women) were interviewed at parties or when visiting scene websites (MDA basecamp 2009).

[7] In 2008, the event services offered by ChEck iT! covered a total of 12 events, with 214 counselling talks.

3 Prevention

According to the EMCDDA classification of prevention, this chapter has been divided into universal prevention, selective prevention and indicated prevention[8]. However, in practice the terms of primary and secondary prevention[9] continue to be used to some extent as this classification is regarded to be less stigmatising. In Austria, the corresponding measures are primarily implemented at local and regional levels, in accordance with expert consensus. In this context, the provincial Addiction Prevention Units (see Chapter 1.1), the Addiction Prevention Forums of Salzburg and Vienna as well as regional coordination and control bodies (Salzburg) play important roles. As a rule, the prevention measures are oriented towards long-term effectiveness and sustainability, which is aimed at primarily by means of training programmes for multipliers. In line with Austria's comprehensive approach to addiction, many prevention measures are not aimed at specific substances but also encompass forms of addiction that are not related to substances. In recent years, specific interventions concerning legal substances (alcohol and nicotine) as well as forms of addiction that are not related to substances (e.g., compulsive gambling) have become increasingly important. However, this report focuses on unspecific measures or interventions specifically aiming at illicit substances.

In addition to a number of standard programmes carried out at nationwide level, in recent years also numerous regional activities have routinely been initiated and advanced (see Tables A23 and A24 in Annex A). Current prevention measures taken are described on the individual websites and in the annual reports and newsletters of the Addiction Prevention Units, the Ministry of Education (BMUKK), the 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 References). Furthermore, new strategies and approaches have continually been developed in order to optimise the quality of prevention activities and to take into account to a greater extent the specific needs of individual target groups and different settings.

Other activities worth mentioning of the Addiction Prevention Units include network building and public relations work, (financial) support of prevention initiatives and organising further training events for experts, e.g., the expert meeting on the state of the art of prevention in Austria held by *ARGE Suchtvorbeugung* (Working Group for Addiction Prevention) in autumn 2008 at Steinach/Brenner in the Tyrol, or the conference *Männersüchte – Frauensüchte* (Men's Addictions – Women's Addictions) on gender-related aspects of drug use, addiction

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

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

and prevention, organised by the Addiction Prevention Institute of Linz, Upper Austria. In the reporting period, quality assurance was an important focal theme regarding prevention in Austria; it includes both technical standards and standardised interventions and programmes. For instance, new online feedback forms were prepared in Lower Austria to contribute to quality assurance. The return rate was approx. 50%, and the work and services of the Addiction Prevention Unit were assessed very favourably (Fachstelle für Suchtvorbeugung, Koordination und Beratung 2009).

3.1 Universal prevention

For an overview of Austria's universal prevention activities and the general framework of prevention please consult SQ22/25. **Schools** play an important role as settings of implementation. Here, prevention takes place on a statutory basis in the context of the educational principle of health promotion[10]. It is recommended that prevention measures at schools involve all stakeholders of the school community as well as regional addiction experts. On this basis, training courses on addiction prevention and further training events are organised, (e.g., a conference on health promotion advancement in schools held by FGÖ in March 2009), teaching materials and projects are prepared and all stakeholders are offered practical assistance in planning and implementing prevention activities. These activities are primarily aimed at awareness raising and health promotion approaches in the entire system and increasing life skills among students. In the older age groups, often patterns of use are also discussed.

In the reporting period PLUS, a programme for the age group from 10 to 14 prepared by *ARGE Suchtvorbeugung* (Working Group on Addiction Prevention), with *kontakt & co* taking over coordinating functions (see GÖG/ÖBIG 2007b), was also tested in Salzburg and Styria, with promising results. As of autumn 2009 the programme's pilot stage will include implementation with scientific monitoring in other provinces as well. PLUS combines fixed and variable modules that may be adapted to the specific needs of individual groups. In May 2009 Akzente Salzburg, under the title of *Herzens-Bilder* (Images of the heart), organised an expert meeting dealing with the nationwide *Eigenständig Werden* (Become independent) education programme so that teachers working in this profession for a long time may get new impulses and additional motivation for implementing the programme (Rögl, personal communication).

The list of standardised prevention measures and projects for schools available in Salzburg is now complete, and a feedback questionnaire has been prepared for a comprehensive documentation of prevention activities in schools settings (Drogenkoordination des Landes Salzburg 2009). In November 2008 the Vienna Institute of Addiction Prevention (ISP) organised an expert meeting on models, approaches and perspectives regarding prevention in schools: in addition to fundamental knowhow and quality criteria for up-to-date prevention on a scientific basis, the existing prevention services for schools in Vienna were made transparent (Sucht- und Drogenkoordination Wien 2009b). For this purpose also a list of projects of

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

prevention activities in schools of Vienna was compiled. The tendency to use theatre education in prevention contexts has continued: for instance, the reporting period saw a performance of the musical *Helden – Von Sehnsucht und Zuversicht* (Heroes: Of longing and confidence) also in Carinthia (see GÖG/ÖBIG 2008c). Forum theatre methods have been applied more often; the models developed in this context so far primarily focus on alcohol, e.g., *Mit Maß und Ziel – Es kotzt mich an* (In metes and bounds: I'm fed up).

In Upper Austria, a programme of long-term expert coaching for internal projects in vocational schools was agreed upon with the Province School Board (Institut Suchtprävention 2009a). The corresponding activities will include the communication of basic information by the Institute of Addiction Prevention as well as adoption of joint procedures and coaching services when addiction problems arise, assistance in the implementation of interventions and consulting with regard to teaching methods. In addition, a programme that trains vocational school teachers to become addiction coordinators was drawn up. In Styria, as a response to great interest on the part of the vocational schools, an advanced course was organised in cooperation with the University of Education (VIVID 2009). The project It's my life was developed with the aim of promoting the psychological health of young people at vocational schools in Carinthia, and in the school year 2008/9 it was tested at one school (Amt der Kärntner Landesregierung 2009). The students may choose one out of four focal themes (stress, interpersonal conflicts, self-confidence and patterns of consumption), which are then discussed with experts. The project will also integrate enterprises where trainees work and the parents of trainees, and at each school health promotion structures will be established with the assistance of a health circle and a steering group.

The prevention activities targeting **kindergartens** and **families** were continued. They include further training programmes, provision of information materials and information events for parents. New interventions in this field are primarily aimed at advancing the implementation of prevention activities in families by giving concrete advice and enhancing parenting skills, also in connection with drug use. The first five pilot performances of *Echt ... nichts für schwache Nerven!* (The Real thing ... Not for the faint of heart), a join-in theatre play for parents in Lower Austria (see GÖG/ÖBIG 2008c) have shown that the goal of encouraging parents to think about the themes presented has been met (Mellish, personal communication). What turned out to be particularly helpful was to combine the play with a four-hour workshop. New leaflets and/or booklets were prepared in Upper Austria (*ABC der Suchtvorbeugung* [Prevention basics] addressing parents of primary school children), in Styria (*Antworten geSucht* [In dire need of answers] also addressing parents of primary school children and *Was geht ab?* [What's missing?] for parents of young people) as well as in Vorarlberg (*8 Sachen, die Erziehung stark machen* [8 Strong points of parenting]). Some of them are combined with series of lectures (in Vorarlberg: *Kinder stark machen* [Strengthening our children] [11]) or seminars (*Was geht ab?* [What's missing?] in Styria. VIVID succeeded in establishing a cooperation with the foster parent association of Styria and in this context organised courses on the theme of addiction. Akzente Salzburg, cooperating with the specialised addiction outpatient departments of Traunstein (Germany) and Bad Reichenhall (Germany) started a new IN-

[11] www.supro.at (project description of 14 May 2009)

TERREG project[12]: *FamilienBande – Was geht ab?!* (Family ties: What's missing?!; see Drogenkoordination des Landes Salzburg 2009). Its goals, in addition to those already mentioned, also include awareness raising among adults with regard to their roles as models, and developing risk awareness. The 'parent tables' are central elements of the project: here persons trained in prevention visit mothers and fathers at home to discuss parenting questions related to substance use; and they also approach this issue in computer games[13]. The course programme *Hilfe, mein Kind pubertiert* (Help, my child is going through puberty) is another element worth mentioning; it addresses parents of adolescents aged 10 to 16 and specifically targets parents who cannot easily be reached and motivated in other ways. So far, a number of intensive courses for parents have taken place, and as of autumn 2009 the implementation of the programme will be enhanced.

The majority of prevention measures taken in the **workplace** aim at preventing trainees from developing patterns of addiction behaviour. Other interventions concentrate on preventing the development of addiction in everyday work, with the focus placed on alcohol. In Styria the current further training schemes for trainers and managers have now been complemented by courses for supervisors in the residence halls for trainees.

The prevention activities targeting **young people** have not seen new interventions or trends, and the existing programmes have been continued. In this setting media education has tended to play an increasingly important role in the corresponding interventions, and also aims at combining the communication of prevention issues and media skills. The focus is typically placed on drinking, however (e.g. in the programmes *prEvent* and *BilderRausch* [The ecstasy of images] in Vienna, or Reflect and Act in Vorarlberg). A study on the role that detached youth social work plays for prevention (GÖG/ÖBIG 2009b) has shown that this type of social work may serve as a health-promoting structure and can be regarded as part of unspecific prevention measures. Because of its special approaches and methods it has the potential to counteract addiction and violence. This potential could be enhanced if additional measures were taken (such as further training programmes as well as better networks or cooperation with experts in this field) and if the necessary framework for activities in this regard were created by granting sufficient resources and independence in practical approaches.

The trend towards prevention activities at **community** level has continued. Apart from awareness raising among the general public, initiatives in this field also aim at defining and implementing concrete measures oriented towards the special situation of the region in question. It is important that communities take steps themselves and adapt measures to their specific needs. In Upper Austria, *Wir setzen Zeichen* (We're making a point) is an example of prevention at community level. A guideline for the implementation of such initiatives was prepared, which describes the individual steps to be taken (Institut Suchtprävention 2008). In the district of Vöcklabruck (see GÖG/ÖBIG 2008c) a variety of further training events were organised until summer 2009; they were primarily oriented towards youth social work but also addressed parents, teachers, instructors of trainees, decision makers and other interested

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

[13] www.familienbande.cc (30 July 2009)

parties[14]. In spring 2009 a regional set of measures was drawn up, which, in addition to activities promoting prevention in schools and kindergartens, also includes measures of early detection and early intervention, lifestyle-oriented interventions as well as the expansion of detached youth social work and sparetime activities organised for children and young people. A follow-up project will be started in Wels, Upper Austria, in autumn 2009[15], and the first meeting of experts and interested private persons has already taken place in June 2009. Akzente Salzburg organised *PräventionsFrühstück – Prävention, die aufweckt und schmeckt* (Prevention breakfast: prevention that raises your spirit and tastes good), an informal experts' event in which new projects and information may be communicated to a large number of networking partners, key actors and other multipliers (Rögl, personal communication). This event has taken place twice so far and in future it will be a permanent element in the reform strategy for the regionalisation of prevention in Salzburg.

Other activities in the reporting period include the Peer Drive Clean project of the EU, which was started as a pilot project in Upper Austria in 2008[16]. It is a peer project aimed at providing specific information for young people on the risks of drinking and drugs in road traffic. For this purpose, students aged between 18 and 24 are trained and assisted by the Institute of Addiction Prevention. The project system is that two peers cooperate to organise a 75-minute lesson in the context of obligatory driving school courses. The good results of this approach underline that peers are in a better position to encourage exchange and reflection than teachers in conventional driving school settings. Further training courses on prevention basics were also organised for key actors of the Austrian army, and as a high share of people tested positive for illicit substances, this approach has been intensified (Institut Suchtprävention 2009b)[17].

3.2 Selective prevention in at-risk groups and settings

SQ26 gives an overview of selective prevention measures and the framework in which they take place. The activities to build networks for **children in at-risk families** have been continued. In Lower Austria, five goals of the networks were set: apart from further training, network building and increased awareness raising and lifting the taboo on addiction in the public discussion, another point is to establish direct services for children in families with addiction problems (Mellish, personal communication). As of this year, Burgenland has organised a series of further training courses focusing on the theme of children in at-risk families and a seminar for the target groups of social education workers as well as child and youth welfare workers, on identifying, understanding and coping with difficult life conditions of children and young people (Hausleitner 2009). In Vorarlberg and Carinthia, a cooperation standard and guideline, respectively, were agreed upon by the youth welfare departments and drug help units, which will permit joint approaches to counselling and treatment on the basis of clearly defined competencies (ENCARE 2009a, 2009b). The eventual aim is to optimise the care

[14] www.wirsetzenzeichen.at (30 July 2009)
[15] www.praevention.at (news of 30 June 2009)
[16] www.praevention.at (project description of 30 July 2009)
[17] www.praevention.at (news of 26 Jan. 2009)

structures for children of addicted parents. On the one hand, the children may thus be supported in their development and it should be possible for them to live with their parents permanently, and on the other, the cooperation between parents and the drug help system is improved. In the Tyrol and Styria, a further training event for kindergarten teachers was organised, which provided information on addiction and the situation of children living in families with addiction problems (ENCARE 2009a, 2009b). The participants were also advised on how to enter into talks with parents. In addition a leaflet for parents was prepared, in which needs of children are described and an appeal is made to the parents to make assistance and support available to their children.

In addition to the aforementioned focus, in Austria prevention activities for specific target groups are primarily found in **recreational settings**, with the aim to communicate a critical approach to psychoactive substances (risk competence) as well as alternatives to substance use. In this context, the club and party scenes are relevant settings. In 2008 MDA basecamp, supported by the Provincial and Local Governments of the Tyrol, was able to expand its services by integrating the new MDA basecamp flexteam approach (MDA basecamp 2009), which permits regular services provided by the team at events in the individual districts of the Tyrol. ChEck iT!, responding to incidents connected to Spice (see Chapters 2.1 and 10.3), prepared an information leaflet on Spice that addresses (psychological) parents of children and young people, and in January 2009 an information event was organised (VWS 2009a). In Vienna, peer activities in sparetime settings play a relevant role, but the corresponding project (Party Fit!) run by ISP is oriented towards alcohol (Sucht und Drogenkoordination Wien 2009a).

Young first-time drug users have also been defined as a specific at-risk group, and measures in this field primarily aim at early detection and early intervention targeting young people who show risky patterns of use but no manifest addiction symptoms. A training course was organised, and further procedures to be pursued were defined, for *FreD goes net*, an early intervention project at EU level, which is coordinated and currently tested in Austria by the Institute of Addiction Prevention in Linz, Upper Austria (see GÖG/ÖBIG 2008). Young drug users (aged 14 to 21) reported to the police for the first or second time, after an orientation talk to decide upon eligibility, may attend a FreD course at an addition or drug counselling centre. The programme is supported by the police and health authorities as well as the public prosecutors' offices. The Tyrol saw an expansion of the services of *Walk About*, a project focusing on experience-based approaches for the target group of young people between 14 and 22 who have drug use problems (see Chapter 9.3). Initial results of the *ViVA* programme (see GÖG/ÖBIG 2008c) have shown that binding written agreements should be concluded with the centres where the programme is implemented (SUPRO 2009). The ProFi programme (see GÖG/ÖBIG 2008c) could not be expanded to reach a greater number of people as it was not possible to motivate young people to take part in a course voluntarily, without the pressure of having to undergo compulsory health-related measures or similar obligations (SUPRO 2009).

Regarding the target group of **immigrants**, the *Anababa – Ailem ve Ben* film project of Vorarlberg mentioned in the report of last year (see GÖG/ÖBIG 2008c) was concluded with a premiere performance of the film[18], which is now shown at prevention events for parents of Turkish background. In Vienna, the ISP institute cooperated with representatives of Municipal Department 17 (Integration and Diversity) and the Dialog association to establish the SUP-MIG working group whose aim is to communicate prevention issues to people with a background of immigration (Sucht- und Drogenkoordination Wien 2009a).

People with **hearing disabilities** are a new target group for whom the existing information services on prevention are unavailable or insufficient. Therefore the ISP of Vienna, in cooperation with the association equalizent, will prepare special information materials available on DVD and as a booklet (Sucht- und Drogenkoordination Wien 2009).

3.3 Indicated prevention

Indicated prevention in the sense of the EMCDDA definition (see Chapter 3) has not been implemented in Austria so far. The majority of measures addressing particular target groups are based on social factors in the sense of selective prevention. The majority of measures that are adopted in response to patterns of behaviour of individual persons are not based on an additional medical diagnosis but only on addictive or at-risk behaviour and behavioural disorders associated with addiction. However, this does not correspond to the EMCDDA's definition of indicated prevention, for which a diagnosis by a physician is required.

3.4 National and local media campaigns

In Austria, in agreement with experts in this field, no media campaigns on illicit substances are launched. The only exception is a number of community-oriented projects in the context of public relations work which are announced through media campaigns (e.g., at Vöcklabruck, Upper Austria).

[18] www.supro.at (project description of 21 Jan. 2009)

4 Problem Drug Use

The EMCDDA's current definition of problem drug use is 'injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines'[19]. However, recent discussions at EU level aim at expanding this definition (e.g., to include problem use of cannabis as well). Austria's definition of problem drug use largely corresponds to the one of the EMCDDA, but underlines that it is primarily patterns of use and not substances as such that are risky or safe. Problem drug use means that drug use is accompanied by physical, psychological or social problems. If exclusively legal problems have ensued the term problem drug use does not apply (see, e.g., GÖG/ÖBIG 2008d).

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

Poly-drug use with opioids, which often are injected, has traditionally played a significant role in Austria. In the past decade the range of substances taken in the context of poly-drug use has widened. Injecting use of cocaine has also become more relevant in the street scene. However, the DOKLI data on patterns of use among clients of the drug counselling system show that opioids continue to predominate as primary drugs (see e.g., GÖG/ÖBIG 2009a).

According to recent estimates, a prevalence rate of 22 000 up to a maximum of 33 000 problem opioid users, mostly in the context of multiple drug use, seems realistic for Austria. However, prevalence estimates of problem drug use are difficult to give as methodological problems arise due to the complexity of the subject, and the figures obtained are conclusive to a limited extent only. Thus any results given are rough approximations and have to be interpreted with caution. The prevalence rate of alcohol dependence, compared to illicit drugs, is estimated to be 5% of the population over 15 in Austria. This means that a total of 350 000 people in Austria are to be regarded as alcoholics (Uhl et al. 2009).

4.1 Prevalence and incidence estimates of PDU

In Austria scientific estimates of the prevalence of problem drug use are only available for opioids and for poly-drug use with opioids. The most recent estimates relate to the year 2007. Taking into account also other data sources it is safe to assume that the prevalence of problem drug use, after a rise until 2004, has slightly gone down again in recent years (for details see GÖG/ÖBIG 2008c).

[19] http://www.emcdda.europa.eu/themes/key-indicators/pdu (30 Sept. 2009)

The data from DOKLI, the nationwide documentation system of clients of Austrian drug help units, indicate that apart from persons showing patterns of (poly-)drug use with opioids, another group also plays a major role in the treatment system, at least in the category of people undergoing long-term outpatient treatment: a share of 24% out of the total number of people starting long-term outpatient therapy in 2008 named cannabis as their only primary drug (compared to 4% of inpatients; see Chapter 5.3 and GÖG/ÖBIG 2009a). It would be a point worth discussing whether this high share actually is the result of health problems or psychosocial problems caused by cannabis use (which would mean that this group should be taken into account when prevalence rates of problem drug use are studied) or whether it rather reflects repressive policies regarding cannabis use (see Chapter 11). Another question is whether the needs of this group of clients are adequately met in the existing drug help centres. More detailed studies based on these results found in the context of the routine monitoring of DOKLI would be needed in order to obtain further insight.

Apart from these two groups, i.e., clients showing (poly-drug) patterns of use with opioids and clients with only cannabis used as their primary drug, few other clients are found in the drug help system. 12% of clients in the outpatient sector, and also 12% in the inpatient sector, do not belong to either group (GÖG/ÖBIG 2009a). If cannabis is not taken into account, one may conclude that almost all people registered in the drug help system have opioid problems (in the context of poly-drug patterns of use). As exactly this group is covered by the CRC estimates, and assuming that, with regard to patterns of use, clients of drug help units are representative of all problem drug users, this means that the estimates obtained reflect almost all problem drug users in Austria.

4.2 Data on problem drug use from non-treatment sources

A recent multi-city study on patterns of use, which also includes data from Vienna (Eisenbach-Stangl 2009) gives both an analysis of available quantitative data and the results of qualitative interviews to describe drug use in Vienna[20]. Thus, the following typology is characteristic of Vienna:

Marginalised poly-drug users: this group primarily uses morphine, benzodiazepines and other psychopharmaceuticals as well as cannabis, and at times also heroin and cocaine. More than two out of three people of this marginalised group are undergoing drug-related treatment and care. This group is estimated to comprise between 7 500 and 14 000 people.

Cocaine and heroin users: different to the above group, the drugs that are primarily used are heroin and cocaine or morphine (often combined), and at times cannabis and benzodiazepines. This marginalised group of approximately 280 to 1 000 people mostly remains outside the treatment system.

[20] A total of 14 semistructured interviews (12 face-to-face, 2 phone interviews) were held with stakeholders in the fields of drug policy, drug treatment, the police, street social work, opioid substitution treatment, pill testing, youth psychiatry and grow shops, and with one cannabis user. In addition interviews with 30 drug users that took place in the context of another project were included.

Cocaine snorters: among them, cocaine snorting predominates, and at times, also heroin or other drugs are used. This group of 30 000 to 40 000 people is primarily composed of socially privileged persons whose income is sufficient to finance their drug use. They are hardly registered by the drug help system.

Recreational drug users: this group (estimated to include around 5 000 people) is part of the party scene; the primary drug used is cannabis, and sometimes they also take ecstasy, amphetamines, cocaine, hypnotics, LSD and mushrooms. The group members are socially integrated and hardly turn to drug help centres.

Cannabis smokers: they use cannabis as the only illicit drug, from daily to occasionally. This group comprises approximately 100 000 people who are socially integrated.

The groups described above can clearly be distinguished from each other, with the exception of the group of cocaine and heroin users, which may overlap with the group of marginalised poly-drug users.

If one compares the above groups to the groups of persons showing problem drug use with opioids in GÖG's prevalence estimates it is obvious that the latter estimates only relate to the groups of marginalised poly-drug users as well as cocaine and heroin users. The estimated number of people in the respective groups of this study also largely corresponds to the results of the CRC estimates. No reliable estimates can be given regarding the number of people in the other three groups who show problem patterns of use (health or social problems because of drug use).

Salzburg provided analyses of patterns of use among persons examined according to Section 12 of the SMG[21] (Drogenkoordination des Landes Salzburg 2009). As in previous years, use of cannabis predominates in this group of persons (88% out of 367 examinations). 12% of examinations was related to use of cocaine or ecstasy or opioids, respectively, 6% to speed and 3% to hallucinogenic drugs. 72% of examinations was carried out because of use of one substance, 17% resulted from use of two substances (typically cannabis combined with opioids, cocaine or ecstasy) and 8% from three or more substances. For more details on persons showing patterns of problem drug use in the party scene and, in part, problem patterns of recreational drug use, see Chapter 2.3.

As in previous years, also in 2008 several reports mention high-risk use of substances with GBL ingredients, e.g., in scene locations in Vienna and St. Pölten (see Chapter 10.3).

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

5 Drug-related Treatment: Treatment Demand and Treatment Availability

Austria has an almost nationwide network of centres that provide drug-related counselling, care and treatment services[22]. A total of almost 200 specialised units provide inpatient and outpatient treatment or counselling related to addiction and illicit substances (investigations by GÖG/ÖBIG). Drug counselling, care and treatment services are provided both by specialised centres and in the context of the general health care system (e.g., psychiatric hospitals, psychosocial services, established physicians). Inpatient treatment is open to people from all over Austria and also from abroad. In quantitative terms, opioid substitution treatment (OST) has become the most important form of treatment in Austria, and efforts to improve it have continuously been made.

Austria attributes great importance to the diversification of available treatment options. As a result, in the past decade the inpatient sector saw a development from long-term to short-term treatment and generally to more flexibility with regard to possible kinds of treatment, for instance in the form of modular systems. Opioid substitution treatment may be obtained in inpatient settings, and withdrawal is also possible in outpatient departments. The goal of this development has been to take into account to a greater extent individual needs and the patients' situation in life. This also means that a variety of substitution substances may be prescribed. As the general aim is to maintain a comprehensive treatment and care network, most service providers also organise a variety of preparatory and aftercare measures as well as recreational and reintegration services (see Chapter 8.2) and also interventions for specific target groups (e.g. young people or persons with psychiatric comorbidity). For an overview of available drug help services please consult ST24, SQ27 and the Addiction Help Compass[23], which is currently being revised. For detailed descriptions of available services please consult the websites as well as the annual reports and newsletters of the individual centres, ÖBIG's previous reports and the Best practice portal of the EMCDDA (see References).

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

Since 2006, data on clients of drug help units have been obtained from the DOKLI nationwide documentation system, which covers the majority of relevant centres providing drug-related services in Austria. The data gathered include all questions defined by the EMCDDA, and in addition, data on infectious diseases (also according to EMCDDA guidelines) and ICD-10 codes are collected on a voluntary basis. The substitution registry, which has been

[22] The maps showing the regional distribution of drug help centres and services are being revised and therefore not included in this report.

[23] http://suchthilfekompass.oebig.at

maintained at the Federal Ministry of Health since 1989, is a further data source worth mentioning. Regarding personal data of clients, only gender, age and province of residence are registered, however.

5.1 Strategy/policy

Drug treatment strategies and policies are defined in the drug or addiction strategies of the individual provinces and in the corresponding laws (see Chapter 1). The reporting period did not see relevant changes in this field, but a number of studies were drawn up and recommendations for improvements of addiction treatment were made. For instance, according to an expert opinion drawn up in Carinthia, integrated care structures for addiction patients should be aimed at (Prehslauer, personal communication). In order to build the necessary addiction-related competencies in the health and care institutions concerned, a set of measures to this end is required (see Chapter 1.2). Another demand that has been identified is the need for specific therapy services for children and families with addicted parents.

The majority of studies and suggestions have focused on opioid substitution treatment, however. In cooperation with the Provincial Commissions of Experts (see GÖG/ÖBIG 2008c), reports on the effects of the new regulations for OST were drawn up in 2008, from which recommendations by the working group of the Federal Drug Forum were derived (see Chapter 1.2). Recommendations in this field also came from the Quality Assurance Commission for Addiction Diseases at the Superior Public Health Council. The recommendations by the two commissions will form the basis for a further amendment in autumn 2009.

Reports from the provinces confirm the effects mentioned already in previous years (see GÖG/ÖBIG 2008c), i.e., a reduction in the number of physicians providing opioid substitution treatment (Lower Austria, Upper Austria), insufficient treatment and care capacities in a number of provinces (Lower Austria, Upper Austria, Tyrol), rising numbers of clients in drug outpatient clinics, which results in long waiting times and bottlenecks regarding other drug help services (Upper Austria, Salzburg). It is also reported that a number of physicians who still provide opioid substitution treatment have refused to take part in additional further training programmes and therefore will not be eligible for OST after the end of the transition period (Upper Austria). However, there are also provinces, e.g., Vienna and Vorarlberg, where no reduction in OST physicians has been registered. Several provinces report declining numbers of patients who are allowed to take substitution substances at home, paralleled by a rising number of patients who have to take these substances under supervision in pharmacies (Vienna, Styria). This does not seem to be the case in Upper Austria. The provinces have taken a variety of measures in order to ensure care structures that meet the corresponding demand, for instance, financial incentives modelled after Vienna's remuneration agreement between the Medical Association and the provincial health insurance fund: such agreements have either been concluded already (Upper Austria, Salzburg) or they are planned (Lower Austria). Another measure in this field is the decision not to publish the lists of physicians qualified for opioid substitution treatment, which have to be maintained according to the Oral Substitution Further Training Decree (Upper Austria). Several provinces plan to build additional capacities especially for diagnosing and determination of maintenance doses. In both Upper Austria and Salzburg (see GÖG/ÖBIG 2008c) this will be performed by

specialised physicians who work at regional counselling centres (Sturm und Schwarzenbrunner 2008). This plan has not (fully) been implemented in either province, however. Styria and the Tyrol consider the possibility to establish additional, or expand already existing, specialised outpatient departments (Ederer, personal communication; Ärztekammer Tirol 2008).

In addition, a number of recommendations for improvement of the existing situation have been made: for instance, a reduction of training requirements (i.e., of the necessary number of training hours) and training obligations only for physicians in charge of deciding on maintenance doses, as well as ensuring diversified services (several substitution substances to choose from), services for drug patients with psychiatric comorbidity provided by established psychiatrists, or specialised care services at drug outpatient departments for patients whose treatment turns out to be difficult, and also inpatient and semi-inpatient treatment options for substitution patients. The issue of defining substances that should preferably be prescribed has also been discussed controversially (see GÖG/ÖBIG 2007). One of the problems mentioned is that undesirable psychological side-effects of methadone, different to physical intolerance, cannot be assessed objectively (Sturm und Schwarzenbrunner 2008). Another point of criticism concerns the lack of nationwide guidelines, e.g., regarding measures to be taken in difficult cases (Sturm und Schwarzenbrunner 2008).

A number of studies on opioid substitution treatment in Austria deserve mention in this regard. However, one has to bear in mind that the surveys on which they are based were conducted before the legal framework was changed in 2007. A cross-sectional study[24] by Springer et al. (2009) shows diverse aspects of assessments of available substitution substances by patients and physicians: while slow-release morphine is assessed as the best substance with regard to suppressing withdrawal symptoms, retention rates and patients' preferences, buprenorphine is assessed more favourably as far as its small risk of abuse is concerned. On the whole, the assessments of slow-release morphine and buprenorphine are positive to similar extents, while methadone is assessed significantly less favourably. Methadone also ranks last in the assessments by patients. It cannot definitely be said to which extent this result may be explained by subjective expectations on the part of respondents and/or objective effects of the substances in question. However, a comparative study on substitution with slow-release morphine v. methadone[25], carried out by Schweizer Haus Hadersdorf (SHH 2009), shows similar results: patients treated with slow-release morphine definitely felt better, stabilisation was easier and could be achieved faster. Different to treatment with methadone, prolonged treatment also led to an improvement of psychopathological behaviour and the patients' current situation. Patients treated with slow-release morphine made significantly greater improvements regarding drug use as well as family situation/social

[24] In the context of this study carried out by the Ludwig-Boltzmann Institute of Addiction Research, cofinanced by the Ludwig Boltzmann Society, the Anton Proksch Institute and Mundipharma, 176 physicians were interviewed who provided substitution treatment to more than two, or four, substitution patients, respectively (in doctor's offices or at drug help centres). Then the interviewees were asked to randomly select between 3 and 5 substitution patients and to complete patient questionnaires for them on the basis of case histories and interviews with the patients in question. Another questionnaire was filled in by the patients themselves. In sum, a documentation of 619 substitution patients was available.

[25] From October 2003 to December 2005, 48 persons were examined or interviewed, respectively. 23 of them obtained substitution therapy once more and were administered either methadone or slow-release morphines. Another 25 patients were prescribed slow-release morphine because of an intolerance of methadone.

and psychological situation compared to methadone patients. The greatest differences showed with regard to overall stress tendencies and general mood. Similar results were also found after patients changed from methadone to slow-release morphine, but to smaller extents. Side effects such as nausea or constipation occurred slightly more often in patients taking methadone compared to slow-release morphine.

According to Springer et al. (2009), the current dose taken does not seem to have an influence on the feeling of contentment of substitution patients, while people to whom substitution substances are dispensed once a week or less often, feel considerably more contented than others. Aeschbach Jachmann et al. (2008)[26], however, state that the doses administered are of great importance for retention and good results of OST but that considerable potential for optimisation exists regarding determination of doses.

Further analyses of the cross-sectional study (Springer und Uhl 2009) reveal that opioid substitution treatment takes considerably more time than the treatment of other patients as numerous additional problems exist. 61% of both general practitioners and psychiatrists who carry out OST have provided this service for more than 10 years. Almost all of them determine maintenance doses and continue to treat their patients also afterwards. 84% of substitution patients are treated in doctor's offices or drug help units where more than 100 patients obtain substitution treatment. While only a small part of respondents generally refuse further training, a large number are against the 40-hour further training requirement and say that they will not undergo training to this extent. The cooperation with the public health officers is generally described as satisfactory. Although these results relate to the time before 2006, they partly correspond with reports from the provinces communicated in 2008.

Another relevant issue in the field of opioid substitution treatment concerns benzodiazepines that are prescribed in addition to the substitution substance, and the problems arising from this practice (interaction, addiction potential). In Upper Austria, between 10% and 20% of substitution patients are also prescribed benzodiazepines (Sturm und Schwarzenbrunner 2008). According to the study by Springer et al. (2009) this applies to 23% or 22%, respectively, of patients taking methadone or slow-release morphines, and it seems to be related to taking high doses of the substitution substance (31% of patients). The study by Aeschbach Jachmann et al. (2008) found a rise in additional prescriptions of benzodiazepines in the period analysed, but paralleled by a significant decline in the relationship of benzodiazepine prescriptions to opioid prescriptions. Still, in 2005 an average of 27% of patients were administered additional doses of benzodiazepines, which was found to be related to the type of substitution substance taken (the greatest number of benzodiazepine prescriptions concerned patients taking slow-release morphines and the smallest number was found with regard to patients taking buprenorphine). The study confirms that a certain part of OST patients actually need benzodiazepines, but the share of patients taking additional doses of benzodiazepines still seems too high, in particular with regard to the fact that many patients turn to

[26] The long-term prescriptions issued in the 3rd quarters of the years 2002 and 2005 and financed by the Vienna Health Insurance Fund were analysed. In addition, general practitioners provided data on additional prescriptions of benzodiazepines. Those doctors who did not treat the required number of substitution patients (i.e., < 11 patients) were not included in the analysis. The data material thus comprised 21 145 prescriptions by 154 general practitioners. The data concerning the remaining 151 physicians were included in the analysis of prescription practices of individual persons.

another physician to get these prescriptions. Fischer[27], in an interview concerning this study, found a correlation of this prescription practice with the number of substitution patients per doctor. In order to reduce additional prescriptions of benzodiazepines, Fischer recommends intensified further training of attending physicians as well as treatment in specialised psychiatric outpatient clinics of addiction patients suffering from additional psychiatric diseases (which is a typical reason for administering benzodiazepines). This would ensure correct diagnoses of these comorbidities, so that adequate forms of treatment could be started, and possible interactions between opioids and psychopharmaceuticals could be taken into account. Eventually, she also points out the need for transparent error management systems at the Medical Associations, as well as a restriction to a sensible number of substitution patients per physician – i.e., roughly 45 to 50 patients, according to Fischer.

In 2008 Vienna's Expert Commission on Opioid Substitution Treatment started to draw up guidelines for the treatment of benzodiazepine dependence (Sucht und Drogenkoordination Wien 2009). These guidelines focus on prescriptions to be issued and the resulting costs, as well as on further training programmes for physicians prescribing benzodiazepines. The Dialog association has already drawn up its own guidelines for treating benzodiazepine dependence and now attempts to discuss this problem with each patient treated, and to achieve a reduction of benzodiazepine use (Dialog 2009b), either by outpatient reduction programmes or inpatient partial withdrawal.

5.2 Treatment systems

The capacities of Austria's drug help system have continually been expanded but are insufficient nevertheless. This is reflected in waiting lists and in waiting times which, depending on treatment centre, may be up to six weeks for the first counselling talk, several months for admission to treatment and up to six months for inpatient withdrawal treatment. Pronounced regional differences show in this regard, however: for instance, the Addiction and Drug Coordination of Vienna reports no waiting times for the province of Vienna. The reasons for insufficient capacities in the counselling centres have remained the same (see GÖG/ÖBIG 2008c), and in the outpatient treatment departments, the results of changes in OST regulations show (see Chapter 5.1). In the inpatient sector, lack of beds is the main reason for capacity problems. The Carina therapy department also reports strong demand for therapy places, which has led to waiting times of several months (Stiftung Maria Ebene 2009b). This in turn is supposed to have effects on the duration of treatment.

In order to increase capacities in the individual areas, a number of new services were made available or planned in the reporting period. In Vorarlberg, it was decided to establish a detoxification department affiliated to the Lukasfeld therapy department (Neubacher, personal communication); implementation is scheduled for the next two years. The plan includes a withdrawal area separated from the rest of the unit, with seven beds primarily for young patients who want to undergo drug-free treatment (Wölfle und Haller 2008). It is also open to patients who need partial withdrawal or harm-reduction measures or for whom survival and

[27] www.drogensubstitution.at (14 May 2009)

minimisation of infection risks are primary goals. However, the Provincial Hospital of Rankweil will continue to treat those patients who suffer from intoxication or withdrawal symptoms that require supervision, from acute psychoses or disorientation, and those who shoe considerable risk of self-harm or harm to others as well as severe physical comorbidity or secondary diseases that need intensive medical supervision. Since October 2008, as a consequence of rebuilding works, withdrawal treatment at the Anton Proksch Institute (API) has been provided at a new location. This has already resulted in a slight increase of bed capacities, and diversified treatment approaches can be implemented (see GÖG/ÖBIG 2008c). In Lower Austria, API, Caritas of the Diocese of St. Pölten and the Association of Psychosocial Centres (PSZ) cooperated to establish additional addiction counselling units (Hörhan, personal communication). This means that by autumn 2009, the capacities will be at the planned levels in all districts. As of November 2008, the BIZ counselling centre of northern Styria has also taken over the functions of a specialised addiction outpatient clinic (Ederer, personal communication). This service has met with much interest, and after half a year already, waiting lists had to be introduced. In order to increase capacities, supplementary financing was demanded, and a cooperation with the Provincial Sigmund Freud Neurology Hospital (LSF) of Graz is considered. The cooperation of the Drug Counselling Centre of the Province of Styria and the drug outpatient department of LSF was intensified: individual psychosocial counselling sessions have become an integral part of the admission procedure in the context of determining initial maintenance doses for opioid substitution treatment (Drogenberatung des Landes Steiermark 2009).

In order to optimise preparatory care and aftercare services, the Walkabout therapy department plans to establish a separate unit focusing on preparatory care and aftercare, located in the centre of Graz, which will open in autumn 2010 (Mahnert, personal communication). In 2008 the Carina therapy department organised a meeting for former and current patients, which focused on life after treatment. Three groups, headed by facilitators, exchanged experience of the change from the protected treatment setting back to normal life (Stiftung Maria Ebene 2009a). The preparations for the event were integrated in the treatment procedures, which provided an opportunity to deal with organisational difficulties and find solutions with the help of experts.

A number of measures are aimed at optimising counselling and care services to orient them more specifically towards target groups and to address new groups of clients. For instance, the OIKOS counselling centre now offers services by medical specialists for adults with cannabis as their primary drug who live in or around Klagenfurt (Prehslauer, personal communication). This includes detailed diagnosing, monitoring of the patients' development and treatment of drug problems as well as underlying psychiatric diseases. Young people continue to be referred to the outpatient department of child and youth neuropsychiatry. The Beyond the Line service for cocaine users in Vienna (see GÖG/ÖBIG 2008c and Chapter 7.3) takes into account that these clients usually are reluctant to meet other addicted people, therefore they are invited to the centre once a week outside the regular opening hours (Dialog 2009b). As many clients are highly agitated, a staff member is present in the waiting area to answer general questions and to facilitate discussions. Counselling as such takes place in individual settings, with the focus placed on finding short-term strategies for the next few days. Whenever demanded, also addiction acupuncture is available. Experience made so far

shows that acupuncture may be very helpful for initial treatment. Public relations activities for this special target group continue to be a challenge, however. As of the beginning of 2009 Kontaktladen of Graz has run the 12-week KISS programme for control of drug use (Kontaktladen Graz 2009). In weekly sessions of 2 hours and 15 minutes, the participants are supported in setting their own goals and determining periods of time in which to change patterns of use. The aim of this service is to find new ways to address addicted people, to support the clients in their willingness to change substance-related behaviour and to promote the course of treatment. The programme is based on the clients' ability to control their drug use, which definitely exists in a certain share of drug addicts.

In Vienna the working group on children and young people with drug problems addresses the target group of drug users under age; it focuses on counselling and care strategies during the transitional period from adolescence to adult life (Sucht und Drogenkoordination Wien 2009b). Last year, special opening hours for young people were introduced (see GÖG/ÖBIG 2008c), and in addition, the waiting area is now temporarily redesigned at these hours so that the specific demands of this group may be met more closely (Dialog 2009b). During this time, adults over 21 are admitted only if a meeting has been scheduled, and if necessary they have to wait in a separate area. On the other hand, young people may use the structures open to adults only in special cases of crisis. Both clients and staff members have given a very positive feedback regarding this new system. Since May 2009 the Z6 drug counselling centre of Innsbruck has also offered online counselling (Kern, personal communication).

In Vienna a project on the optimisation of inpatient treatment of newborn babies of addicted mothers has been run; its goals include the reduction of the babies' withdrawal phases and ensuring aftercare services for mothers and children (see Chapter 7.3). In Mödling (Lower Austria), the DESK pilot project (focusing on drugs and addiction problem of parents and children) was started in order to provide services for pregnant women who are addicted to alcohol, drugs or pharmaceuticals (Hörhan, personal communication).

A diploma thesis on drug users with a background of immigration[28] (Pajkovic 2008; see also Chapter 8.1) shows that this theme has not often been a subject of expert studies so far in Austria, and as a result, few services for this target group exist. In order to encourage addicted immigrants to turn to the drug help system more often, specific barriers that are encountered by both sides have to be eliminated and accessibility has to be enhanced. Typical barriers that have been identified in the centres include insufficient information on counselling centres, no staff available who speak the clients' mother tongues, racism on the part of other addicted clients in the centres (and often the staff of the unit fail to intervene), resentment by staff towards this group of clients (more time and effort needed), exclusion because of nationality and thus no eligibility for support, counselling and treatment structures oriented towards middle classes, as well as the problem that immigrants are often thought to be drug dealers. The barriers that exist on the part of immigrant drug users are little knowledge of counselling and care services, fear of legal consequences, the view that addiction is a weakness, prejudice by counsellors or the feeling that counsellors are not taking their side, lack of confidence in institutions, negative view of self-reflection and preference of alternative treat-

[28] A literature research was carried out and problem-centred interviews were held with people of the target group.

ment approaches and healing methods practiced in the country of origin. As a response to this situation, the Dialog association has taken a first step and hired an ethnic Turk staff member (Dialog 2009b). In addition, a strategy that takes into account the problems mentioned will be drawn up. At the Hegelgasse office, a worker with a background of immigration helped prepare methodological inputs for services provided to immigrant families, which may be used by the entire staff. In 2009 *Verein Wiener Sozialprojekte* (VWS; Vienna Social Projects Association) hired a worker from Iran, and the new edition of the information booklet on addiction prepared by the wienXtra youth information service in cooperation with the Addiction and Drug Coordination of Vienna also lists addiction-related services that are available in languages other than German.

Regarding quality assurance in addiction treatment, apart from activities focusing on opioid substitution treatment (see Chapter 5.2) a number of other initiatives deserve mention: for instance, in spring 2009 the Dialog association published a manual that describes Dialog's quality management policy (Dialog 2009a). It documents Dialog's guidelines and the general philosophy pursued as well as all processes of quality assurance and further development and also internal knowledge management (communication and documentation) as well as risk and error management. Uniform standards will be defined for the centres of the Addiction and Drug Coordination of Vienna in order to provide the basis for implementing case management procedures (Sucht- und Drogenkoordination Wien 2009b). In the inpatient sector, referral forms and a catalogue of available products have already been drawn up. In 2008 Dialog implemented an assessment model, in which information on forms of drug use and the situation in life of the clients is gathered (Dialog 2009b). The results will be integrated in treatment planning in the sense of risk assessment regarding the future development of patterns of use.

In the reporting period the Ganslwirt centre evaluated its opioid substitution treatment services (VWS 2009): the intended target group can be addressed to the desired extent and improvements were achieved in various respects. However, a problem area mentioned is that treatment is often ended very suddenly. As the fluctuation of staff in the outpatient clinic could be reduced, a better continuity of contacts to clients will be possible.

A new evaluation of the Carina therapy department[29], which is oriented towards drug-free treatment, showed a retention rate of 67% in 2008 and an average duration of treatment of approximately four months (Stiftung Maria Ebene 2009b). This confirms the trend towards shorter long-term treatment (see p. 25), and the results underline previous experience. The catamnestic interviews[30] (clients treated in 2007) also primarily revealed positive developments (Stiftung Maria Ebene 2009c). However, an interesting fact is that in the opinion of respondents, the treatment outcomes could be improved if the treatment periods were longer, if the therapists showed more understanding, if the treatment settings were addiction-free to greater extents and if the clients were better prepared for the time after treatment.

[29] In 2008 a total of 65 patients were treated (12 patients were admitted twice). 61 treatments were concluded in 2008, 41 of them with the desired result. Admission diagnosing took place 2 to 4 weeks after admission, and discharge diagnosing 4 to 2 weeks before the completion of treatment. 29 persons filled in the questionnaire after completion of treatment.

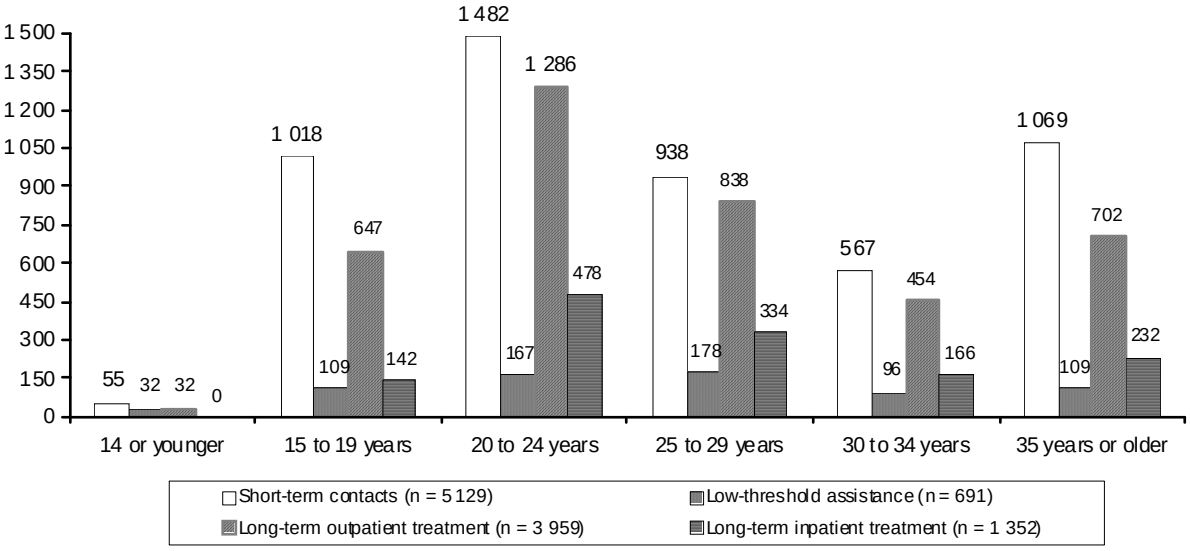
[30] The catamnestic interviews took place one year after the end of therapy, by means of phone calls. 25 out of 54 people who had completed, or prematurely terminated, treatment in 2007 could be interviewed.

5.3 Characteristics of treated clients

The client year 2008 is the third year for which data of the DOKLI nationwide documentation system of clients of Austrian drug help units are available[31].

The drug help centres in Austria that are covered by the DOKLI system communicated data on a total of 3 959 people who had started **long-term outpatient treatment** in 2008. For 1 715 of them this was their first drug treatment in life. 1 352 patients started long-term **inpatient treatment**, and for 168 clients this was their first long-term drug treatment. In addition to these persons undergoing drug treatment in a traditional sense, DOKLI also registered 691 clients requiring **assistance by low-threshold centres** and 5 129 people receiving drug counselling in the form of **short-term contacts**. Generally speaking, the data gathered for 2008 correspond to those of the two previous years.

Figure 5.1: Number of people starting drug-specific treatment or assistance sessions in 2008, by age and type of service



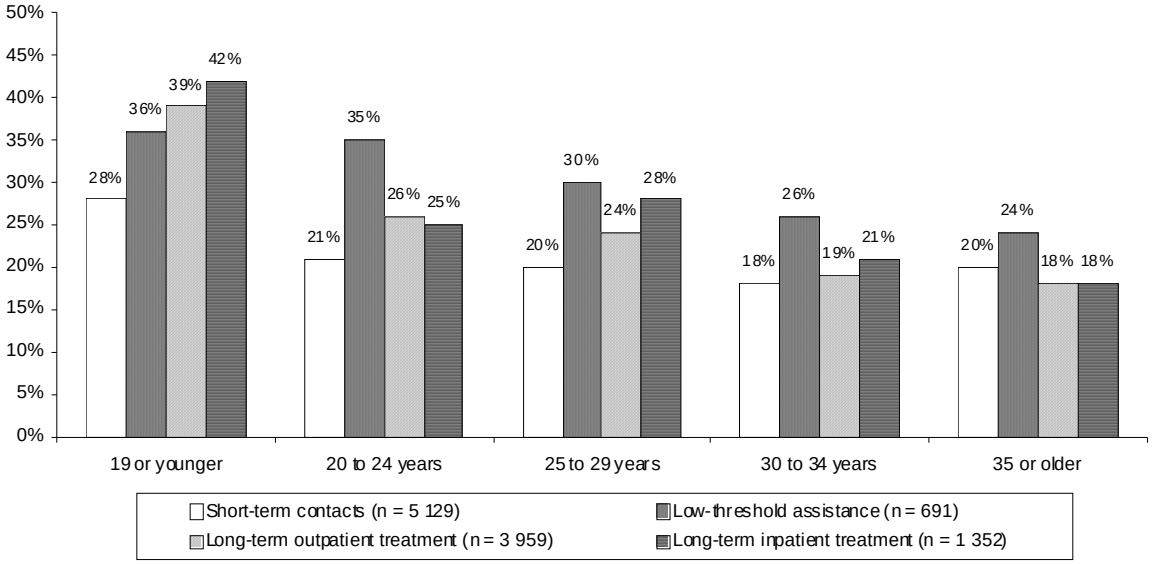
Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008; representation by GÖG/ÖBIG

Approximately one out of five people undergoing treatment or receiving assistance are younger than 20 – with the exception of people treated in the context of inpatient settings, where their share is 11%. Between 47% (short-term contacts) and 60% (long-term inpatient treatment) of clients are in the age group from 20 to 29 years (see Figure 5.1, Table A17 in Annex A as well as ST3 and ST34).

[31] When interpreting the results, one has to bear in mind that, while double counts of clients of one centre can be excluded, due to the aggregate character of the data, double counts of clients who turned to several centres in 2008 cannot be avoided. The share of such cases of multiple treatment can only be guessed at. The report of Vienna's BADO Basic Documentation gives a general idea of the magnitude of this aspect as in the case of BADO, double counts of clients who contacted several drug help centres during the reporting period can be detected by means of an identifier. In 2006, 14% of clients registered in BADO were provided services by more than one centre (11%: 2 centres; 3%: more than 2 centres – see GÖG/ÖBIG 2008a, IFES 2007). However, as drug help centres are more easily accessible in Vienna due to the higher geographical density compared to rural areas, the share of double counts might be slightly smaller in the rest of Austria.

In all settings analysed, the share of women is between 22% and 31%. This roughly corresponds to past experience (e.g. gender distribution regarding patients undergoing substitution treatment – see below – and drug-related deaths; GÖG/ÖBIG 2008b) and primarily seems to reflect the gender distribution in the group of problem users of illicit drugs. Generally speaking (with the exception of short-term contacts) the share of women in people receiving treatment tends to go down with rising age (see Figure 5.2 and Chapter 12.2).This situation also shows in the data on opioid substitution treatment and drug-related deaths and corresponds to experience reported by the majority of countries in the European Union (EMCDDA 2007). In addition, the documentation system reveals that women are younger at the time of first use of most substances and also start injecting drugs slightly earlier than men (see below). These data are in line with studies and analyses of recent years (EMCDDA 2007, GÖG/ÖBIG 2007a, Haas 2005).

Figure 5.2: Share of women in persons starting drug treatment or assistance sessions in 2008, by age and type of service

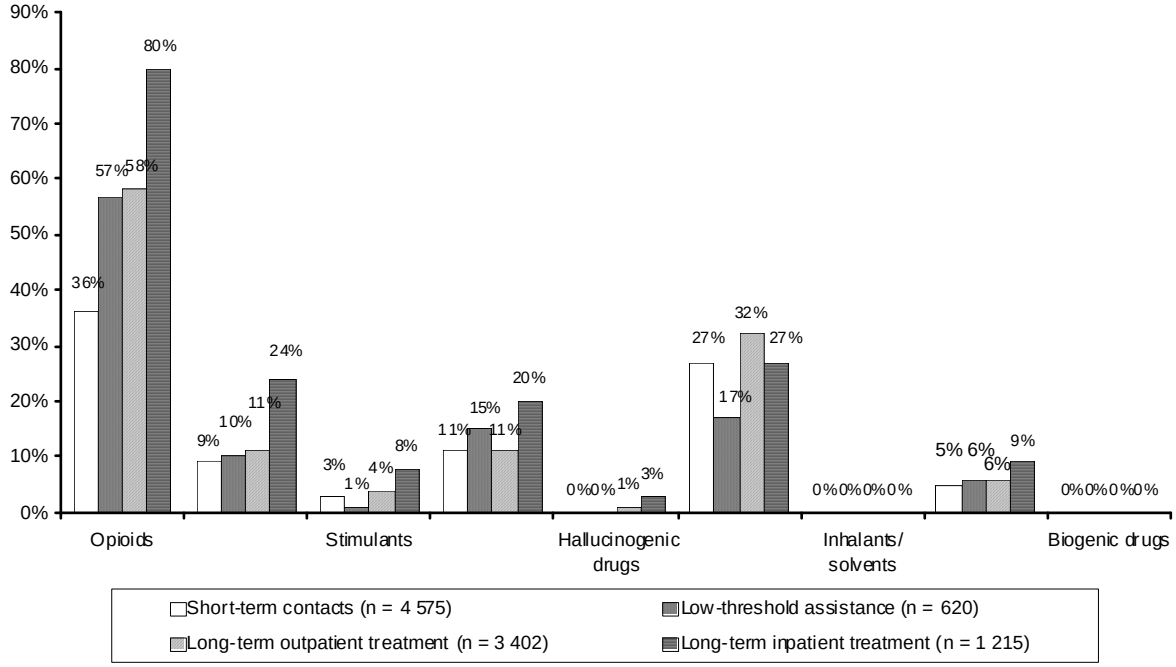


Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008; representation by GÖG/ÖBIG

In sum, approximately half of the clients are undergoing opioid substitution treatment when they turn to a drug help centre (except short-term contacts, for which this aspect is not documented). OST started in the course of clients' contacts to the drug help centre has not been included. The share of opioid substitution patients is rising with age of clients (see Chapter 12.1).

In the field of conventional treatment (long-term outpatient or inpatient treatment), opioids predominate as primary drugs[32]. Cocaine is of marginal relevance as a primary drug (see Figure 5.3 and Table A21 in Annex A). This shows that in Austria, different to a number of other countries of the European Union, opioids (continue to) play an important role in the context of drug use relevant for treatment (see, e.g., EMCDDA 2007). Depending on the treatment setting, the share of cannabis as a primary drug is between 27% and 32%. However, this has to be qualified due to the fact that a very high percentage of persons are referred to compulsory treatment because of use of cannabis as their sole primary drug. For instance, this applies to 62% of clients undergoing long-term outpatient treatment (see also Chapter 4.1).

Figure 5.3: People starting drug-related treatment or assistance sessions in 2008, by primary drug and type of service



Note: Multiple answers were permitted

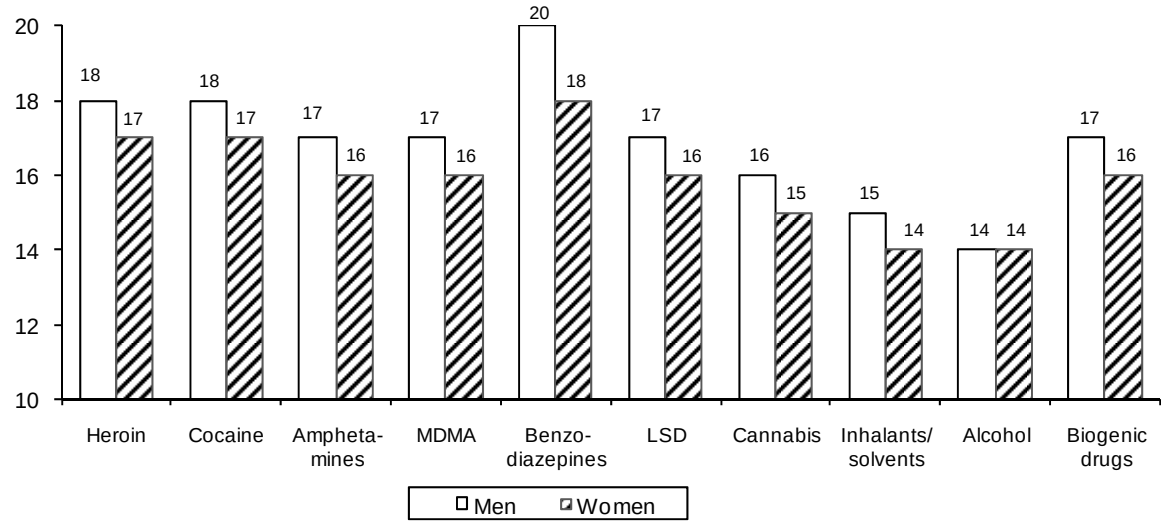
Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008; representation by GÖG/ÖBIG

In long-term inpatient and outpatient settings, women name opioids as primary drugs more frequently and cannabis less often than men. With rising age, opioids, cocaine and tranquillisers/hypnotics are increasingly often indicated as primary drugs – with the exception of in-

[32] For compiling the DOKLI case history, clients are first asked which drugs they have ever taken. Then the drugs mentioned are classified according to current patterns of use, as primary drugs, additional drugs, drugs only taken in the context of experimental use and drugs not relevant for treatment. The primary drug is the drug which causes the greatest problems from the personal point of view of the client. Here, problems – on the basis of ICD 10 – are understood as psychosocial and health-related problems and not solely legal problem situations. As a rule, the primary drug also is the drug because of which the client has started the current treatment. If a client cannot decide which drug is their primary drug, several drugs may be named. Additional drugs are drugs which the client has used in addition to the primary drug in the past six months and which also constitute a problem for the client. Experimental drug use refers to intermittent use of the corresponding drug in the past six-months without harmful use or manifest addiction problems. Drug use not relevant for treatment means that the drug in question has occasionally been taken for more than half a year but no harmful use or manifest addiction problems show, or that the drug was used in the past but not during the six-month period preceding treatment (GÖG/ÖBIG 2009a).

patient treatment settings. Cannabis, on the other hand, is named less often by older clients in all settings (see Chapter 12.2).

Figure 5.4: Age of first drug use (median) of persons starting long-term outpatient treatment in 2008, by substance and gender

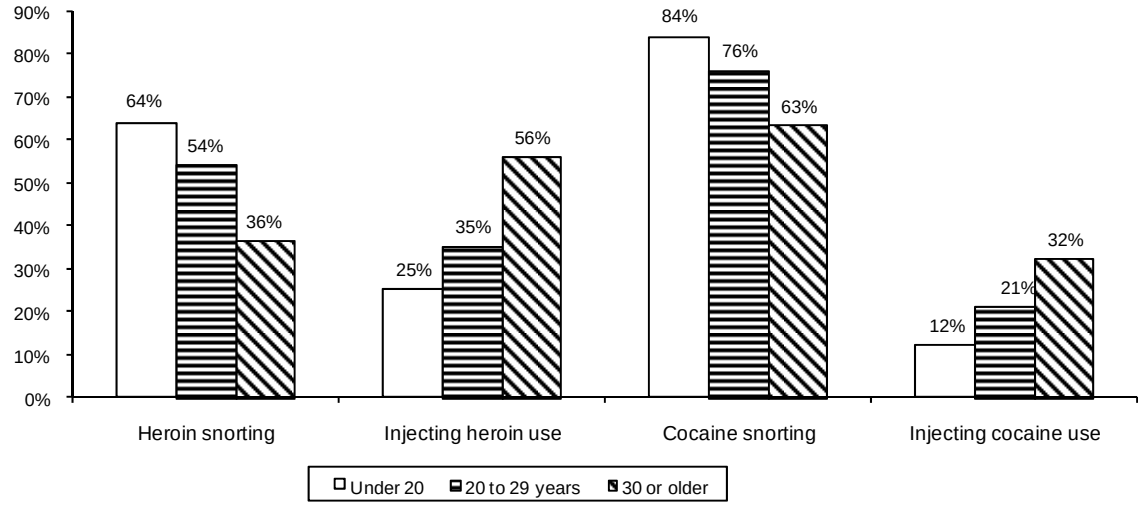


Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008;
representation by GÖG-ÖBIG

Further information on age of first use and predominant form of administration is available only for clients undergoing long-term outpatient and inpatient treatment. The median age of first use has shown to be between 17 and 20 years with regard to the majority of drugs. It is lower only in the case of alcohol and solvents/inhalants (14 years) and cannabis (15 years). A consistent tendency compared to the results for injecting drug use (see above) is that as a rule women are one year younger than men when they use drugs for the first time (see Figure 5.4 and Chapter 12.2).

Persons undergoing long-term outpatient treatment most often name snorting (50%) as their preferred way of heroin use, followed by injecting use (40%; see Table A22). In inpatient settings, the corresponding shares are 36% and 55%. This is an interesting result and was analysed in more detail in the context of the selected issue of last year's DOKLI report (GÖG/ÖBIG 2008a). It showed that a considerable share of heroin users prefer snorting at the beginning of their drug career and turn to injecting use at a later stage, if at all (see Figure 5.5). For possible prevention approaches that might result from these findings please consult GÖG/ÖBIG 2008a. 23% of clients undergoing outpatient treatment and 44% of inpatients primarily indicate injecting as their preferred form of cocaine use. The share of i.v. cocaine users also increases with rising age of clients (see Figure 5.5). Amphetamines are snorted by about two out of three users, and one out of three indicate oral use.

Figure 5.5: Preferred form of use of heroin (n = 2235) and cocaine (n = 2 277) among people starting long-term outpatient treatment in 2008, by age (percentages)



Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008; representation by GÖG/ÖBIG

The selected issues chapter of this year's DOKLI report (GÖG/ÖBIG 2009a) deals with older drug users. For results please consult Chapter 12.

5.4 Trends of clients in treatment (including numbers)

As DOKLI has been available since 2006 only, no statements on trends can yet be given. But time series going back over many years exist for opioid substitution treatment monitoring.

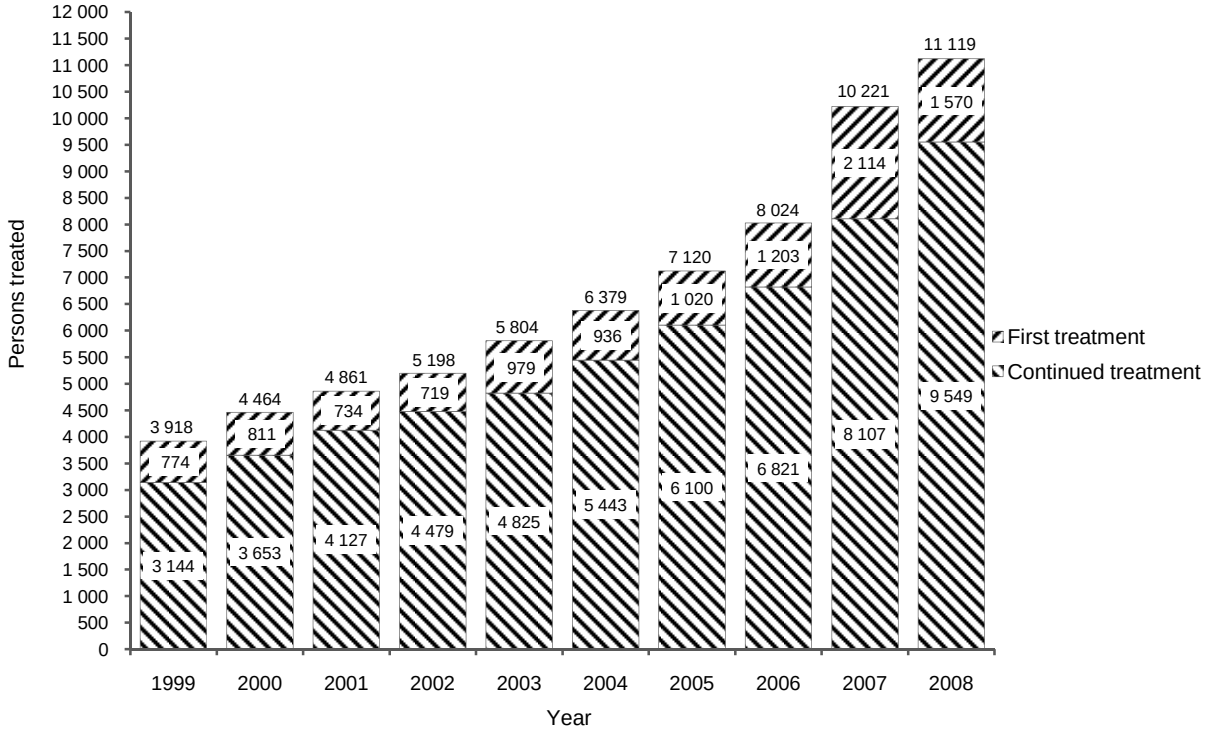
The national monitoring of substitution treatment is performed by the Ministry of Health and based on the reports of attending doctors[33]. Although these reports are not always complete and frequently not provided in due time (see ÖBIG 2003), they still give a general impression of both quantitative developments and characteristics of clients (see ST3 and Figure 5.6).

The problem of ghost cases[34] was a significant deficit regarding data quality. In order to get this problem under control, the Ministry of Health started comprehensive correction routines in 2007, based on enquiries to attending doctors, and it may safely be assumed that the amendment to the Narcotic Drugs Decree (see GÖG/ÖBIG 2007b), which entered into force on 1 March 2007, has considerably improved reporting practices. Because of these corrections and new developments, a number of differences compared to the figures given in previous years show. A considerable part of the rise in the number of treatments reported, and especially first treatments between 2006 and 2007, has probably been caused by the better coverage of cases.

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

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

Figure 5.6: Development of annual reports of persons currently undergoing opioid substitution treatment in Austria by first treatment and continued treatment, 1999–2008



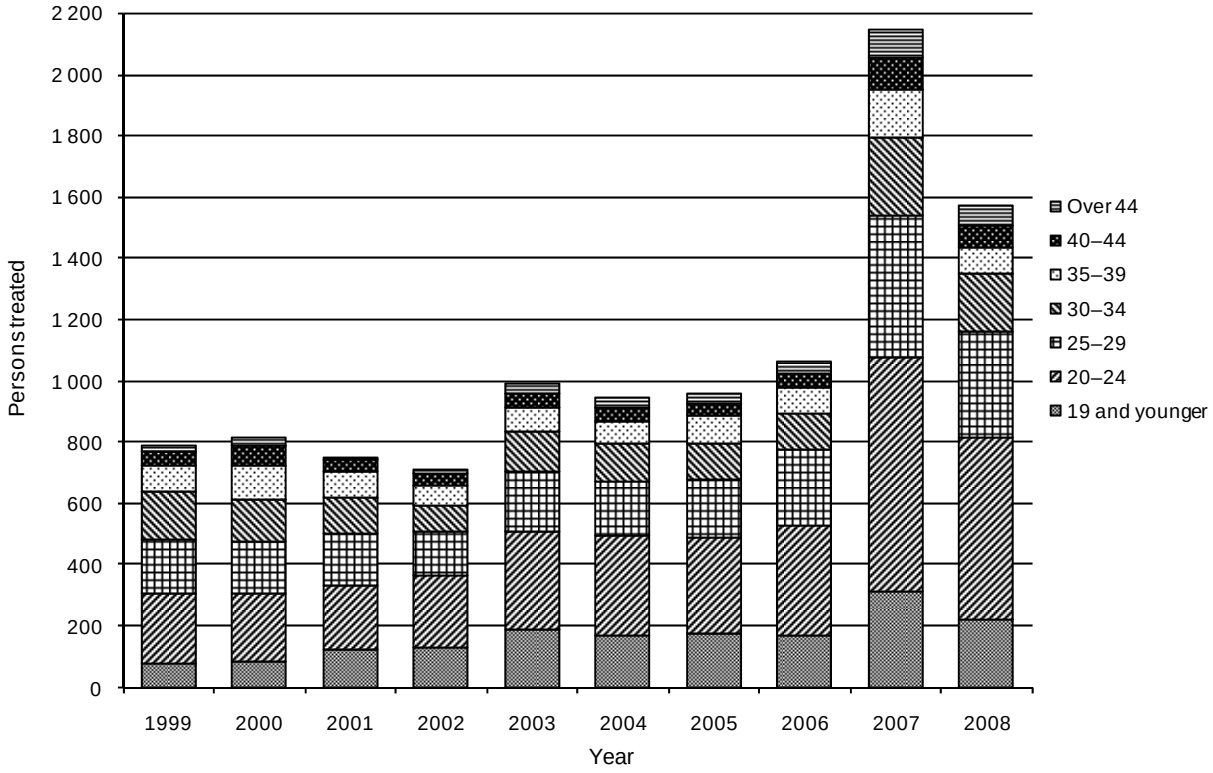
Note: **continued treatment** means treatment started before the respective year or repeated treatment of persons already having undergone substitution treatment in the past. **First treatment** means treatment of persons who have never been in substitution treatment before. Any differences to the figures given in previous years (GÖG/ÖBIG 2008) result from corrections on the part of the BMG.

Source: BMG, calculation and representation by GÖG/ÖBIG

The growing acceptance of and readiness to undergo opioid substitution treatment is reflected in the annually rising number of persons reported as currently receiving OST (see Figure 5.6).

As Figure 5.7 shows, the rise in first treatments in the last few years has primarily been accounted for by the groups up to age 19 and between 20 and 24 years. 2007 is a massive outlier in this respect, with the number of persons treated nearly doubled in almost all age groups (which indicates better coverage). In 2008 the number of first treatments reported has gone down again, but continues to be above the first treatment figures of 2006.

Figure 5.7: First substitution treatment in life, by age, 1999–2008



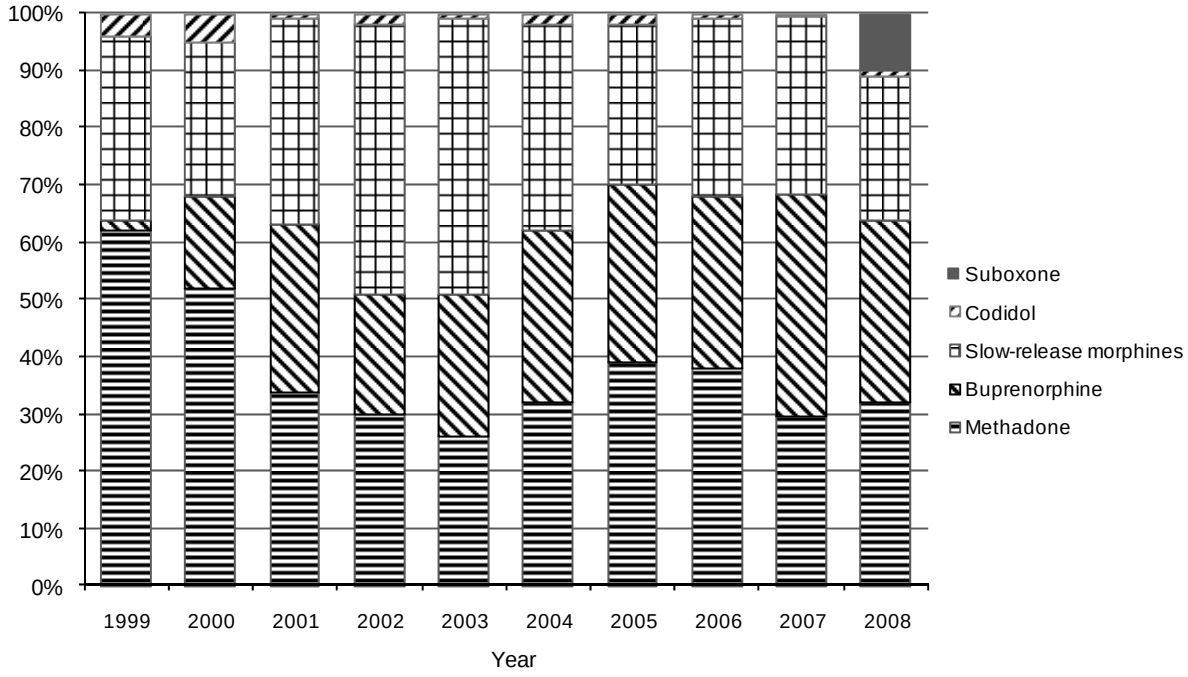
Source: BMG, calculation and representation by GÖG/ÖBIG

An interpretation of this development cannot be given at present because it is impossible to estimate to which extent treatments that had been started earlier were subsequently reported in 2007 and 2008 and therefore incorrectly entered as first treatments in the substitution registry. In 2008, as in previous years, the share of women in first treatments was approximately one out of four. Further analyses according to age and province would not make sense here because of the change in coverage. A list of registered first treatments by province is given in Table A16 in Annex A.

An analysis of the substances prescribed for first treatment also has to be made with caution, as part of the treatments, due to the reasons mentioned above, might incorrectly have been entered as first treatments. The share of slow-release morphines has further gone down compared to previous years and now amounts to 25% (2003: 47%). The prescription rates of methadone have remained roughly the same, and buprenorphine has been prescribed less often. It should be taken into account, however, that in 2008 Suboxone, a preparation combining buprenorphine and naxolone, was included as a new substitution substance (present share: 10%; see Figure 5.8). Still, in previous years, the analyses of the DOKLI data show a different picture: according to DOKLI, slow-release morphines are prescribed most often (45% of long-term outpatient clients; 63% of clients receiving low-threshold assistance and 61% of persons undergoing long-term inpatient treatment), followed by methadone (18% to 27% of patients undergoing OST) and buprenorphine (only between 5% and 21%) (GÖG/ÖBIG 2009a). Buprenorphine is typically prescribed to younger clients.

Again, one has to bear in mind that a comparison of these data is possible to a limited extent only (see GÖG/ÖBIG 2007b).

Figure 5.8: Development regarding kind of substitution substance used for first treatment 1999–2008, percentages



Source: BMG, calculations by GÖG/ÖBIG; representation by GÖG/ÖBIG

For a rough estimate of all people undergoing drug-related treatment in Austria, the data from substitution monitoring and from DOKLI may be combined. In 2008 a total of 1 751 people turned to drug help units covered by DOKLI to receive inpatient treatment, 9 102 people underwent long-term outpatient treatment (GÖG/ÖBIG 2009a), and 11 119 people were registered as patients undergoing OST in 2008 (see Figure 5.7). In order to obtain total numbers, the following assumptions or parameters are considered:

- In the DOKLI system, multiple counts of clients cannot be excluded. But based on the BADO system of Vienna, a correction factor may be calculated. In the BADO system, the share of clients receiving care in several drug help centres is 14% (IFES 2007).
- DOKLI does not cover all drug help units: 71% of inpatient treatment centres and 93% of outpatient centres use DOKLI for case documentation (ST34).
- The overlap between DOKLI and substitution monitoring may be estimated on the basis of the DOKLI item referring to the start of opioid substitution treatment (42% of drug outpatients and 50% of drug inpatients were undergoing OST when they turned to the drug help centres).

Based on these assumptions and parameters, it is estimated that long-term drug-related cares services were provided to approximately 17 000 people in Austria in 2008.

6 Health Correlates and Consequences

Infectious diseases are relevant in particular because of the risk of transmission due to injecting drug use. The available data in this context are based on non-representative samples from the treatment sector or low-threshold centres. While the HIV prevalence rate still was around 20% in the early 1990s, it has remained at a low level since then (0% to 2%). The prevalence rate of hepatitis B was lower than 20% in the reporting year. Hepatitis C-Ab prevalence has remained around 50%. Regarding hepatitis C, the prevalence rates relating to HVC antibody (HCV-Ab) and HCV-RNA tests have been documented separately by a few drug treatment units. This is of interest as it is primarily positive testing for HCV based on PCR tests that indicates a chronic development of HCV.

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

In Austria, the Ministry of Health has collected data on drug-related deaths since 1989. In the case of directly drug-related deaths, a causal connection between death and drug use may safely be assumed, i.e., the patients in question died as a result of acute intoxication (overdose). The data of the annual statistics and analysis are based on the reporting obligations under Section 24c of the Narcotic Substances Act, according to which the following information has to be communicated to the Ministry of Health immediately: the Federal Ministry of the Interior (BMI) has to provide information on any police reports related to suspected drug offences, and the forensic medicine institutions, the public health authorities and hospitals have to report the results of post-mortem examinations or autopsies performed as well as any chemical and toxicological tests carried out on this occasion. If no post-mortem examination or autopsy has taken place, the Ministry of Health obtains the confirmation-of-death certificates that are documented at Statistics Austria. However, a considerable decline has shown regarding the number of cases in which post-mortem examinations including toxicological tests are performed because of suspected drug overdoses in order to verify this suspicion and analyse the substances involved. For instance, in 2008, 32 cases occurred where the confirmation-of-death certificates indicated narcotic drug intoxications but no autopsy or post-mortem examination was ordered by the courts or the public health police, respectively. As a result, these cases could not be verified as cases of overdoses including narcotic drugs, thus, it is not sure whether they are in fact drug-related deaths or not. The number of deaths suspected to involve drug use that have not been examined in further detailed tripled in the past year, which affects the conclusiveness of the statistics and also makes it difficult to compare the corresponding data with those of previous years. In Vienna, as a consequence of the amendment to the Vienna Death and Funeral Act of 2007, the number of suspicious deaths in which no post-mortem examinations and toxicological tests were performed even grew by 400% (GÖG/ÖBIG 2008c). For the year 2008, it is thus impossible to give an exact number of persons whose death is proven to be connected with narcotic drug overdoses. Consequently, no time series and comparisons between provinces can be included.

Nevertheless, the statistics still provide a number of data on patterns of use, gender distribution and average age of people who died of narcotic drug intoxication, which is of relevance for health policies. The problem of the reduced quality of epidemiological data and ways to improve the current situation has already been a topic of discussion in health policy contexts. It would be desirable from the point of view of health policy to perform autopsies in all cases of suspected drug-related death, because complete statistics that provide conclusive information are essential as a basis of decision-making and prevention measures.

6.1 Drug-related infectious diseases

The data on drug-related infectious diseases that are given in Standard Table 9 (ST9) include national as well as subnational samples from low-threshold centres and inpatient treatment units. The corresponding **prevalence rates** are summarised in Table 6.1. The data of the reporting year indicate hepatitis B (HVB) rates ranging from 2% to 19%. The drug-help units again report low HIV prevalence rates between 0% and 2% (2007: 0% to 4%). The HVC antibody (HCV-Ab) prevalence rates of 2008 range from 22% to 60%, with the Lukasfeld therapy department reporting a deviating prevalence rate of 22% (2007: 20%) also this year. A well-founded interpretation of this difference cannot be made. Thus, the trend already observed in previous years of HCV-Ab prevalence rates around 50% has continued (see GÖG/ÖBIG 2007b; GÖG/ÖBIG 2008c).

Regarding HCV-RNA, a chronic development of the disease shows in a high share of patients testing positive for HCV-Ab. Because of the great differences of HCV-RNA prevalence rates that are reported, i.e., between 38% (Anton Proksch Institute) and 75% (Lukasfeld), these data cannot be used as a basis for deriving general statements on chronic developments of hepatitis C infections (see Table 6.1). Regarding HCV genotypes, neither national data nor information by individual centres is available for the reporting year[35].

[35] For details on individual drug-related infectious diseases and HCV-RNA prevalence rates see also ST9.

Table 6.1: Data on hepatitis B, hepatitis C-Ab, hepatitis C-RNA and HIV infection rates in 2008

Data source	HBV rate	HCV-Ab rate[1]	HCV-RNA rate[6]	HIV rate
Lukasfeld therapy department	2% (1/5)[2]	22% (12/55)	75% (9/12)	0% (0/55)
Long-term therapy department at Anton Proksch Institute (API)	19% (13/67)[2]	60% (44/67)	38% (10/26)	1% (1/67)
Low-threshold centre Ganslwirt	8% (7/89)[3]	43% (27/63)	not documented	2% (2/108)
Caritas Marienambulanz outpatient department	13% (19/121)[4]	60% (72/121)	67% (48/72)	0% (0/121)
DOKLI[5]	19% (58/306)	47% (165/350)	66% (94/143)	1% (3/317)
Drug-related deaths (intoxications) in 2008	n.a. [8]	n.a.	n.a.	n.a.

[1] These prevalence rates relate to persons in whom HCV antibodies were found (HVC-Ab) and not to HCV-PCR tests, which permit a direct detection of the virus.

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

[3] This percentage relates to persons in whom antibodies (anti-HBc Ab, anti-HBe Ab, anti-HBs Ab) or HBs antigens were found and who had not yet received hepatitis B vaccinations (isolated anti HBs Ab positive tests; data obtained from Ganslwirt's vaccination project).

[4] Positive test results only refer to HBV-cAb positive and HBV-sAb positive results. In the reporting year, no HBV-sAg positive cases were found.

[5] These data refer to injecting drug users who started drug treatment in 2008; information on their infection status was obtained either by status testing or based on the case history.

[6] Only 100 and 108, respectively, out of a total number of 175 expert opinions on directly drug-related deaths explicitly mentioned the presence or absence of HCV Ab and HIV. 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 in the expert opinion. The two percentages given therefore indicate maximum and minimum levels of HCV-Ab and HIV prevalence rates.

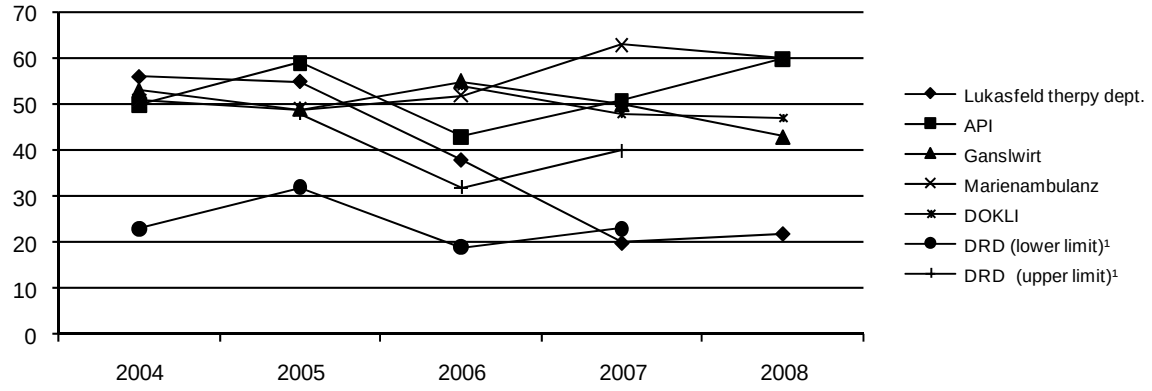
[7] The HCV-RNA rate relates to persons with positive HCV-Ab test results.

[8] n.a. = no data available

Sources: Duspara, Stolz-Gombocz, Haltmayer, Anderwald, Bauer, personal communications; GÖG/ÖBIG 2009a; see also ST9; representation by GÖG/ÖBIG

Generally speaking, the prevalence rates reported are comparable to a limited extent only because of differences in data collection methods by the individual centres (routine examinations v. voluntary test services offered), and lack of representative data sources. A comparison of available HBV, HCV-Ab and HIV prevalence rates covering the period from 2005 to 2008 (see Figures 6.1, 6.2 and 6.3) shows how difficult it is to derive reliable statements on changes and trends regarding the at-risk group of drug users.

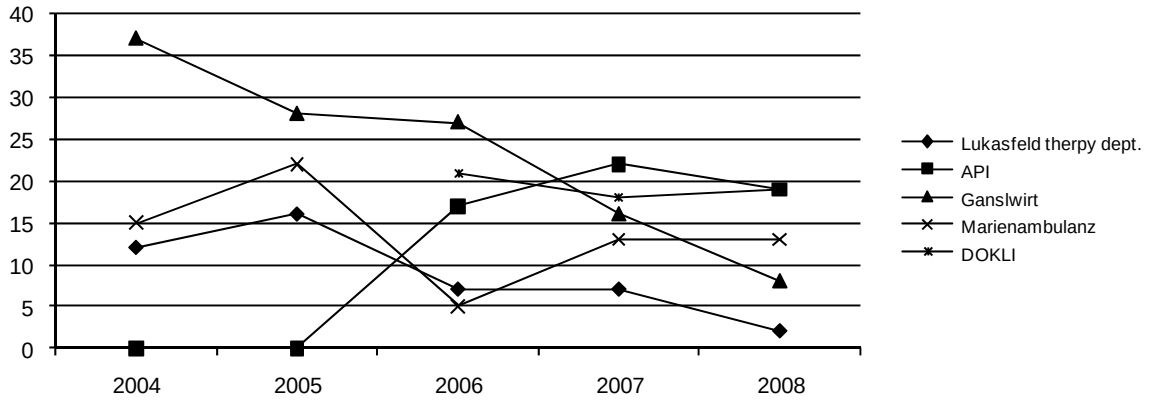
Figure 6.1: Hepatitis C-Ab prevalence rates in Austria; 2004–2008



[1] Not all expert opinions on directly drug-related deaths (DRD) explicitly mention the presence or absence of HDV-Ab infections. In the remaining cases, it is not clear whether the infection status was not tested, or not mentioned because of negative testing. The two percentages given thus represent the upper and lower limits of HCV-Ab prevalence rates.

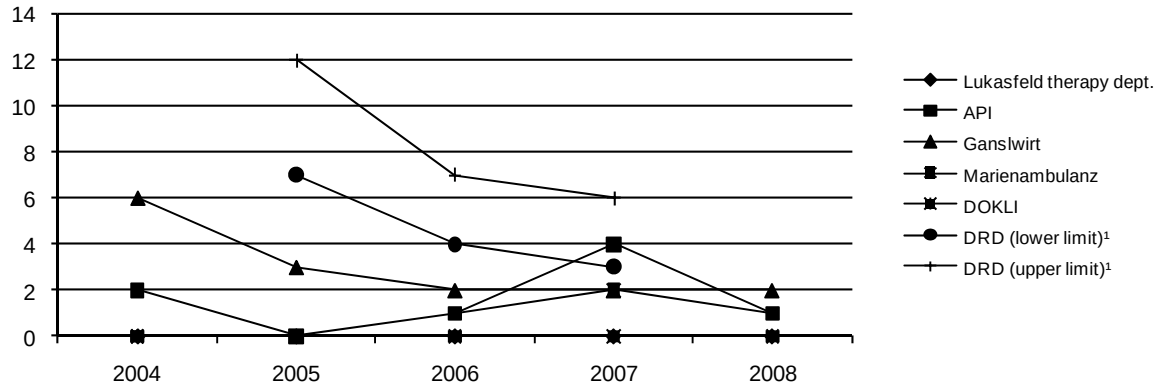
Source: ST9, calculation and representation by GÖG/ÖBIG

Figure 6.2: Hepatitis B prevalence rates in Austria; 2004–2008



Source: ST9, calculation and representation by GÖG/ÖBIG

Figure 6.3: HIV prevalence rates in Austria, 2004–2008



[1] Not all expert opinions on directly drug-related deaths (DRD) explicitly mention the presence or absence of HIV infections. In the remaining cases, it is not clear whether the infection status was not tested, or not mentioned because of negative testing. The two percentages given thus represent the upper and lower limits of HIV prevalence rates.

Source: ST9, calculation and representation by GÖG/ÖBIG

In 2008 a total of 1 048 hepatitis C infections relative to the general population were reported. The hospital discharge statistics alone list 212 patients with acute viral hepatitis C infections and 915 patients suffering from chronic viral hepatitis. In 2008, chronic viral hepatitis C was indicated as the main cause of death of 250 people, and one person died of acute viral hepatitis C. 763 cases of hepatitis B were reported in Austria. According to the hospital discharge statistics, various types of hepatitis B were diagnosed in a total of 317 patients, and in 24 cases, hepatitis B was indicated as the main cause of death. 138 hepatitis A infections were reported, 95 patients suffering from this infection were listed in the hospital discharge statistics and no hepatitis A infection was documented in the cause of death statistics (see BMG 2009b; BMG 2009c; Statistik Austria 2009a; Statistik Austria 2009b).

Due to the aggregate character of the above data, they cannot be linked, and thus, prevalence and incidence rates of hepatitis in the general population cannot be derived from these statistics. In addition, although hepatitis infections have to be reported, at least regarding HCV a reporting bias is likely (Strauss et al. 2003). Early in 2009 an electronic epidemiological reporting system (EMS) was introduced in Austria in order to improve reporting quality: now monthly statistics on reports are provided, broken down by infectious disease and province. Due to lack of information on routes of infection it is not possible, however, to identify potential at-risk groups such as injecting drug users.

The reports from the long-term national AIDS statistics show that injecting use is the second-most risky situation (16 reports) after heterosexual contacts (n = 25) and before homosexual contacts (n = 12). In 2008, 10 cases were filed as ‘other/unknown’, and in two cases, the virus was transmitted by transfusion. The statistics on AIDS deaths by risk situation and year show that half out of a total of 18 deaths listed were related to injecting drug use (BMG 2009a; see Table A3 in Annex A).

Data on other drug-related infections are available only for tuberculosis (TB). No person out of 101 for whom tuberculosis entries are given in the corresponding DOKLI data set had positive TB diagnoses. Three clients indicated TB infections when the case history was compiled. These figures confirm that TB still does not constitute a problem in Austria. The data on TB vaccination rates are based on a sample of 239 people. This year’s data confirm the low vaccination coverage regarding TB: it was 5% in 2008, and 8% in 2007 (see Chapter 5.3; GÖG/ÖBIG 2008a; GÖG/ÖBIG 2009a).

The DOKLI data set on hepatitis A vaccinations includes 420 people, and regarding hepatitis B vaccinations, a sample of 569 people. The resulting **vaccination coverage** of 28% for hepatitis A and 31% for hepatitis B is in fact small. However, among people under 20, higher vaccination rates have been registered than in the other age groups (see GÖG/ÖBIG 2009a). This HBV vaccination coverage is similar to the rates communicated by the inpatient departments of Lukasfeld (27%) and API (34%) but not by the Marienambulanz low-threshold outpatient clinic (10%; see ST9). The figures reported generally reflect previous vaccinations rather than the actual status of immunisation (GÖG/ÖBIG 2009a).

In the context of an anonymous standardised survey carried out at Caritas drug help units in Innsbruck, within one week a total of 62 drug users were asked for information on previous HIV and HCV diagnoses or HAV/ABV vaccinations. This also included questions concerning patterns of drug use as well as **behaviour-related data** on syringe use and safer sex. At present the results of the survey are analysed (Schäfer, personal communication).

6.2 Other drug-related health correlates and consequences

The Carina therapy department at Maria Ebene Foundation provided systematic diagnoses regarding **psychiatric comorbidity** according to ICD 10, which reveal that almost all patients suffer from one or several personality disorders. Affective disorders were found in 18% of patients, while the share of neurotic, stress or somatoform disorders among total diagnoses was small. Only 4% of patients had diagnoses of anxiety disorders (see Table 6.2; Stiftung Maria Ebene 2009b).

Table 6.2: Psychiatric comorbidity by ICD-10 diagnose, Maria Ebene Foundation, patient year 2008

ICD 10 chapter	Block	Code	Percent
Disorders of adult personality and behaviour (F60–F69)	Specific personality disorders (PDs) (F60. –)	Paranoid PD (F60.0)	7% (6/88)
		Dissocial PD (F60.2)	11% (10/88)
		Emotionally unstable PD (F60.3)	28% (25/88)
		Histrionic PD (F60.4)	11% (10/88)
		Anxious (avoidant) PD (F60.6)	9% (8/88)
		Dependent (asthenic) PD (F60.7)	7% (6/88)
		Other specific PDs (F60.8)	8% (7/88)
	Mixed and other personality disorders (F61. –)	Paranoid PD (F61.0)	17% (15/88)
Mood (affective) disorders (F30–F39)	Recurrent depressive disorder (F33. –)		16% (12/77)
	Persistent mood (affective) disorders (F34. –)		3% (2/77)
Neurotic, stress-related and somatoform disorders (F40–F48)	Phobic anxiety disorders (F40. –)	Social phobias (F40.1)	3% (2/77)
	Other anxiety disorders (F41. –)	Mixed anxiety and depressive disorder (F41.2)	1% (1/77)

Source: Stiftung Maria Ebene 2009, calculation and representation by GÖG/ÖBIG

Significant gender differences in the psychiatric diagnoses show with regard to eating disorders (women: 42%; men: 6%). When the diagnoses were made, particular attention was paid to complex post-traumatic stress disorders, i.e. serious diseases as a reaction to stress, which were found in 39% of all patients – and in 69% of women. This means that more than two out of three women treated have experienced traumatic situations. Taking into account the corresponding ICD-10 diagnoses, this trauma frequently results from experience of sexual and/or physical violence suffered over a long time (see Stiftung Maria Ebene 2009b).

The DOKLI data also provide information on psychiatric comorbidity (see Chapter 5.3). In 159 out of 239 people (66%) for whom at least one ICD-10 diagnosis not related to addiction was entered, a mental and behavioural disorder was found. The diagnoses range from affective disorders (e.g., depression), personality and behavioural disorders to neurotic, stress and somatoform disorders. On the other hand, Grüner Kreis states that in the reporting year 38% out of 102 patients suffering from psychiatric multimorbidity had diagnoses of schizophrenia as well as schizotypal and delusional disorders. At the Carina therapy department, this type of comorbidity is found in only 4% of patients. Grüner Kreis diagnosed personality and behavioural disorders in 33%, and affective disorders in 32%, of patients with comorbidity (see GÖG/ÖBIG 2009a, Grüner Kreis 2009, Stiftung Maria Ebene 2009b). The results of the retrospective study on the prevalence of personality disorders at the API long-term therapy department at Mödling, Lower Austria, still have not been published (see GÖG/ÖBIG 2008c).

Need for crisis intervention among clients was reported primarily by low-threshold centres. For instance Substanz (Upper Austria) reports 46 acute crisis interventions in the reporting year (2007: 16 interventions), i.e., cases in which clients needed spontaneous help immediately. This concerned issues such as support of relatives after a person's death, trauma because of violence in the drug scene, losing one's home or crisis in the partnership. In 2008, four persons used the psychotherapeutic crisis intervention service more than 50 times (Substanz 2009). The statistics of the low-threshold centres in Vienna reveal that mental health, after accommodation and drug use, ranks third in the list of themes addressed in counselling talks. The number of crisis interventions (n = 371) more than doubled compared to the year before (n = 157; VWS 2009a).

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

In the reporting year, the low-threshold centres of Vienna reported 97 instances of life-saving measures taken, which is a slight decline compared to the year before (n = 109). According to statistics of Vienna's ambulance service, in 2008 the number of patients with suspected overdoses of illicit substances was 897 in Vienna. This corresponds to 0.5% of total patients in this period. The increase that shows compared to the year before (n = 586) results from a modification in the documentation of ambulance data (Sucht- und Drogenkoordination Wien 2009; VWS 2009a).

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

6.3 Drug-related deaths and mortality of drug users

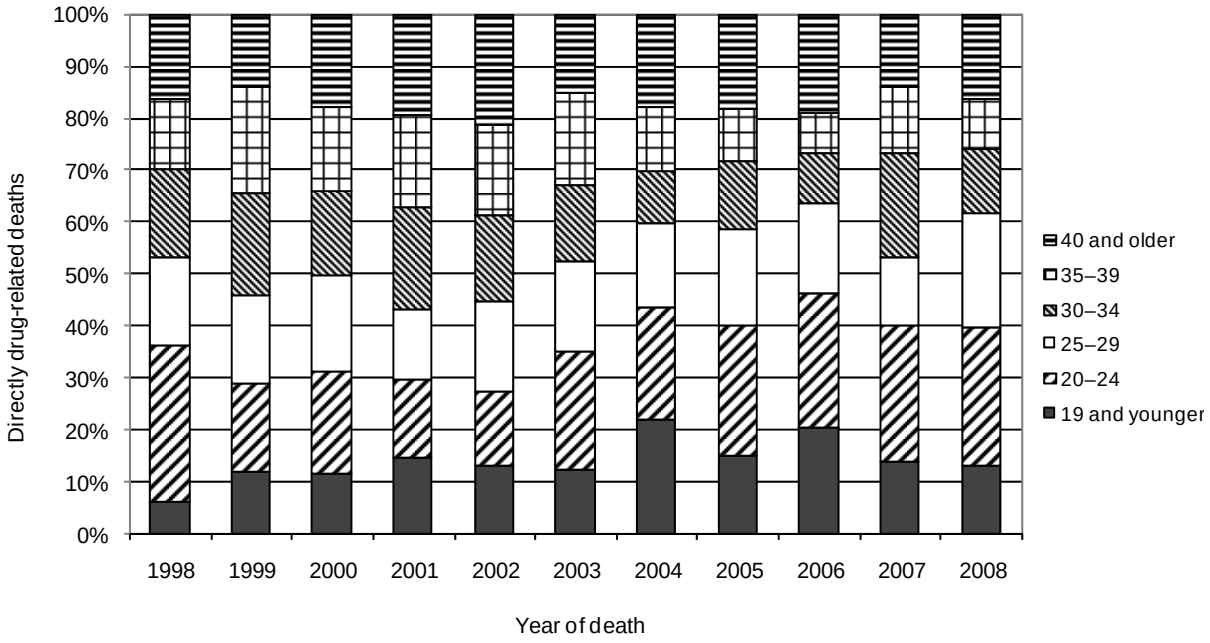
Regarding drug-related deaths, a distinction is made between deaths directly caused by drug use and indirectly related deaths (for details on methodology see GÖG/ÖBIG 2009c).

Based on autopsy findings, a total of 169 directly drug-related deaths could be verified. This figure has to be regarded as the lower limit, however. In fact, if one also includes suspicious cases that were reported and for which only confirmation-of-death certificates (based on an external examination of the body) are available, between 169 and 201 deaths might directly be drug-related. For this reason, it cannot be assessed whether the number of deaths has gone down or risen compared to last year (175), and no statements on trends can be given.

In 12% of cases of drug-related death, the toxicological analyses revealed only illicit substances (one drug or a combination of several drugs). In addition, psychoactive substances were also found in 54% of cases, in 9% alcohol was detected as well, and in 25%, both substances, i.e., alcohol and psychoactive drugs. As in previous years, poly-drug intoxications with opioids clearly predominate (97% of intoxications with known substances. The share of persons who had exclusively taken opioids (approx. 8%) remained at a level similar to the

year before (2006: 16%; 2007: 6%). Patterns of poly-drug use, where the effects of different substances may be potentiating and thus are difficult to control, continue to be widespread and constitute serious health hazards (see Chapter 4).

Figure 6.4: Age distribution of directly drug-related deaths in Austria, 1998–2008; percentages



Source: GÖG/ÖBIG 2009c; representation b GÖG/ÖBIG

The grouped median[36] of the age at death was 25.7 years in 2008: the age median of the reporting year thus again is at a level similar as in previous years, after a rise in age had shown for the first time in 2007 (2005: 25.9; 2006: 24.6; 2007: 28.3). The share of persons under 20 (13%) was within the range of previous years (2005: 15%; 2006: 20%; 2007: 14%; see Figure 6.4). The share of persons between 20 and 24 years was 27%, which corresponds to the average of the last few years (2004: 22%; 2005: 25%; 2006: 26%; 2007: 26%). The share of women in directly drug-related deaths, i.e., 21%, is in line with the long-term average.

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

7 Responses to Health Correlates and Consequences

In Austria the responses to health correlates and consequences include a wide range of interventions. The relevant measures focus on drug-related infectious diseases, in particular low-threshold assistance 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)[37]. Treatment of health consequences is primarily provided by the general health-care system (e.g. emergency physicians, psychiatrists), and to an increasing extent also in the context of consulting hours of physicians/specialists in low-threshold centres. In the past year, also the themes of diagnosing and treating hepatitis C, as well as comorbidity, were of particular relevance. The available information and data primarily come from the annual reports of individual units and the Drug and Addiction Coordination Offices of the provinces.

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

At present, the steering group of the Austrian Federal Drug Forum (BDF) that was convoked in February 2009 is preparing a special meeting of the BDF to discuss possible interventions to reduce drug deaths. The goal of the meeting is to draw up a comprehensive national strategy paper on the prevention of drug-related deaths. Specific initiatives focusing on drug-related emergencies and deaths are mainly pursued in the low-threshold drug help sector, by individual centres, and in some cases also at provincial level. In Vienna a study on drug-related deaths is being conducted in order to increase the quality of knowhow on risk factors and to derive interventions aimed at harm reduction and prevention of deaths (Sucht- und Drogenkoordination 2009b).

In 2008 the CONTACT hospital connection service for drug addicts in Vienna was called in 386 cases to provide assistance (2007: 346). A total of 1 026 contacts during stays in hospital and 1 279 contacts after release from hospital were registered (Sucht- und Drogenkoordination Wien 2009a; see also Chapter 7.3).

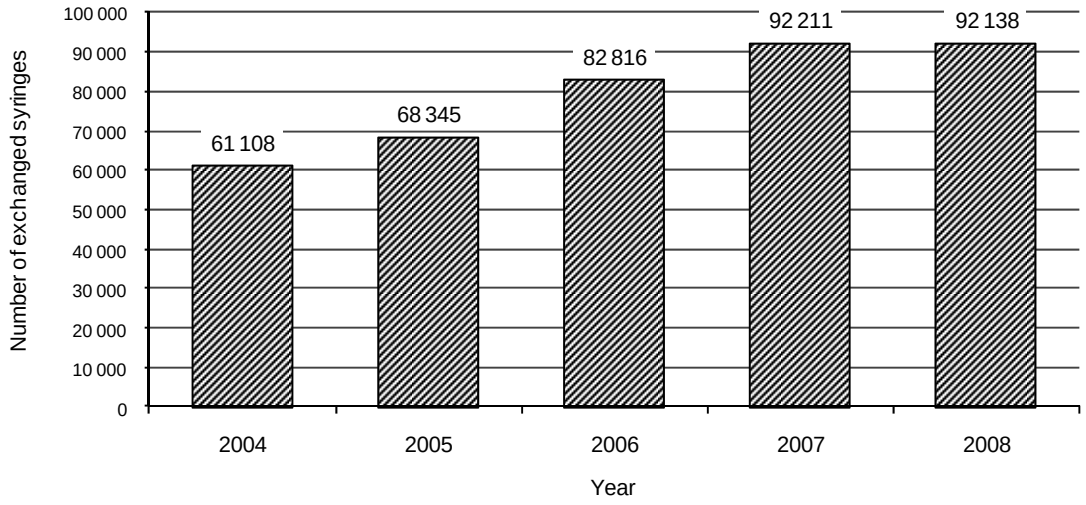
In the low-threshold sector, first aid still plays a predominant role. This theme is presented in information material or at events as well as in inhouse magazines (e.g., at the ‘theme bistro’ of streetwork/VWS). Clients of Komfüdro (Tyrol) may also train practical first aid measures in a group setting. In the reporting year Komfüdro again organised an obligatory first-aid training course for its staff. This ensures quick responses to (drug) emergencies that occur in the centre, and the knowledge obtained may be passed on to clients (see VWS 2009a; Komfüdro 2009).

[37] http://suchthilfekompass.oebig.at

7.2 Prevention and treatment of drug-related infectious diseases

Preventing infections continues to play an important role in low-threshold centres and outreach work: here the **exchange and sale of syringes** is especially important. In addition to the established programmes for the exchange and sale of syringes that are run at provincial level, in Austria it is also possible to buy syringes and needles in pharmacies and vending machines. In the reporting year a vending machine was installed also in Dornbirn (Vorarlberg). Vorarlberg now has a total of seven vending machines, the safer sets for which are prepared by *do it yourself*, a low-threshold contact point, in the context of an occupation project (do it yourself 2009). Salzburg has taken steps to implement low-threshold services for drug users. At present, syringes can only be bought at two vending machines or at the offices of the AIDS Hilfe centre (Drogenkoordination des Landes Salzburg 2009).

Figure 7.1: Syringe exchange at the Substanz centre (Upper Austria), 2004–2008



Source: Substanz 2009; representation by GÖG/ÖBIG

All data on syringe exchange by province that were systematically collected relate to the reporting year 2007 (see ST10; GÖG/ÖBIG 2008c). For this reporting year, only a few data from individual units are available, which again indicate high levels of, or strong rises in, syringe sales and syringe exchange. The trend of past years hat thus continued. For instance, at the Substanz low threshold centre of Upper Austria 92 138 sets were exchanged. If one adds the syringes exchanged and sold at the café as well as sales in the prevention vending machine, a total of 98 406 sets were distributed (see Figure 7.1; Substanz 2009). The services for injecting drug users, in addition to making syringes available, continue to include the provision of sterile injection equipment (e.g., spoons), alcohol pads, medical filters and disinfectants.

In spite of high return rates of over 95% drug users have repeatedly been reported to leave behind equipment in public places. The VWS centres attempt to contribute to awareness-raising in this regard, both by individual talks and in the form of postcards, which have been distributed since early in 2009 (VWS 2009a).

Safer use and **safer sex** continue to be essential issues that are addressed in the context of outreach drug social work, usually on the occasion of syringe exchange. No significant developments compared to the previous year have taken place here. In 2008 the drug help units of Vienna published a guidebook for drug users that deals with the subjects of injecting drug use and its risks, alternatives to i.v. use, as well as information on individual substances and safer sex (VWS 2009b). In 2008 Komfüdro (Tyrol) again placed the focus of its work on safer use and hepatitis C prevention. In the context of a peer education project, a workshop on safer use and hepatitis was organised in cooperation with selected clients. Because of the positive feedback, a continuation of this initiative has been planned. Komfüdro's activities of preventing infections, which address not only drug users, are also taken into account in the sanitary inspections of the individual centres. In this context daily work routines at the centre are tested with regard to sanitary standards (Komfüdro 2009).

Hepatitis vaccination projects are further essential interventions to prevent and treat drug-related infectious diseases. They are organised at regional level or as initiatives by individual centres. In most cases the offer of vaccination is combined with cost-free HIV and viral hepatitis testing. For instance, in 2008 the Ganslwirt low-threshold centre (Vienna) registered 123 and Kontaktladen (Graz) 58 HAV/HBV vaccinations, and *do it yourself* (Vorarlberg) reported six hepatitis vaccinations.

Treating infectious diseases in drug users has become increasingly important in the whole country. A prerequisite for successful treatment is that multiprofessional networks exist which link drug help institutions and providers of medical care. For instance, in Vienna drug patients who suffer from hepatitis B or C may also obtain treatment in all gastrointestinal outpatient departments of the individual hospitals. Other provinces have also taken steps to create a basis for effective treatment or to increase the quality of treatment for this difficult group of patients. For this purpose the drug help centres and the medical sector cooperate in the context of quality circles[38]. This goal was also on the agenda of the fifth expert meeting on hepatitis C[39], which took place in Vienna in June 2009. Regarding HIV treatment, the cooperation with the pulmonology and dermatology outpatient and inpatient departments of Vienna's hospitals has been intensified (see GÖG/ÖBIG 2008c; Sucht- und Drogenkoordination 2009b).

Drug consumption rooms continue to be an issue in Austria. In February 2009 a meeting held in Innsbruck focused on new ways in drug policy and an international comparison of consumption rooms. In addition to an exchange of international experience, themes related to consumption rooms and safety as well as low-threshold approaches were presented and discussed, also with regard to their relevance for Austria. The plan of 2007 to establish a drug treatment point in Graz is also oriented towards this aspect. The original plan has meanwhile been revised and is about to be presented to the Ministry of Health. The new plan takes into account recommendations by the Federal Government such as comprehensive evaluation routines, as well as decisions in favour of support for this approach on the part of the Local Government of Graz and the Regional Parliament of Styria. After its revision, the

[38] www.oegabs.at
[39] www.hepatitiscfachtag.org

plan will be discussed by the Federal Drug Coordination (of the Federal Ministries of Justice and the Interior, headed by the Federal Ministry of Health) and the Federal Drug Forum (Zeder, personal communication). In the context of Vienna's drug monitoring, the acceptance of consumption rooms among the general population was surveyed: in 2009, only 34% said that this was a sensible step, 22% were neither against nor in favour of consumption rooms, and 41% rejected the idea. However, distributing sterile syringes to drug users is accepted by 68% of the population. Still, it is interesting so see that the acceptance of consumption rooms, i.e. 34%, has been the best result so far. Since 1997, acceptance rates have been between 20% and 31% (IFES 2009).

7.3 Responses to other health correlates and consequences

Services with regard to **psychiatric comorbidity** are still part of the activities of the agencies providing drug help services. The services delivered by the individual centres hardly differ from those reported in previous years (see GÖG/ÖBIG 2007b, GÖG/ÖBIG 2008c). In the reporting year, Grüner Kreis established mobile long-term care services for patients showing psychiatric comorbidity. The patients' individual needs are specifically taken into account to achieve their best possible occupational and social reintegration (Grüner Kreis 2009). The drug outpatient clinic (ASK) of Vienna expanded its multiprofessional diagnosing services: now also psychiatric comorbidities such as trauma, abuse or schizophrenia as well as addiction-related infectious diseases can be considered more specifically. Patients and their relatives obtain consulting in these fields and if necessary they may also receive treatment (Sucht- und Drogenkoordination Wien 2009b). Addiction and psychiatric comorbidity continue to be relevant issues at events organised for staff of drug help centres (see GÖG/ÖBIG 2008c; Hörhan, personal communication).

Interventions and measures that aim at the **general state of health** of drug users are integrated in all treatment and care fields covered by the drug help network, with different focuses depending on the setting in question. In particular in the low-threshold field, the corresponding services also include dressing of wounds, health information, hygiene practices, etc. At the Ganslwirt centre, because of its specific group of clients, emergency services such as crisis intervention and observation play important roles. As a rule, the theme of health and disease predominates in this setting. In addition, general practitioners or medical specialists provide consultation services in low-threshold centres. The services include verification of the current infection status, vaccinations, urinalysis and pregnancy tests, as well as medical counselling and treatment (see VWS 2009a; Kontaktladen 2009; Substanz 2009).

The Beyond the line project addresses the group of cocaine users, who are often socially integrated but cannot easily be reached (see Chapter 5.2). This group is characterised by high psychiatric comorbidity rates (anxiety disorders, depressive disorders) and specific health problems (proneness to tachycardia, persistent arterial hypertension). The available services include medical (physical and psychopathological) examination as well as psychosocial counselling. If necessary, also acute concomitant diseases are treated or patients are referred to further specialist examination and treatment (Dialog 2009).

Special health promotion services addressing women continue to be an integral part of the work of the low-threshold centres (see GÖG/ÖBIG 2008c). The corresponding services include counselling and support regarding problems that specifically concern women (e.g. prostitution to finance drug use, experience of violence), which usually occur in a clearly defined setting. For instance, women's cafés take place at regular intervals in the restructured contact points of streetwork/VWS (Vienna) and also Substanz (Upper Austria). A number of centres (e.g., Kontaktladen, Ganslwirt) also provide gynaecological consultation, often in cooperation with medical specialists. Comprehensive services for pregnant drug users and their children are another focus of activities. At first, this problem area was primarily approached from a medical point of view, but meanwhile also other professions and institutions have been integrated in the care structure. In Vienna, the hospitals cooperate with the social work team of General Hospital Vienna, the CONTACT hospital connection service and eventually also with the Youth and Family Offices of the City of Vienna to respond to this cross-sectional issue. The goal here is to create a care network in which optimised services are provided to parents and children during the inpatient withdrawal treatment phase for the child, to intensify the bond between mother and child and to deliver subsequent outpatient services after the discharge from hospital. The counselling units provide regular care services for addicted mothers, which is a requirement defined by the Youth and Family Offices. These care services include a variety of measures and treatment interventions for the child to monitor and promote their development. The services for mothers focus on the comprehensive theme of living with a child. The multi-agency care approach described above is based on regular network meetings in which the structure of services and cooperation are further optimised (see Chapter 5.2; Sucht- und Drogenkoordination 2009b; Dialog 2009).

MDA basecamp reports that 59% of all online enquiries were about counselling and assistance in the sense of support and stress relief, and 21% of enquiries asked for medical information. Already in 2007, it showed that rising numbers of enquiries concerned opioids, and this trend has continued in the reporting year (21%). 24% of enquiries were related to cannabis (see Chapter 4.2; MDA basecamp 2009).

The issue of nursing services for addicted patients is getting increasingly important. As of autumn 2009 API will organise a training course on nursing addicted patients, which includes the communication of basic knowhow on addiction as well as care interventions in cases of detoxification and withdrawal, basic principles for responses to addicted patients, orientation towards health and resources in addiction care and care services for patients suffering from borderline personality disorder and psychiatric comorbidity.[40] In the last few years the CONTACT hospital connection service (Vienna) has also held further training programmes and individual talks for hospital staff in Vienna, which deal with the specific care situation of patients suffering from addiction (see GÖG/ÖBIG 2008c).

[40] www.api.or.at

8 Social Correlates and Social Reintegration

The main sources for this chapter are the nationwide documentation system of clients of Austrian drug help centres (DOKLI), annual reports of addiction help centres and similar institutions as well as information issued by the Addiction and Drug Coordinations in the provinces.

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

Interventions for social (re-)integration of (former) drug addicts are directed at both clients after drug-free treatment and people who are currently using drugs. In Austria, interventions of this kind have traditionally been of major importance, especially in the areas of housing, work and (further) education and training. To some extent they are part of the chain of therapy and integrated in the corresponding treatment modules. The various interventions, some of them low-threshold in kind, are available after treatment or as a part of drug assistance. Creating networks of drug-specific organisations in order to provide better service to clients has become more and more important.

8.1 Social exclusion and drug use

Among the clients of 2008 registered in the Austrian DOKLI system (see Chapter 5.3), the share of people with jobs continues to be smallest in the group undergoing inpatient treatment (2008: 13%; 2007: 10%). Here, the percentage of persons who indicate that they are unemployed is also highest (2008: 44%; 2007: 49; 2006: 45%). Especially among clients of long-term outpatient care, the share of women who have jobs is significantly smaller compared to men (28% of women and 36% of men). While smaller shares of women state that they are jobless, recipients of welfare assistance are found more often among women than among men (see Table A18 in Annex A). An average of 48% of clients of low-threshold centres whose data are covered by DOKLI said they had stable accommodation (2007: 51%), compared to approximately 90% out of the group of people receiving long-term services (see Table A20 in Annex A). Regarding educational level, around two thirds of clients of Austrian drug help centres aged 19 or older said that their highest degree was a compulsory school leaving certificate. Around one out of five women and one out of four men said they had completed an apprenticeship. However, the share of women is higher in the categories referring to completion of vocational intermediate secondary school as well as general education and vocational education upper secondary schools (GÖG/ÖBIG 2009a).

The social situation of the clients of drug help services in Austria definitely continues to be worse than that of the general population (as to housing, education, employment and income). However, it should by no means be concluded from this that drug problems arise mainly in the group of socially disadvantaged people. All it shows is that this group will more

readily turn to the drug help service system than people who (still) have their own social and financial resources (see Chapter 5.3).

The diploma thesis by Pajkovic (2008)[41] provides information on drug use and persons at risk of using drugs in socially disadvantaged or excluded groups. It is shown that immigrants are facing major stress factors such as identity crises, limited participation rights and inferior conditions with regard to housing, work and education. Therefore especially teenagers and young adults are exposed to substantial risks with regard to drug use. At the drug help centres, there are specific barriers caused on the one hand by inhibitions on the part of the clients themselves, on the other by restricted accessibility on the part of the centres (see also Chapter 5.2).

At the Vienna Job Exchange (WBB) a remarkable rise of active referrals by Public Employment Service counsellors was registered in 2008. Compared to 2007, also the number of young people counselled by the competent Public Employment Service unit has tripled (from slightly more than 40 to 138). With few exceptions, the main reason for counselling was drug problems. In this group the share of women was 58%, compared to a 27% share of women among all clients of WBB. Half of the clients had been unemployed for more than two years, and more than two thirds were counselled mainly because of drugs (Wiener BerufsBörse 2009).

8.2 Social reintegration

In the context of **training** and **employment**, since the beginning of 2009 the Public Employment Service has facilitated access to socio-economic enterprises for people with addiction problems also if they are not long-term unemployed. Especially for clients undergoing inpatient treatment this makes it easier to access the secondary labour market directly, with the aim of eventually achieving the transfer to the regular labour market (Sucht- und Drogenkoordination Wien 2009b). The possible (re-)integration into the job market has proven especially difficult for older drug users (see also Chapter 12.3).

Since January 2008 an overall plan for the reintegration of persons with addiction problems has been implemented in Vienna, with the aim of providing demand-oriented care to problem drug users and to improve the cooperation between relevant actors. According to this plan, clients are referred to the Diagnoses Institute to have their (in)ability to work diagnosed. Clients are referred by the Labour Training and Rehabilitation Centre (BBRZ) as part of an EU-supported project for the reintegration of drug patients into the job market. The diagnosing procedure of the clients concerned consists of several parts focusing on social work, psychological and specific medical aspects, which are combined in an addiction-related report and a recommendation regarding follow-up treatment.

However, Spirig et al. (2009) state that many of the drug users concerned are not entitled to receive unemployment benefits because of repeated interruptions in their career or a non-

[41] In addition to research of relevant literature, members of the surveyed groups were studied and interviewed in the course of 5 months.

existent employment record. This problem is further aggravated by Public Employment Service policies with regard to assessing job fitness. In Austria the financial needs of (long-term) unemployed people are covered by unemployment benefits or unemployment assistance. As a precondition for being entitled to obtain unemployment benefits or long-term unemployment assistance, clients must be willing and able to work, i.e., they should be 'at the disposition of the labour market' and take on jobs that are regarded as acceptable. Spirig et al. (2009) have observed that at the Public Employment Service Vienna, drug users tend to be classified as unable to work. As a consequence they are excluded from unemployment benefits and can only obtain welfare assistance. In the case of older drug users, even if they receive welfare assistance it is not guaranteed that their needs are met (e.g. regarding full coverage of care services).

In 2008 the socio-economic enterprise *gabarage* was able to initiate Corporate Social Responsibility (CSR) cooperation with major Austrian enterprises such as Fernwärme Wien, Fest, TILAK or Knauf. Between 2006 and 2008 revenues were increased by 66%, to EUR 120 649, which clearly reflects the success of *gabarage* (Sucht- und Drogenkoordination Wien 2009b).

As a result of continuous and excessive use of narcotic substances, cognitive capabilities are often impaired; therefore, the association Dialog (in Vienna) initiated cognitive training programmes. As a part of the project *Standfest* (steadfast, see GÖG/ÖBIG 2008c) Dialog organises a four-week social competence training programme with the aim of giving clients a daily structure and an opportunity to make contact in a group setting as an incentive to try something new. Especially the newly established and ongoing courses of memory training under the slogan *Use it or lose it* as well as the recreation group and the health group respond to actual needs (Dialog 2009).

In Vorarlberg, Caritas runs the project *Startbahn* (Departure Gate) – a low-threshold programme for young people between 15 and 25, in which 14 young clients can work as day labourers and are paid a wage at the end of each working day. The high number of young people who are referred to trainee places, jobs in businesses and on the job training through this project is very promising. Also run by Caritas, the project *Kompass* provides coaching to people looking for work, with the aim of integrating them in the first labour market. In 2008, the project had 167 clients (Caritas Vorarlberg 2009).

In Graz the project *Offline*, providing occupation for drug patients, was started in 2009. This project of the private foundation Santner Privatstiftung is run by Caritas of the diocese of Graz-Seckau on behalf of the foundation and provides individually designed, low-threshold work places for long-term unemployed drug patients. It aims at supporting clients to regain social competences that are of relevance in the labour market, such as reliability, punctuality, etc., as well as a sustainable stability of their condition. The project's working hours take into account the drug use patterns of the participants, who must be legally employable and have at least a work permit. Clients of Aloisianum may participate following a phase of stabilisation, as well as clients of Kontaktladen and individuals with drug problems who, independent of these two centres, show interest in the project upon their own initiative (Caritas Diözese Graz-Seckau 2009).

In Lower Austria a joint project of the Addiction Coordination and the Public Employment Service of Lower Austria is being developed in order to improve the position of former drug patients in the labour market (Hörhan, personal communication).

In 2008 the association Grüner Kreis started a new programme for training during treatment, providing training courses for future catering experts at the seminar hotel Grüner Kreis at Mönichkirchen. This is a well-established and recognised training course organised in cooperation of the association Grüner Kreis with the International College of Tourism and Management (ITM), the Hotel Management School Semmering and the Public Employment Service of Lower Austria. The programme runs parallel to treatment and aims at providing job qualifications for the patients to increase their opportunities for re-entering the job market. In 2008 nine clients completed the training course (Grüner Kreis 2009a).

A catamnestic survey[42] (among clients of 2007; see also Chapter 5.2) at the Carina therapy department showed that one year after completing treatment, 56% of the respondents said they held regular jobs. The employment quota before treatment had merely been 12%. There is a broad range of occupations, including positions that require qualification (Stiftung Maria Ebene 2009c).

According to the DOKLI report (GÖG/ÖBIG 2009a) and as mentioned under 8.1, nearly half of the clients of low-threshold centres live in an unstable housing situation[43], which gives **housing** programmes special significance. In Vienna, SDW and Wiener Wohnen GmbH have continued the liaison service Konnex. In autumn 2008 the services of Konnex were expanded to the entire area of housing assistance for the homeless in Vienna by means of specific events and responses to individual requests. Following a positive evaluation of the performance of Konnex, the service started regular operation (Sucht- und Drogenkoordination Wien 2009a and 2009b; see also GÖG/ÖBIG 2008c).

At Caritas in Vorarlberg, addiction-specific work and assistance to the homeless have been combined since 2008 in order to create a joint pool of ideas and efforts. According to statistics of the emergency sleeping facility run by Caritas of Vorarlberg, a decline in the number of clients has been registered, which is attributed to the successful prevention approach followed there. In many cases it was possible to secure sustainable housing by means of outpatient assistance (Caritas Vorarlberg 2009).

In Klagenfurt the emergency sleeping facility Eggerheim run by Caritas of Carinthia is available also for drug patients. In 2008, 14 clients slept there, the total number of overnight stays being 2 618. Another 7 clients, who were not able to live alone, stayed in the care unit all year round, spending a total of 2 562 nights. The facility was increasingly often frequented by young adults showing challenging behaviour and signs of neglect (Kärntner Caritasverband 2009).

[42] The catamnestic interviews took place one year after the end of treatment, by means of phone calls. 25 out of 54 people who successfully completed treatment or discontinued treatment in 2007 were interviewed.

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

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

The data for the present chapter were provided by the Federal Ministry of Justice and the court criminal statistics maintained by Statistics Austria. Other sources of information include a research project run by the Federal Ministry of Justice, on opioid substitution treatment in prison, the annual reports of drug help units and communications by the Addiction and Drug Coordination in the Provinces. Last year's report (GÖG/ÖBIG 2008c) contains a detailed presentation of the amendment to the Narcotic Substances Act which entered into force on 1 January 2008, and all the resulting changes.

As explained in previous years and also stressed by the responsible Ministry of the Interior (BMI 2009), the data concerning reports of offences permit only limited conclusions regarding the development of illicit drug use and misuse, because they primarily reflect the intensity and focus of police measures in this field.

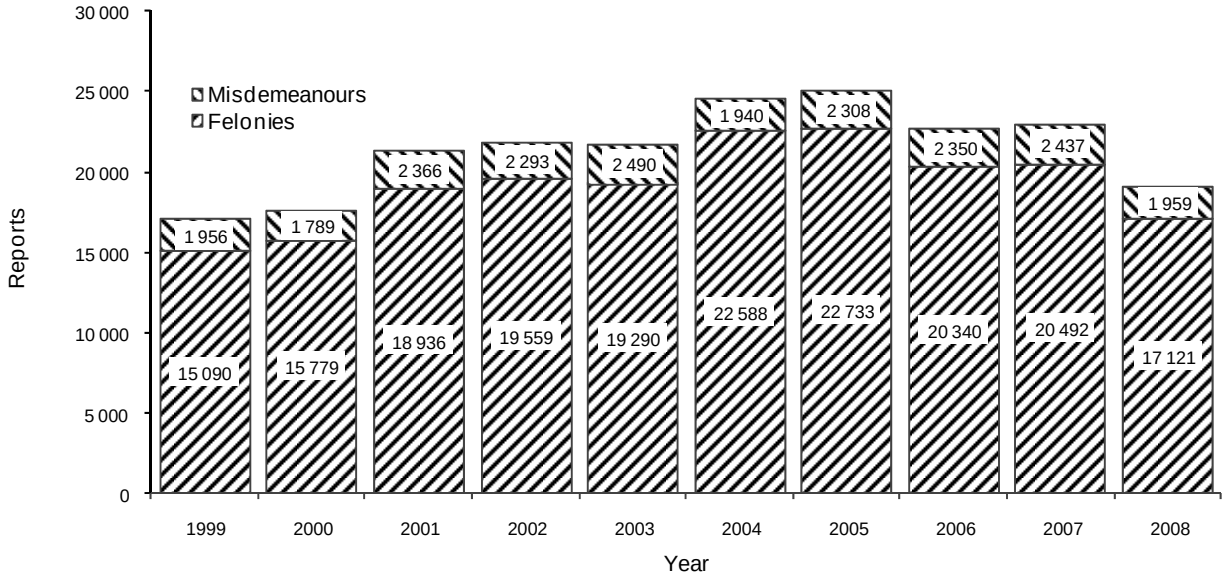
In 2008 there was a marked decline in the number of reported violations of the Narcotic Substances Act (SMG) compared to the previous year. Regarding offences against the SMG, there was a strong decline of convictions based on misdemeanours (Section 27) compared to last year. The number of convictions for felonies (Section 28) is only slightly lower than in 2007. In this context it should be noted that in the present report, the term felony is used for all violations of Section 28 and Section 28a of the SMG, whereas offences against Section 27 of the SMG are referred to as misdemeanours.

9.1 Drug-related crime

In 2008, the number of reported violations of the Narcotic Substances Act (SMG) was 20 043 (2007: 24.166; see also Table A4 in Annex A and ST11), which represents a major decline compared to the two previous years. A total of 19 080 reports related to narcotic drugs (2007: 22 929), the rest to psychotropic substances. Regarding type of report (see Figure 9.1), there was a substantial decrease of reported violations in 2008 compared to 2007 regarding both misdemeanours (illicit handling of narcotic substances – Section 27 of the SMG) and felonies (preparation of trafficking – Section 28 of the SMG and trafficking – Section 28a of the SMG). This means that in the reporting year, the number of reported misdemeanours and felonies went down by approximately 20% compared to the previous year (see Chapter 1.1).

In terms of substances involved (see Table A6 in Annex A and ST11), compared to the previous year there was a general decline in the number of reported violations, which was especially strong in the case of cannabis (see Figure 9.2). Detailed information on reported violations in the context of cannabis is presented in Chapter 11 of this report.

Figure 9.1: Development of reports of violation of the Narcotic Substances Act, by misdemeanours and felonies in Austria, 1998–2008



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

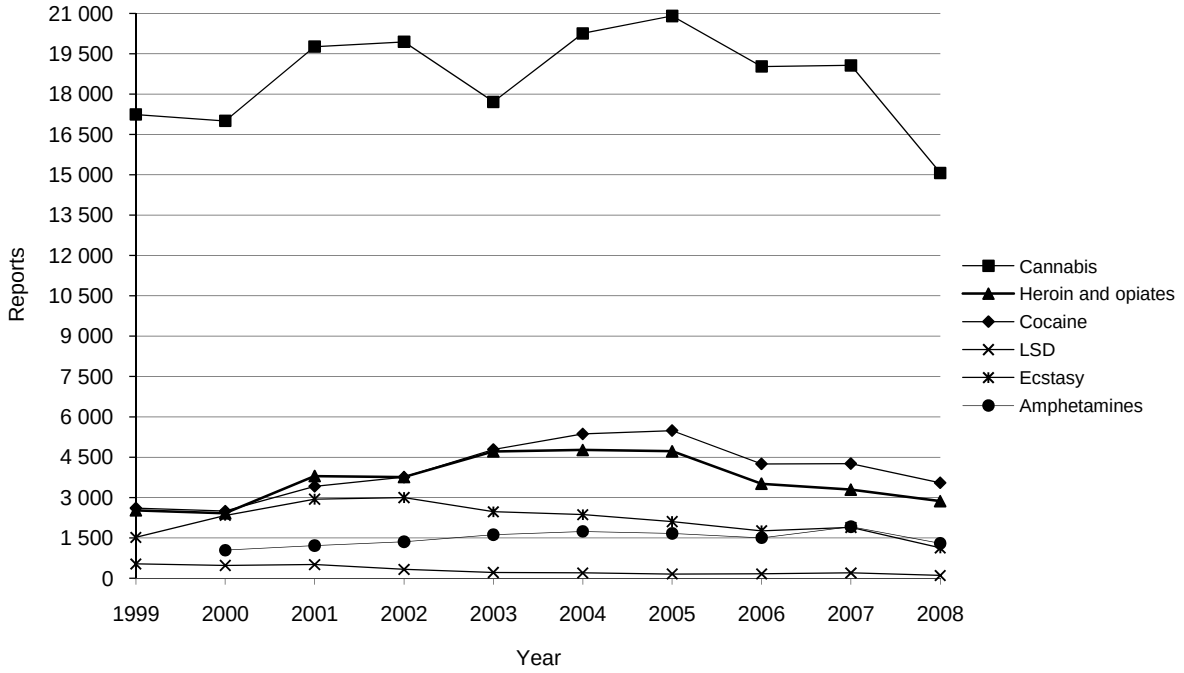
Source: BMI/.BK, representation by GÖG/ÖBIG

At provincial level, compared to the previous year the number of reported offences shows the same trend as the nationwide situation: in almost all provinces the number of reports regarding almost all substances decreased in the reporting year. Exceptions are minor increases in Burgenland regarding cocaine, in Salzburg and the Tyrol in the context of psychotropic substances and in Vorarlberg regarding heroin and opiates (see Table A7 in Annex A).

In 2008, a total of 20 043 reports led to 2 490 arrests (2007: 3 195) in connection with narcotic drug investigations; however, regarding arrests no detailed information (type of offence, substances involved, etc.) can be given.

According to BMI/.BK the decline in the number of reported violations referred to above is due to investigations of structures, which led to the targeted smashing of drug rings, with similar amounts seized as in the previous years and a simultaneous decrease in the number of seizures. One also has to bear in mind that part of the police force were assigned to tasks in the context of events of the European Football Championship 2008 that took place in Austria.

Figure 9.2: Development of reports of violation of the Narcotic Substances Act by type of substance, 1999–2008

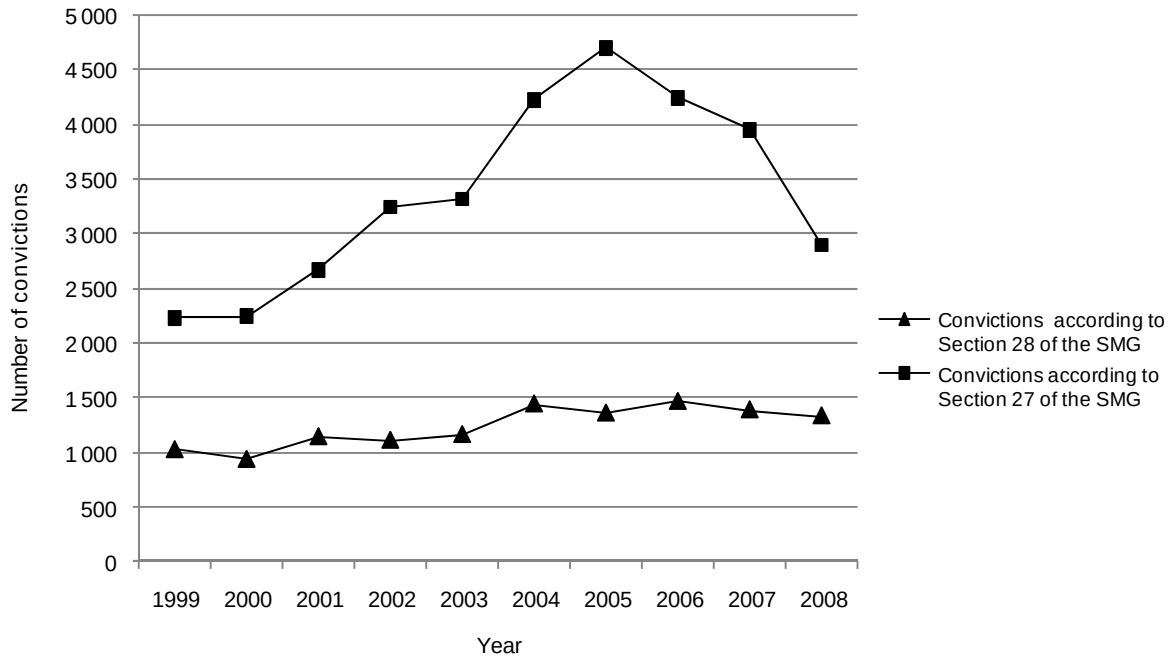


Source: BMI/.BK; representation by GÖG/ÖBIG

Figure 9.3 below as well as Table A8 in Annex A with data provided by the court criminal statistics show the development of the number of convictions under Sections 27 and 28 of the Narcotic Substances Act over the past ten years. Compared to previous years a significant decline of the total number of convictions (n = 4 291) according to the SMG was registered in 2008. The number of prison sentences without probation (n = 1 247) declined to a similar extent. The continued decrease in the total number of convictions relating to the SMG has resulted in a decline of the share of these convictions in the total number of convictions in 2008. While each of the offences have decreased in number, the share of misdemeanours (Section 27 of the SMG) continues to be much higher (2 899 cases) than that of felonies (Section 28 of the SMG, 1 332 cases). However, the share of felonies in the total number of convictions related to the SMG, which had been 26% in 2007, rose to 31% in 2008.

Table A10 in Annex A gives an overview of convictions according to age and basis of conviction. Here the comparison to 2007 shows a general downward trend of the numbers for young people and adults in 2008, in line with the development described above. However, more adults were punished with fines and prison sentences with probation in connection with felonies. The number of adults is also higher with regard to other forms of punishment in connection with misdemeanours.

Figure 9.3: Convictions according to Sections 27 and 28 of the Narcotic Substances Act in Austria, from 1999 to 2008



Until 2007: Section 28 of the SMG = trafficking, possession, etc, of large quantities of narcotic drugs (commercial trafficking)
Section 27 of the SMG = trafficking, possession, etc., of small quantities of narcotic drugs

As of 2008: Section 27 of the SMG = illicit handling of narcotic drugs
Section 28 of the SMG = preparation of trafficking of narcotic drugs
Section 28a SMG = trafficking of narcotic drugs

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

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

71% of all convictions resulted in prison sentences (2007: 67%; 2006: 66%), with a share of prison sentences suspended on probation of 45% out of the total number of prison sentences (2007: 47%; 2006: 44%), which is a slight decrease compared to the previous year. The share of young people sentenced to imprisonment was 3.1% (2007: 3.4%), and for 2.1% the prison sentence was suspended on probation (2007: 2.2 %).

Detailed statistical data on convictions in Austria were presented in Chapter 11 of last year's report (GÖG/ÖBIG 2008c). A comparison of the development of reported offences, convictions and implementation of alternatives to punishment as provided by law is included in Chapter 9.3 of the present report.

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

9.2 Prevention of drug-related crime

In addition to a number of individual initiatives in the context of prevention at the level of provinces and drug-help units, interventions for raising the general feeling of security and ease in the public sphere are gaining in importance. One example is the project SAM 9,

which was presented in detail in last year's report and submitted to an external evaluation by *Institut für Konfliktforschung* (Conflict Research Institute), with positive results (see GÖG/ÖBIG 2008c).

In connection with the redesign of Karlsplatz square in Vienna, scheduled for 2010, a working group for developing future perspectives and approaches to drug-related problems at Karlsplatz was established. Its task is to prepare proposals for improvement in the sense of taking the pressure off the public sphere at Karlsplatz and a better integration of the clients into the addiction and drug help system in Vienna (Sucht- und Drogenkoordination Wien 2009b).

In October 2008 the City of Vienna and *Verein Wiener Sozialprojekte* (Vienna Social Projects Association) issued an information leaflet for the promotion of peaceful co-existence in the public sphere. It is aimed at people who move in the public sphere frequently and are not quite sure what is permitted there and what is not. This may result in conflicts among different population groups in the public sphere. The leaflet provides information on rights and duties in the public sphere; it has been published in nine languages in addition to German; the title of the English version is "The Dos and Don'ts" / Guidelines for People in Public (VWS 2009a).

In autumn 2008 the European Centre for Social Welfare Policy and Research on behalf of the Vienna Addiction and Drug Coordination Unit launched a social research study on drug patients in the public sphere. It is designed to provide a well-based investigation of the question whether drug patients who move in the public sphere have access to the Vienna addiction and drug help system and whether it is necessary to devise new interventions in this context. The study is due to be completed in autumn 2009 (Sucht- und Drogenkoordination Wien 2009b).

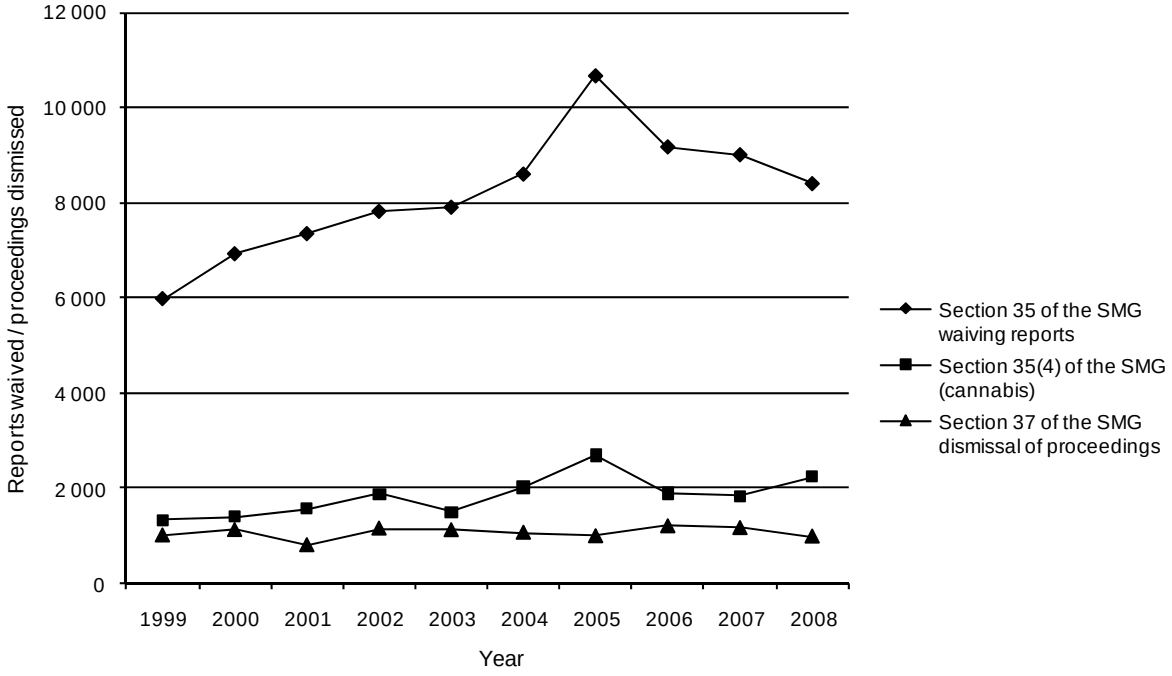
9.3 Interventions in the criminal justice system

In Austria the application of alternatives to punishment, especially suspension of sentence in the context of the principle of Therapy Instead of Punishment, is regulated by law.

Regarding implementation of the legal framework, information on the application of statutory alternatives to punishment is available (for more details see ÖBIG 2004). In addition to convictions (see Chapter 9.1), data regarding temporary (probationary) waivers of reports (Section 35 of the SMG) and proceedings dismissed (Section 37 of the SMG) are presented in Figure 9.4 and in Table A10 in Annex A.

As the figure shows there has been a decrease in the number of waivers of reports since 2005 and of proceedings dismissed since 2006. Only for cannabis, following a decline between 2005 and 2007, the number of waivers of reports increased. Table A9 in Annex A contains further information on final convictions according to the Austrian Narcotic Substances Act in 2008, based on type of conviction, gender and age group.

Figure.9.4: Development of statutory alternatives to punishment applied in Austria from 1999 to 2008



Until 2007: Section 35 SMG = temporary waiving of reports by the public prosecutors
Section 35 (4) SMG = temporary waiving of reports in the case of small quantities of cannabis for personal use
Section 37 SMG = temporary dismissal of proceedings by the courts

As of 2008: Section 35 SMG = temporary discontinuation of penal action by the public prosecutors
Section 35 (4) SMG = temporary waiving of reports in the case of small quantities of cannabis for personal use
Section 37 SMG = temporary dismissal of proceedings by the courts

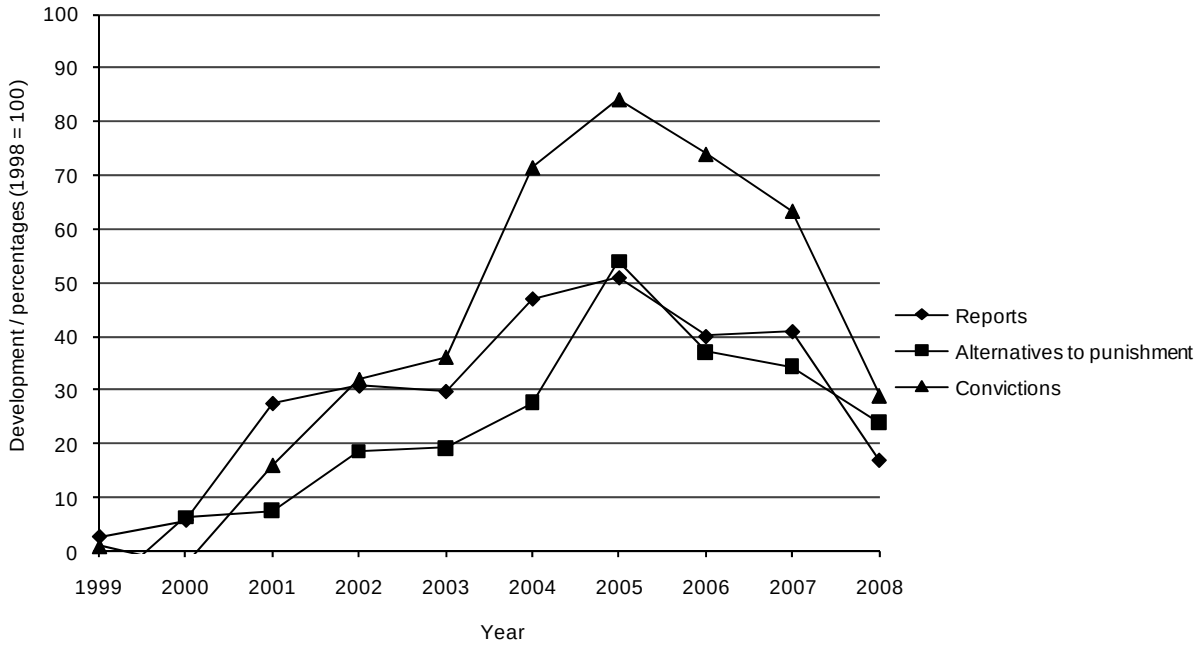
Note: Data on Section 39 SMG (suspension of sentence – therapy instead of punishment) are not available at present.

Source: BMG, representation and calculation by GÖG/ÖBIG

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

A comparison of trends regarding reports of offences, convictions and application of alternatives to punishment shows interesting results. Based on an index taken as 100% in 1998, i.e., in the year when the SMG entered into force, Figure 9.5 reveals that in the period of analysis between 1999 and 2005 the shares of convictions went up most significantly. As of 2007 reports and convictions declined to similar extents, contrasted by a slight rise in the implementation of alternatives to punishment.

Figure 9.5: Comparison of index-related development of reported drug offences, convictions and application of statutory alternatives to punishment in Austria from 1999 to 2008



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

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

Since 2008 young people have had the option to take part in the project Walk About at the drug counselling centre Z6 in order to fulfil court conditions imposed. Walk About is a secondary addiction prevention project for young people between 14 and 22 who already show noticeable drug use habits. In the course of the project, an activity of at least three day duration is planned, realised and reflected with a group of four to six adolescents. This process makes it possible to build intensive contact to the young people concerned on a basis of trust, and to involve their circle of friends. The project promotes drug-free experience, alternative patterns of action, it reveals group processes and encourages self-perception, self-esteem and self-reflection. The preconditions for taking part in the Walk About project, which is applied as an alternative to the usual health-related interventions, are a stable living situation and the voluntary decision of the client to opt for this kind of intervention. It is also necessary that clients are not addicted and psychologically healthy. The total duration of this health-related intervention should be between four and six months, with at least five contacts (including the 3-day activity referred to above; Kern, personal communication, Z6 2008).

In the Festschrift celebrating its tenth anniversary, Schweizer Haus Hadersdorf reports that due to the policy of making opioid substitution treatment available also in inpatient settings, a great number of clients came to Schweizer Haus Hadersdorf upon a court order according to Section 39 of the SMG pertaining to the Therapy Instead of Punishment model. In this area drug especially patients are found who formerly had no possibility of inpatient opioid substitution treatment. Therefore, today more than three out of four patients have the costs of their treatment covered by the State (upon court order) (Schweizer Haus Hadersdorf 2009).

9.4 Drug use and problem drug use in prisons

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

9.5 Responses to drug-related health issues in prisons

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

A survey supervised by Gegenhuber et al. (2008)[44] gives an overview of the Austrian penal system, after a project phase during which prisoners and staff of only three prisons in the Vienna area were interviewed. The survey was aimed at investigating the effects of opioid substitution treatment on drug-addicted prisoners and on the prison as an administrative unit in the Austrian penal system, from the perspective of those concerned and involved. At the same time, the intention was to reveal common as well as differing aspects of opioid substitution treatment in the participating prisons.

Prisoners were interviewed in groups of ten to twelve; while they filled in anonymous questionnaires individually, the interviewer was available for questions that might come up. The criteria for inclusion of respondents in the survey were a minimum age of 18, serving a prison sentence or pre-trial imprisonment as well as participation in an opioid substitution treatment programme. A sufficient knowledge of German was also required. At the time of the interviews, 654 prisoners were undergoing opioid substitution treatment, 183 (28%) of whom participated in the survey.

The results of the study show great differences between staff and prisoners and between the participating prisons. Compared to staff, in most cases the prisoners definitely have a more positive view of the effects of opioid substitution treatment. In general, prisoners consider maintenance programmes to be an effective means to limit drug use and drug trafficking in prisons, as they reduce health risk factors related to injecting use or sharing of injection equipment.

The staff members that were interviewed stated to have registered noticeable changes regarding auto-aggressive behaviour and an improvement of the physical and psychological condition of the prisoners. Slightly more than one fifth of the interviewed staff said that their general working situation had improved since opioid substitution treatment had been introduced.

One of the remarkable aspects of the survey is the high share of prisoners sentenced to a period of more than ten years (more than one out of five respondents). The total share of injecting use that was indicated was almost 90%, which is extraordinarily high. One fourth of

[44] Following a research project that took place between 2005 and 2007 at European level, on behalf of the Federal Ministry of Justice (BMJ) 123 prison staff (about one third of which were women) and 183 male prisoners were interviewed between November 2007 and January 2008 (Gegenhuber et al. 2008).

the respondents started opioid substitution treatment during their present term of imprisonment; more than three out of four respondents state that access to such treatment had been easy. However, they said that when they were last undergoing substitution treatment before their imprisonment they had had more influence on the choice of substance than in prison (84% vs. 44%).

Differences between prisons were noticed mainly regarding two issues. One the one hand, the choice of substitution substance is regulated differently in the participating prisons, which may lead to problems if prisoners are transferred to another prison. At the time of the survey, methadone was used in all participating prisons, while buprenorphine was administered additionally in eleven out of sixteen prisons and slow-release morphines in thirteen prisons. Three prisons used methadone only. On the other hand, the possibilities of taking up an occupation while in prison differed greatly, as prisoners undergoing substitution treatment in some cases are excluded from certain activities.

A general overview of opioid substitution treatment in prisons is provided by a statistical survey by the BMJ, according to which in 2007, 772 prisoners in Austrian prisons were undergoing opioid substitution treatment. Based on an estimated total number of 9 000 prisoners in Austria, this is a share of 8.6% (Kahl, personal communication).

Drug-free zones have existed in Austrian prisons since 1995 and have continuously been expanded (ÖBIG 1997). The treatment of drug-addicted prisoners is also highlighted in a publication by the Federal Ministry of Justice, which is outlined in greater detail in the report of 2005 (ÖBIG 2005).

SQ 23/29 contains further information regarding drug-related harm reduction and prevention, treatment of patients with infectious diseases in prison and prevention of overdosing after release from prison, which, however, is hardly pursued at present, if at all. Large-scale HCV tests are conducted among prisoners starting their imprisonment period, whereas individual counselling regarding infectious diseases in prison only takes place to a limited extent. The same applies to practical advice and training in connection with safer use. In Austria there are no syringe exchange programmes in prisons. Nevertheless training programmes for health promotion with regard to syringe exchange are run for the prison staff. There is no information material available on how to respond to drug-related emergencies in prisons. At the time of release from prison, HCV tests are carried out only very rarely.

The fourth European conference on health promotion in prisons, which took place in April 2009 in Vienna, focused on promotion and maintenance of health for prisoners as well as staff (Gesundheitsförderung in Haft 2009).

In Graz clients of Kontaktladen continue to be counselled also in case of imprisonment; special attention is attributed to the issue of health promotion in prison. A booklet on this subject (*Haftinfos des Kontaktladens*; see GÖG/ÖBIG 2008c) was presented to the public on the occasion of a theme-specific event in 2009. The event was aimed at creating a basis of communication between all relevant stakeholders in order to develop interventions in the sense of health promotion in prisons for the benefit of drug users and also for staff, based on a broad consensus (Kontaktladen 2009).

9.6 Reintegration of drug users after release from prison

There is no information available that relates specifically to the reintegration of drug users after release from prison. Most reintegration measures for drug users are also open to former prisoners.

10 Drug markets

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

Information about the availability of illicit drugs can be derived from some questions of the ESPAD surveys (Strizek et al. 2009, under preparation) and the General Population Survey 2008 (Uhl et al. 2009, under preparation) (see Chapter 2.1). Data on seizures referenced in this chapter were provided by the Federal Ministry of the Interior / Federal Criminal Agency (BMI/.BK), the data on price and purity were collected by ChEck iT! and BMI/.BK.

10.1 Availability and supply

Table 10.1 gives details on the responses to the question of the ESPAD survey on how difficult it would be for the respondents to have access to various enumerated legal and illicit substances if they wanted them. While 80% of the young people found it rather easy or very easy to get alcohol (wine/sparkling wine: 80%, hard liquor: 56%), the corresponding share for illicit drugs is slightly over one third (35 %) in the case of cannabis. Both ecstasy and amphetamines were considered to be available rather easily or very easily by 20% (Strizek et al. 2009, under preparation).

Table 10.1: Assessment of the difficulty to have access to various psychoactive substances

Difficulty to have access to the substance in question	Substance						
	Cannabis	Ecstasy	Ampheta-mines	Tranquillisers/ sedatives	Cigarettes	Wine/ Sparkling wine	Hard liquor
impossible	17 %	28 %	23 %	28 %	2 %	3 %	6 %
very difficult	13 %	18 %	17 %	20 %	2 %	2 %	10 %
rather difficult	15 %	14 %	16 %	16 %	3 %	8 %	19 %
rather easy	24 %	13 %	16 %	10 %	28 %	26 %	30 %
very easy	11 %	8 %	8 %	4 %	57 %	54 %	26 %
don't know	21 %	20 %	20 %	23 %	9 %	7 %	10 %

Source: Strizek et al. 2009, under preparation; representation by GÖG/ÖBIG

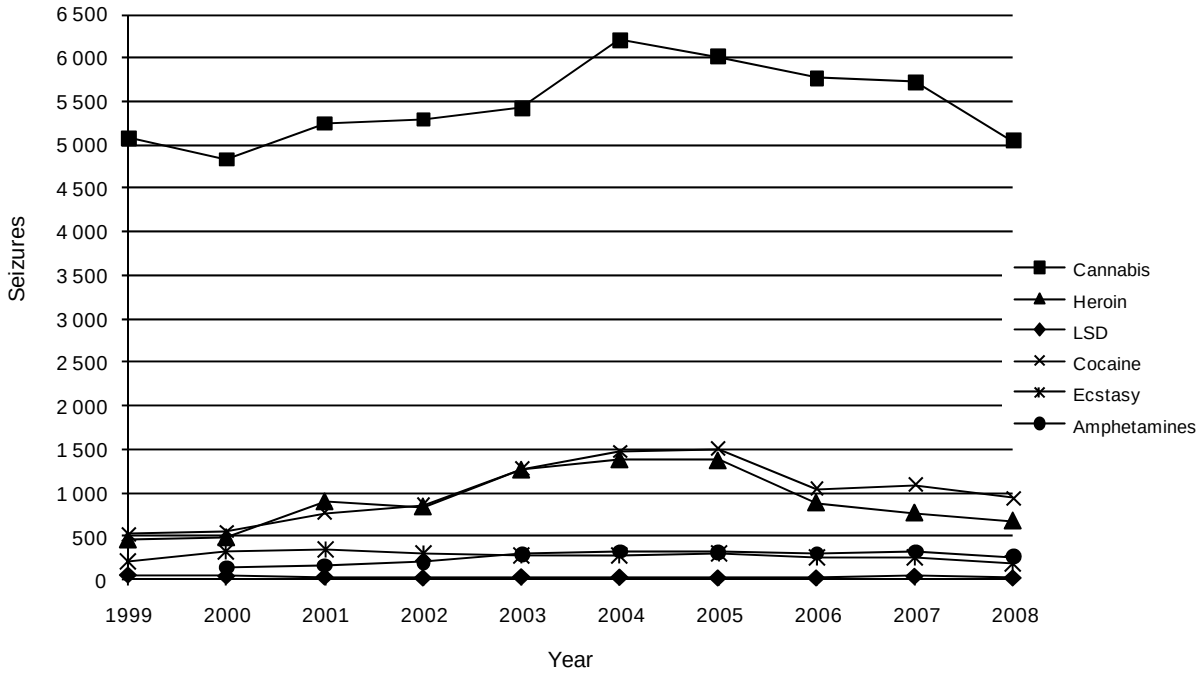
According to the results of the general population survey of 2008 (Uhl et al. 2009, under preparation) 2.7% of the Austrian population was unexpectedly offered illicit drugs for free by strangers. 4.5% stated that they had been unexpectedly offered drugs for free by acquaintances. Regarding unexpected offers to purchase drugs, the figures are 3.7% (strangers) and 2.3% (acquaintances). Austria does not play a significant role as a country where illicit drugs

are produced. While cocaine reaches Austria primarily by air and by sea from South America, for heroin the route over the Balkans (Turkey, Bulgaria, Serbia, Croatia, Slovenia, Austria) is the dominant trafficking route. Cannabis products are imported from various countries and regions such as the Netherlands, the Balkan countries and Morocco; and to a small, but increasing extent, they are home grown in Austria. Amphetamines and derivatives are mainly imported from the Netherlands (BMI 2009).

10.2 Seizures

According to the Federal Ministry of the Interior (BMI) in 2008 the number of seizures slightly decreased for all drugs compared to the previous year (see Figure 10.1 and Table A12 in Annex A). The BMI also states that the decline in the number of reported violations of the Narcotic Substances Act in 2008 does not reflect a reversed trend in the area of drug-related offences, but is rather rooted in the focus of police activities, which was mainly on investigations of structures (see Chapter 9.1).

Figure 10.1: Number of seizures of narcotic drugs in Austria, 1999–2008



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

Compared to the total number of reports to the police there was no significant change in the amounts of narcotic substances seized (see Table A13 in Annex A and ST13). At the BMI registry for precursor substances, 247 investigated cases were reported; in the course of 12 seizures, 22 kilograms of precursor substances were seized. In 2008 three small drug laboratories were dismantled in Austria, all of which were kitchen laboratories used by the operators to produce methamphetamine for their own use.

10.3 Price/purity

In the context of the ChEck iT! project (see Chapter 2.3), which tests the purity and ingredients of substances bought as ecstasy or speed during events of the party and clubbing scene, in 2008, 146 samples bought as ecstasy (pills) and 99 samples purchased under the name of speed were analysed during a total of seven music events (goa, techno, electronic) in the provinces of Burgenland, Lower Austria and Vienna (VWS 2009a).

The percentage of pills bought as ecstasy that did not contain psychotropic substances other than MDMA, MDE or MDA was 63%, which is approximately at the level of the previous year and lower than the years before that (70% to 90%). In more than one fourth of the cases (26%) users had to be warned urgently not to take the pills they had bought under the name of ecstasy, the main reason being that MDMA had been replaced by non-controlled benzylpiperazine derivatives, as had already been the case the year before. 26 of the tested pills (17%) contained meta-chlorophenylpiperazine (mCPP). Compared to MDMA, mCPP has a reduced psychoactive effect, but causes rather unpleasant side-effects such as headaches, nausea, kidney pain, nervousness, heavy breathing, fatigue and a hangover of several days. In addition, simultaneous use of MDMA may lead to convulsion. In 15 of the 26 pills containing mCPP, also metoclopramide was found, an anti-emetic (agent used to treat nausea and vomiting), which supposedly was added to suppress side-effects of mCPP such as nausea. Metoclopramide may interact with many substances and in some cases accelerate their effects, while it slows down the users' reactions. Again, in 2008 the pharmaceutical buflomedil was detected in pills sold as ecstasy. This substance is used for the treatment of peripheral vascular disorders (VWS 2009a; see also GÖG/ÖBIG 2008).

In July 2009 ecstasy pills containing PMA were detected for the first time since 2001. Compared to MDMA, PMA (para-methoxyamphetamine) has a retarded effect, which entails the danger that more pills are used in order to achieve the desired effect. The resulting accumulation of the active ingredient may lead to death. The Austrian nationwide information and early warning system located at GÖG/ÖBIG informed all relevant organisations, hospitals and experts of this problem. The early warning system of the EMCDDA issued the warning all over Europe. A warning was also broadcasted by the Austrian radio and television network and published in numerous print media.

A mere 15% of the substances bought as speed and analysed by ChEck iT! contained amphetamine only, whereas 27% was a mixture of amphetamine and caffeine and in 36% of the cases, amphetamine was mixed with other pharmacologically active substances (see Tables A14 and A15 in Annex A and ST15). 11% of these samples were classified as posing a serious threat to health (VWS 2009a).

Autumn 2008 saw a public discussion about reports of a sudden rise in the use of an incense blend under the name of Spice that was legally available at that time. According to instructions on the packages the various Spice products were intended for use as fragrant incense for air freshening in rooms and by no means for smoking. However, the psychoactive effect of smoking this blend was propagated over the internet. At first, experts had no explanation for the effects of the Spice products, which users described as similar to cannabis. By the end of 2008 and beginning of 2009, several cannabinomimetic ingredients (CP-47,497, JWH-018, HU-210) had eventually been detected in Spice products (see Chapter 2.1).

In spring 2009 several adolescents had to be taken to hospital after using gamma-butyrolactone (GBL). According to information by the emergency department of the General Hospital Vienna, incidents involving GBL have repeatedly been registered in Vienna (Frossard, personal communication). Following the prohibition of gamma-hydroxybutyric acid (GHB) users have purchased GBL instead, which is legally available, e.g., as a wheel rim cleaner for cars.

Information by the Ministry of the Interior on the purity and prices of various drugs sold at street level is given in Table 10.2 (see also ST14 and ST16). As in previous years, a considerable variation of the potency of drugs sold at street level was noted. The data referring to ecstasy, amphetamines and cocaine are generally consistent with the figures registered by ChEck iT! (Nagy, personal communication).

Table 10.2: Purity and price (EUR per gram/pill**) of various drugs sold in the street in 2008*

		Herbal cannabis *	Cannabis resin*	Brown heroin*	White heroin*	Cocaine*	Ampheta-mines*	Ecstasy**	LSD**
Purity	Minimum	0.04 %	0.5 %	0.1 %	–	0.7 %	0.5 %	3.5 %	–
	Maximum	50 %	47 %	71 %	–	96 %	66 %	100 %	–
	Typical	7 %	8 %	9 %	–	27 %	5 %	28 %	–
Price	Minimum	9	8	60	–	60	15	5	30
	Maximum	10	10	80	–	90	20	10	35
	Typical	10	9	80	–	70	20	10	30

Note: These data are based on information by undercover police agents. For the individual drugs, between 40 and 368 purity analyses were carried out.

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

PART B

Selected Issues

11 Cannabis markets and production

In Austria, cannabis is the illicit substance that is most frequently used. This chapter, based on available data of the Federal Criminal Agency at the Federal Ministry of the Interior (BMI/.BK), gives an overview of cannabis production and cannabis markets in Austria. The Federal Ministry of the Interior (BMI) communicated the respective figures to GÖG/ÖBIG; most of these figures can also be found in the annual reports on drug-related crime issued by the BMI.

11.1 Markets

Scientific reports on medical (self-)experimentation with cannabis go back as far as the mid 19th century (e.g., Schroff 1857). There are a few historical reports that mention cannabis cultivation and use in Austria, but production has not played a significant role in Austria at least as of the early 20th century (Springer, personal communication). Under Sections 27, 28 and 28a of the Narcotic Substances Act (SMG) it is forbidden in Austria to grow cannabis plants for the purpose of obtaining narcotic drugs. The sale of young cannabis plants that do not yet contain THC (cuttings) and also of seeds may be classified as aiding and abetting a criminal act (i.e., the production of a narcotic drug) or as an attempt to commit an offence, which is punishable according to Sections 12 or 15, respectively, of the Criminal Code (BGBl 1974/60). As of 2009, under an amendment to the SMG (BGBl I 2008/143) the Austrian Agency for Health and Food Safety (AGES), or a subsidiary company founded for this purpose, has been permitted to grow cannabis plants in order to obtain pharmaceuticals as well as for scientific purposes related to this field (see Chapter 1.1.)

There are grow shops that sell both cannabis plants and any equipment needed for growing cannabis. At present, only few grow are shops left where seeds and/or cuttings may be obtained. The typical range of products of grow shops includes equipment for growing and smoking cannabis and, in most cases, a great variety of legal ethnobotanical products, mostly psychoactive plants or plant products from all over the world. In 2005 approximately 60 grow shops existed in Austria, and as many as 20 of them in Vienna (BMI 2006); more recent figures are not available, but the number of shops is not likely to have changed significantly.

In the past, cannabis was usually imported to Austria, but according to the Federal Criminal Agency at the Federal Ministry of the Interior (BMI/.BK) in recent years a rise in cannabis production in Austria, by means of indoor and outdoor cultivation, has been registered, with a yield of good quality. The cannabis produced in this way is not only used by the growers themselves and their friends but increasingly often it is also sold for profit. In 2008, illicit professional indoor cultivation was practiced not only by Austrian nationals but also nationals of a number of foreign countries. However, according to BMI/.BK, the scope of cannabis production in Austria still is insignificant compared to other countries. The figures on cannabis seizures by the police indicate that greater amounts of herbal cannabis than resin are produced and brought into circulation in Austria. No conclusive figures on market shares of individual products are available for Austria, however. Although several seizures of

cannabis revealed with very high THC contents, according to BMI/.BK, sinsemilla, i.e., specially grown unpollinated buds of female plants with above-average THC contents, does not play a relevant role in Austria.

Data by BMI/.BK indicate that organised groups manage the import and eventually the street sale of cannabis products in Austria. Cannabis is primarily imported from the Netherlands, the Balkan countries, the Schengen Area, Morocco and Switzerland. Austria also is of growing relevance as a country of transit for cannabis products from the Far East (India, Nepal) to Western Europe. According to BMI/.BK, cannabis products are sold all over Austria, but especially in and around cities in both public places or streets and bars known as places of drug dealing. In addition to Austrian dealers, also groups of dealers composed of third-generation ethnic Turks or Yugoslavs of Austrian nationality, citizens of the countries of former Yugoslavia, west African states and – in particular in the areas of Innsbruck, Graz and Vienna – organised north African groups are involved in cannabis trade. While some dealers or groups seem to specialise in cannabis, other dealers or groups also sell other substances. Regarding market shares of the individual groups, no information is available. It is not known to which extent the cannabis used in Austria is self-grown or shared among friends or bought. Obviously, the quantities of cannabis purchased strongly differ according to individual user.

Tables 11.1 and 11.2 give wholesale and street prices of herbal cannabis and resin. In sum, the prices of cannabis products seem to have risen in the last few years. The data on prices are based on undercover investigations by the police, i.e. they reflect the prices for which dealers offered cannabis to undercover police agents. In the past, these prices were gathered every three months, and now once or twice a year, by the Drug Crime Office of the Federal Criminal Agency. Police reports on drug offences and routine surveys are additional helpful data sources.

Table 11.1: Wholesale prices of cannabis products; comparison 2004–2008 (prices in euro per kg)

Product	2004	2005	2006	2007	2008
Cannabis resin	2 000–2 500	2 000–2 500	1 500–2 500	2 000–3 500	3 500–4 500
Herbal cannabis	700–1 000	700–1 000	700–1 000	2 500–3 500	4 000–5 000
Herbal cannabis produced in the EU	300–600	300–600	300–600	2 500–3 500	4 000–6 000

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

Table 11.2: Street prices of cannabis products; comparison 2004–2008 (prices in euros per g)

Product	2004	2005	2006	2007	2008
Cannabis resin	7–8	7–8	6– 8	8–10	8–10
Herbal cannabis	3–4	3–4	3 –4	9–10	9–10
Herbal cannabis produced in the EU	3–4	3–4	3–4	9–10	9–10

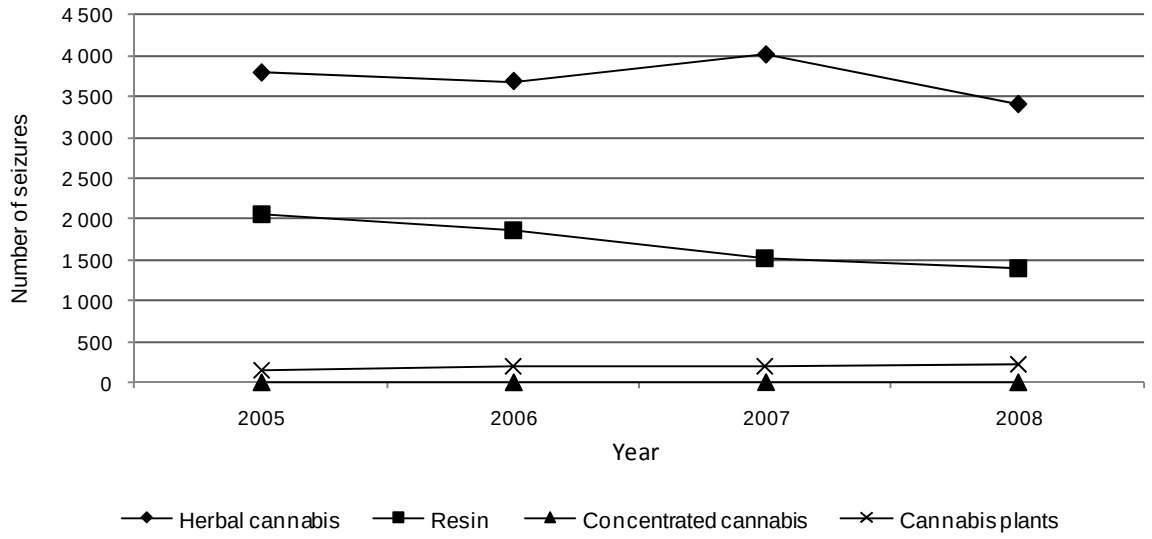
Source: BMI/.BK, representation by GÖG/ÖBIG

11.2 Seizures

According to information by BMI/.BK, drug offences are prosecuted in Austria independent of the type of substance involved. The corresponding activities aimed at supply reduction concentrate on combating street crime on the one hand and investigations of structures on the other. In addition, a number of focal areas have been defined: enhancement of international cooperation (partnerships for security), participation in international projects (e.g., through Interpol and Europol), intensified use of criminal analysis, national and international cooperation with justice and customs authorities, prevention, increased skimming off of profits gained from offences, strategies against money laundering and nationwide surveillance of trade in drug precursor substances in the context of the Drug Precursor Reporting Agency.

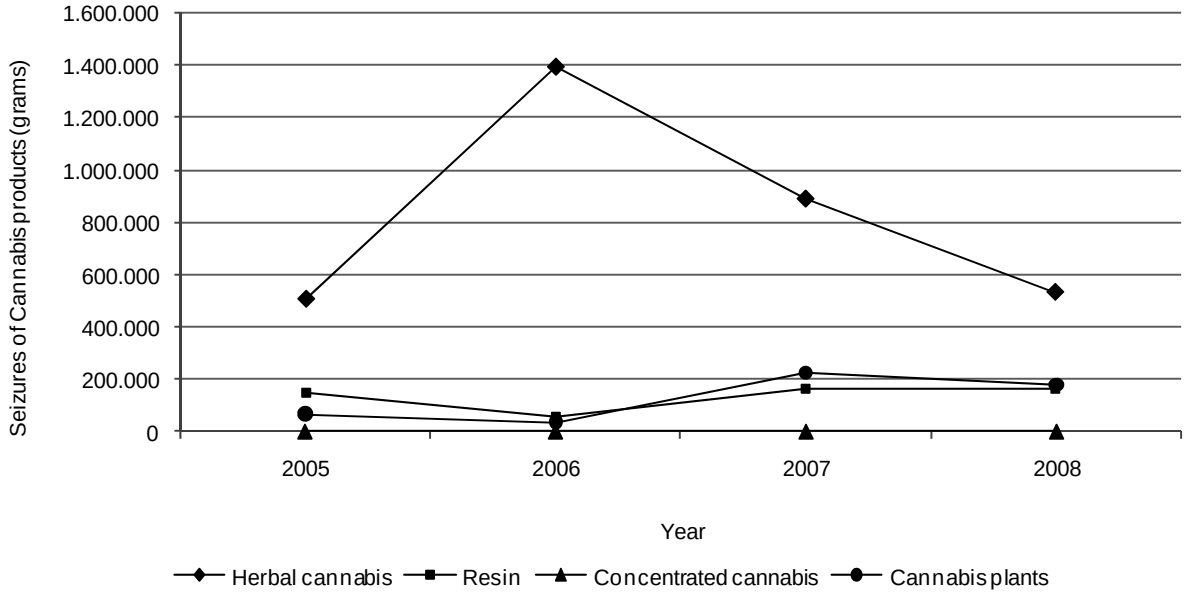
Figures 11.1 and 11.2 give the numbers, types and quantities of cannabis products seized between 2005 and 2008. As mentioned in Chapter 11.1, the majority of seizures concerns herbal cannabis, although pronounced variations show depending on the year of observation.

Figure 11.1: Number of seizures of cannabis products from 2005 to 2008



Source: BMI/.BK 2008; representation by GÖG/ÖBIG

Figure 11.2: Seizures of cannabis products from 2005 to 2008; grams



Note: In correspondence with the United Nations Office on Drugs and Crime (UNODC), quantities are given in grams

Source: BMI/.BK 2008; representation by GÖG/ÖBIG

Table 11.3 gives seizures in 2008 by number of cases, type of cannabis and weight. What deserves mention is that 92% of seizures of herbal cannabis, and 97% of seizures of resin, concern weights between 0 and 150 grams. In terms of absolute quantities, 70% of resin seizures and 65% of herb seizures related to quantities under 5 grams. These figures indicate that the majority of cannabis seized was intended for personal use. Correspondingly, the statistics on police reports described in Chapter 11.3 show a similar picture: 92% of reports relating to cannabis were made because of violations of Section 27 of the SMG, which regulates illicit handling of drugs but not large-scale, professional trafficking.

Table 11.3: Seizures of cannabis products in 2008

	Herbal cannabis	Cannabis resin	Cannabis plants	Concentrated cannabis
Weight	**Number of cases**	**Number of cases**	**Number of cases**	**Number of cases**
0–150 g	3 145 (92%)	1 363 (97%)	132 (57%)	8 (100%)
150g–1 kg	183 (5%)	28 (2%)	59 (26%)	0
1 kg–50 kg	82 (2%)	19 (1%)	39 (17%)	0
> 50 kg	0 (0%)	0 (0%)	0 (0%)	0
Total	3 410 (100%)	1 410 (100%)	230 (100%)	8 (100%)

Source: BMI/.BK 2008; representation by GÖG/ÖBIG

A list compiled by BMI/.BK (see Table 11.4) gives the presumed countries of origin of the cannabis products seized, the last country of transit before the products entered Austria and the countries that were supposed to be the planned destinations. A breakdown by percentages is not available, however. As described in Chapter 11.1 and illustrated in the corresponding table, Austria has meanwhile also become relevant as a country of origin of herbal cannabis. An overview of available information on the organisational structures of international trade to and through Austria is also given in Chapter 11.1.

Below, seizures of cannabis grown in Austria are discussed in more detail. In 2006, a total of 236 kg of cannabis plants were seized in Austria in the context of 204 police raids. 2007 saw seizures of 224 kg at 200 raids, and 2008, 178 kg at 230 raids (see Figures 11.1 and 11.2). As there are no international guidelines that define, for instance, what size a patch where cannabis is cultivated must have to be regarded as a plantation, no official statistics on the number of plantations or indoor and outdoor growing exist. The corresponding figures have been registered by BMI/.BK but they are not published as no comparison at international level can be made. The annual report of BMI/.BK (2007) provides some information; e.g., an indoor plantation of a size of 4000 m² was detected in Upper Austria and 4 500 cannabis plants were seized. In Vienna, an indoor cannabis cultivation area of 450 m² was found and 239 kg of cannabis plants was seized, and in Lower Austria an outdoor area with 102 kg of cannabis plants was detected. However, if one adds the weight of the cannabis plants obtained at these large seizures it shows that this figure is higher than the aforementioned total number of 224 kg of cannabis plants found in 200 seizures. According to BMI/.BK this results from a problem of registration: because there are no guidelines that specify when the plants have to be weighed and whether plant parts that have already been dried are to be entered as plants or as herbal cannabis, therefore these large seizures are not directly reflected in the statistics of BMI/.BK but as entries in the categories of plants and herbal cannabis (Mader, personal communication).

Table 11.4: Origin of cannabis products seized from 2004 to 2008

	2004			2005			2006			2007			2008		
	Presumed country of origin	**Last country of transit**	**Presumed country of destination**	**Presumed country of origin**	**Last country of transit**	**Presumed country of destination**	**Presumed country of origin**	**Last country of transit**	**Presumed country of destination**	**Presumed country of origin**	**Last country of transit**	**Presumed country of destination**	**Presumed country of origin**	**Last country of transit**	**Presumed country of destination**
Herbal cannabis	Albania Bosnia and Herzegovina Bulgaria Germany Croatia Netherlands Switzerland Spain former Yugoslavia	Croatia Germany Hungary Netherlands Slovenia	Austria Germany Italy Switzerland	Albania Bosnia and Herzegovina Bulgaria Croatia Germany Netherlands Switzerland Serbia and Montenegro Spain	Croatia Germany Hungary Netherlands Slovenia	Austria Germany Italy Switzerland	Albania Bosnia and Herzegovina Bulgaria Croatia Germany Netherlands Switzerland Serbia and Montenegro Spain	Croatia Germany Hungary Netherlands Slovenia	Austria Germany Italy Switzerland	Austria Bosnia and Herzegovina Switzerland	Croatia Slovenia	Austria Germany	Austria Netherlands Switzerland	Germany	Austria
Resin	Bosnia and Herzegovina Germany Morocco Nepal Netherlands Switzerland Spain former Yugoslavia	Croatia France Germany Slovenia	Austria Czech Rep. Germany Italy Switzerland	Bosnia and Herzegovina Germany Morocco Nepal Netherlands Switzerland Serbia and Montenegro Spain	Croatia Germany Hungary Netherlands Slovenia	Austria Czech R. Germany Italy Switzerland	Bosnia and Herzegovina Germany Morocco Nepal Netherlands Switzerland Serbia and Montenegro Spain	Croatia Germany Hungary Netherlands Slovenia	Austria Czech Rep. Germany Italy Switzerland	Morocco Nepal	Belgium France UK	Austria Germany Italy Switzerland	India Morocco	France Spain	Austria Germany Italy

Source: BMI/.BK 2008, representation by GÖG/ÖBIG

11.3 Offences

In the provisions of the Narcotic Substances Act (SMG) the offences of purchase, possession, production, transport, import, export, passing on and making available to others of narcotic substances are not listed in separate sections but are covered by one single section. Consequently, the statistics on police reports and on convictions are organised according to section, and a breakdown by production, trafficking and retail dealing cannot be made. The table below only covers Austria's statistics on police reports because this permits a breakdown by substance and thus data on offences related to cannabis are available (see Table 11.5).

The decline in reports in 2008 compared to 2006 and 2007 does not necessarily mean that trafficking or use of cannabis has gone down, however (see Chapter 9.1).

Table 11.5: Reports relating to Sections 27–29 from 2006 to 2008

Year	Product	Sect. 27 SMG	Sect. 28 SMG	Sect. 28a SMG	Sect. 29 SMG	TOTAL
2006	Herbal cannabis	11 565	1 226		0	12 791
	Resin	5 281	632		0	5 913
	Concentrated cannabis	7	9		0	16
	Cannabis plants	218	83		0	301
	2006 Cannabis total	**17 071**	**1 950**		**0**	**19 021**
2007	Herbal cannabis	12 271	1 181		0	13 452
	Resin	4 708	575		1	5 284
	Concentrated cannabis	20	7		0	27
	Cannabis plants	230	70		0	300
	2007 Cannabis total	**17 229**	**1 833**		**1**	**19 063**
2008	Herbal cannabis	10 014	276	530		10 820
	Resin	3 497	109	264		3 870
	Concentrated cannabis	16	2	5		23
	Cannabis plants	275	44	31		350
	2008 Cannabis total	**13 802**	**431**	**830**		**15 063**

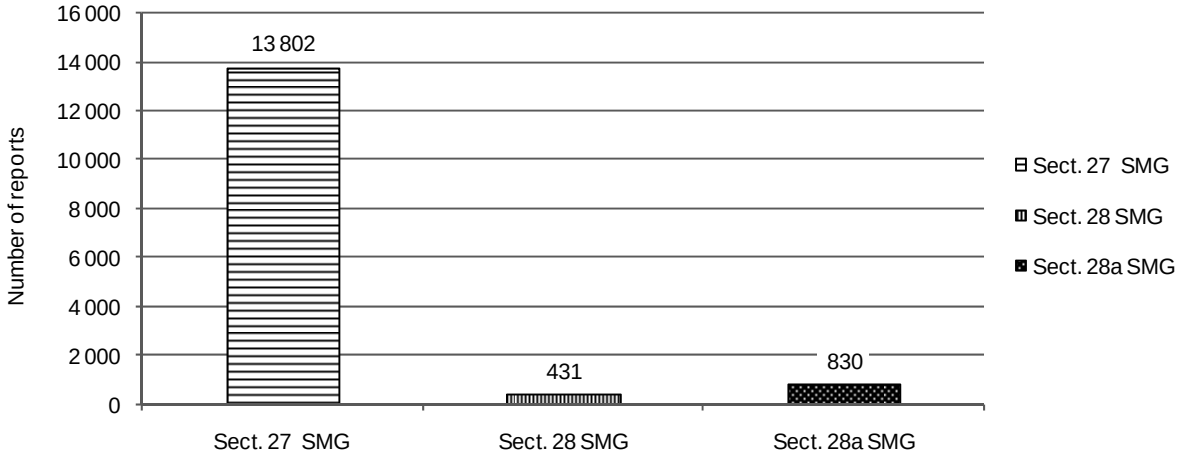
2006 and 2007:
Section 27 SMG = trafficking, possession, etc., of small quantities of narcotic drugs
Section 28 SMG = trafficking, possession, etc., of large quantities of narcotic drugs
Section 29 SMG = public propaganda for drug abuse

As of 2008:
Section 28 SMG = preparation of narcotic drug trafficking
Section 28a SMG = narcotic drug trafficking

Source: BMI/.BK 2008; representation by GÖG/ÖBIG

If the reports are studied with regard to shares accounted for by the individual SMG sections (Figure 11.3) it shows that, as described in the previous chapter, in 2008 the majority of reports relating to cannabis concerned violations of Section 27 of the SMG (illegal handling of drugs) and only a small part concerned Section 28 (preparation for drug trafficking) or Section 28a (drug trafficking) of the SMG. This means that in terms of quantities, it is primarily cannabis users who are apprehended and reported.

Figure 11.3: Distribution of reports relating to cannabis by section of the Narcotic Substances Act (SMG), in 2008 (n = 15 063)



Source: BMI/.BK 2008; representation by GÖG/ÖBIG

12 Treatment and Care for Older Drug Users

In the context of the following chapter, older drug users are defined as persons aged 40 years and older who use at least one illicit substance. The presented results are based on data provided by the uniform reporting system on clients of drug help services (DOKLI), data on opioid substitution treatment and drug-related deaths as well as findings of the EU project SDD-Care (Senior Drug Dependents and Care Structures) referring to the situation in Austria; the analysis focuses on opioid users. Wherever the size of the available sample allows, a distinction is made according to age groups of 39 or younger, between 40 and 49, between 50 and 59, and 60 and older. The focus of data interpretation is on the comparison of users older than 40 with users younger than 40. It should be noted that the share of drug users over 60 is very low, so that any data for this age group can only be interpreted with great caution.

In Austria drug use as a modern phenomenon started in the mid-1960s. Under the assumption that problem drug use begins at age 18, the first generation of drug patients are those born between 1952 and 1957 (see GÖG/ÖBIG 2009a).

12.1 Age trends in drug users in and out of treatment

There are several indications of a rising trend in the number of older drug users in Austria. Looking at data from the national substitution register, the number of drug users in substitution treatment aged 40 and older is observed to have doubled over the past few years (see Table 12.1, Chapter 5.3).

Table 12.1: Number of persons in opioid substitution treatment as reported to the Ministry of Health between 2001 and 2008, by age group

Year	Age (years)							
	39 and younger		40–49		50–59		60+	
	%	%*	%	%*	%	%*	%	% *
2001	77.3	81.5	21.0	17.0	1.7	1.4	0.1	0.0
2002	75.1	80.0	22.9	18.3	1.9	1.6	0.1	0.1
2003	73.3	79.0	23.9	18.8	2.6	2.0	0.2	0.2
2004	71.2	77.6	25.1	19.7	3.5	2.5	0.2	0.2
2005	70.3	77.4	25.3	19.4	4.1	2.9	0.2	0.2
2006	70.1	77.6	24.6	18.9	5.0	3.4	0.2	0.2
2007	71.3	78.0	22.9	17.9	5.5	3.9	0.3	0.2
2008	70.8	78.3	22.4	17.1	6.4	4.4	0.3	0.2

* after ghost-case corrections

Source: BMG; calculations and representation by GÖG/ÖBIG

For example, in 2001, 47 clients aged between 50 and 59 were undergoing opioid substitution treatment (taking into account ghost-case corrections – for a definition see GÖG/ÖBIG 2008c, GÖG/ÖBIG 2009, under preparation), and by 2008 the number of clients in this age category had risen to 314. However, it should be noted that the available data are incomplete

and can therefore be used for an assessment of the age development of drug users to a rather limited extent only (GÖG/ÖBIG 2006 und 2007b).

As to **directly drug-related deaths** the share of drug users aged 40 and older was 7.3% in 1995 (ÖBIG 2005), it rose over the following years and reached 17.4% in 2000. By 2007 the number of deaths in this age group had fallen again, to 14.3%. No assessment of future trends can be made at this point (see Chapter 6.3).

In their **survey included in the SDD-Care project**, Eisenbach-Stangl and Reidl (2009) come to the conclusion that the number of older drug users will rise (their focus is on users aged 35 and older). Age-stratified analyses based on prevalence estimates have shown that problem drug use including opioids has increased in this age group (2001: 28%; 2007: 33%). At CONTACT (Vienna) the number of clients aged 40 and older rose continually over the past few years. Until 2002 the number of older drug users had remained at 10% over a long period, but in recent years, the number of clients in this age group has increased to 28% in 2008 (Sucht- und Drogenkoordination Wien 2009b). **Organisations in the drug help system** of other provinces have also reported a rise in clients over 40 years of age (Drogenkoordination des Landes Salzburg 2009, B.I.T. 2008).

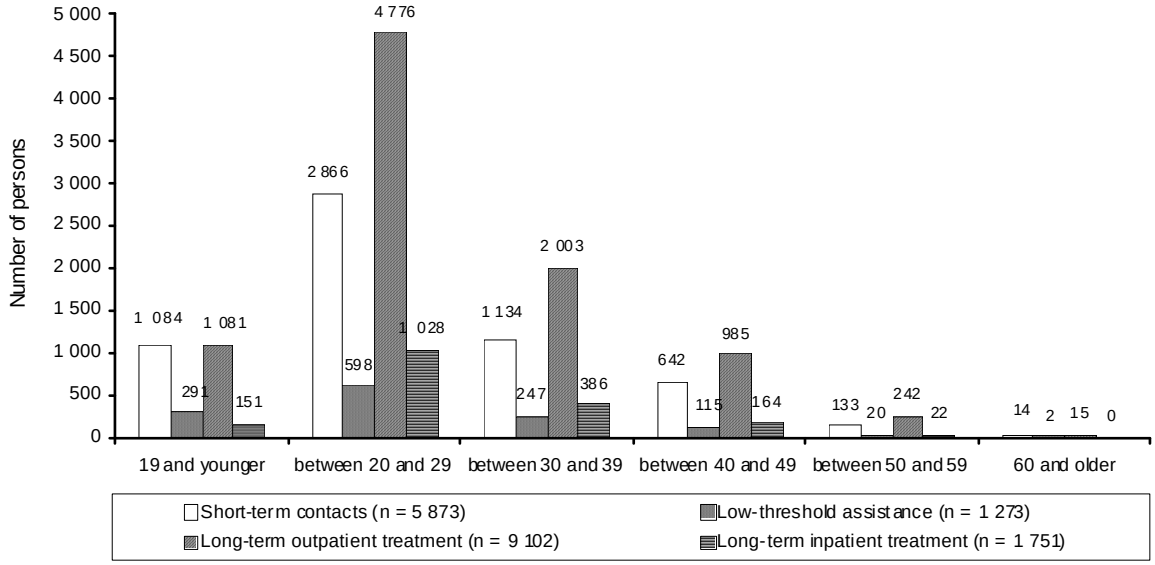
Individual surveys conducted at national level enumerate the **relevant factors regarding the rising number** of older drug users but give no detailed analysis of the situation. Attention is drawn to the fact that ageing plays a key role in present society (strong effects of the baby-boomer generation born between 1946 and 1964). In addition, services by the drug help system and opioid substitution treatment programmes contribute to the rising number of older drug users that has been registered. Regarding age structure of drug users, a number of **contextual factors** should be taken into account, such as the historical development of drug use in a country. Other factors are differences in mobility which are influenced by patterns of use, or the accessibility of the drug help system, to name but a few (GÖG/ÖBIG 2009a).

12.2 Drug use, health and social characteristics of current older drug users

Based on the DOKLI data (see Chapter 5.3) a number of parameters have been selected to compare age cohorts in an attempt to find evidence of specific characteristics and needs of older clients of the Austrian drug help system. For the following analyses, the basic population used was all clients who were in long-term inpatient or outpatient treatment in 2008. Furthermore, where deemed significant, a comparison is made between clients using opioids as a their primary drug (for a definition see Chapter 5.3) and the total population of clients.

In 2008, 86% of clients needing drug-related assistance were less than 40 years old (see Figure 12.1). 11% of the clients were aged between 40 and 49, 2% were aged between 50 and 59, and a mere 31 persons were 60 or older.

Figure 12.1: Number of people who required drug treatment or assistance in 2008, by age and type of service



Source: GÖG/ÖBIG 2009a, DOKLI, DOKLI analysis of client year 2008; representation by GÖG/ÖBIG

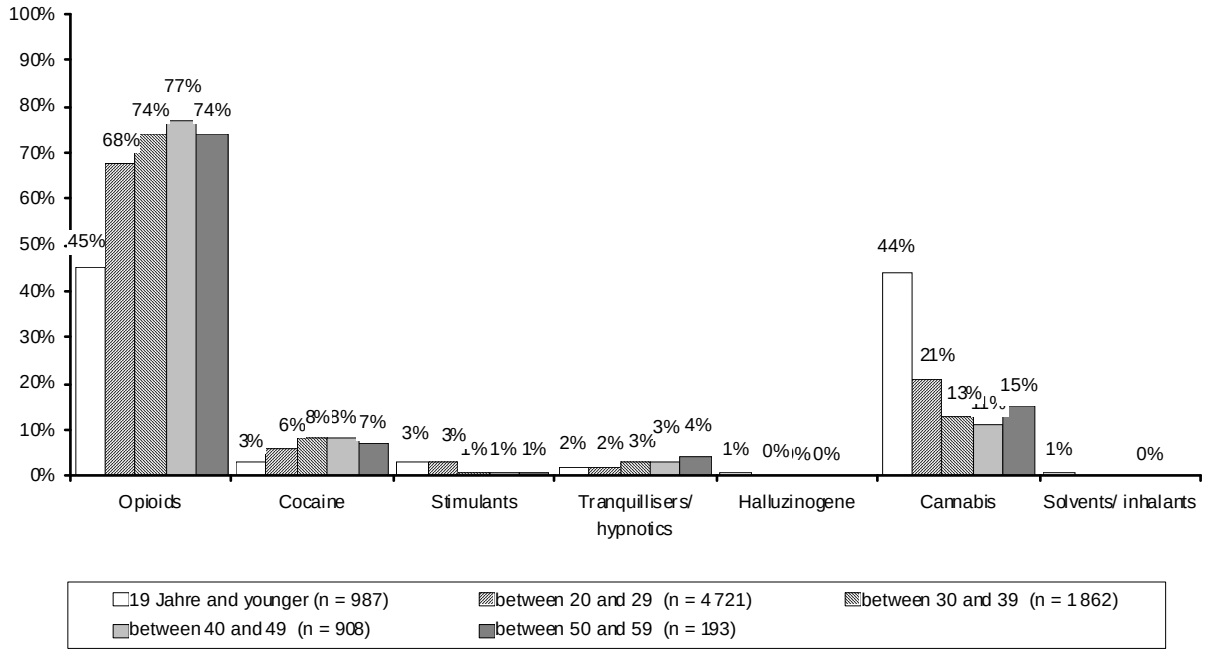
The **duration of treatment** in the age groups below 40 years was less than four months in approximately half of the cases (see Table A25 in Annex A). In the age group between 40 and 49, about one fourth of the clients were assisted for four to six months; among this age group, for 17% the duration of drug assistance was between 13 and 24 months and for 13%, between 25 and 36 months. As a general trend, clients aged 40 and older showed a longer period of treatment than the younger age cohorts. Data on the duration of treatment should be interpreted with great caution, as for a reliable assessment the coming client years will have to be taken into consideration (for details see GÖG/ÖBIG 2009a).

In all age groups, the clients' **main impulse for contacting a drug help unit** was their own initiative (see Table A26 in Annex A). For slightly more than half of the clients aged 40 and older with opioids as their primary drug this is the main incentive to undergo long-term inpatient or outpatient treatment (between 39% and 49% of clients younger than 40). In general, the influence of family and friends has been observed to decrease with age, whereas the significance of the clients' own initiative rises with age. In all age groups (with the exception of clients younger than 19) a court order or obligation in the context of a health-related measure for drug users was indicated as the second-most frequent main impulse for contacting a drug help centre. Furthermore, the age analysis shows that among drug users aged 40 or older the general practitioner tends to give the main impulse for contacting a drug help unit in a greater number of cases than in younger cohorts. On the basis of a total population of all person who were in long-term inpatient or outpatient assistance during 2008, the same trends as for the clients with opioids as primary drug may be observed, with only slight differences in the distribution of percentages. However, the influence of family was registered to rise again in the age group of users over 60 (see Table A27 in Annex A).

Data analyses by Eisenbach-Stangl and Reidl (2009) as well as analyses of the DOKLI data for the client year 2008 indicate that drug users in different age groups show different **patterns of drug use**. Analyses based on the primary drug of use reveal that apart from the fact

that the share of opioids rises and the share of cannabis decreases with age, there are no major differences between the age cohorts (see Figure 12.2). It is interesting to note that, in the age group between 50 and 59, this trend is reversed (i.e., a slight decrease in the share of opioids, and a slight increase in the share of cannabis as a primary drug is observed in the group between 50 and 59).

Figure 12.2: Persons who required inpatient or outpatient treatment or assistance in 2008, by primary drug (according to EMCDDA) and age group (percentages)



Note: As only four persons were 60 years and older, this age group is not represented in the graph.

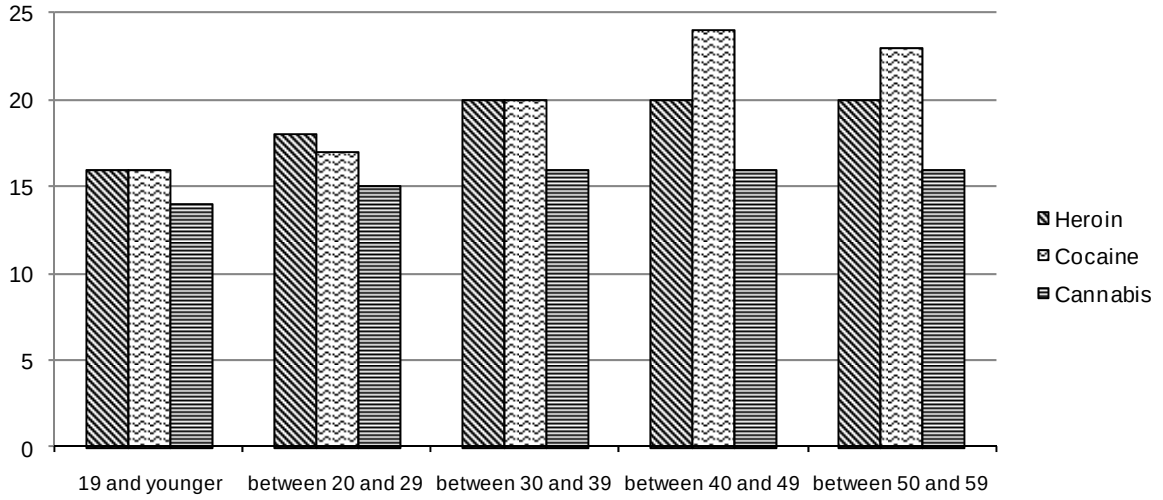
Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008; representation by GÖG/ÖBIG

Among persons aged 40 or older in long-term outpatient or inpatient settings using opioids as primary drug, injecting is named most frequently as the **predominant form of administration of heroin** (about 70%), followed by snorting (between 17% and 22%). By contrast, snorting is indicated most often in the group of clients younger than 30 (between 46% and 56%). Like the older cohorts, clients in the age group between 30 and 39 again indicate injecting as their predominant form of heroin use (see Table A28 in Annex A). Regarding the predominant form of using **cocaine**, snorting is most frequent in all age groups, followed by injecting (see Table A30 in Annex A). As a general trend it has been observed that the share of persons who indicate that they inject heroin or cocaine continually rises with age. In the age group between 50 and 59, the share of intravenous cocaine users is slightly lower. Snorting as a predominant form of heroin use declines with age, and until the age of 59 in the case of cocaine. Based on a total population of all persons who were in long-term inpatient or outpatient treatment or assistance, parallel trends have been registered for heroin and cocaine use (see Tables A29 and A31 in Annex A). Moreover, there is evidence that in the course of their drugs career clients change their mode of use from snorting to injecting (see GÖG/ÖBIG 2008a, Chapter 5.3).

With regard to the **median age of first use** it has been found that the age of first use was higher for older drug users than for younger ones (see Figure 12.3). The median age of first

use of cannabis was between 14 and 16 in all age groups (see Table A32 in Annex A). Based on a total population of all person who were in long-term inpatient or outpatient treatment, only slight differences in the median age of first use are noticeable; in the age group between 50 and 59, the age of first use of cocaine was slightly higher (24.5 years; see Table A33 in Annex A). The question whether older drug users actually started using drugs at a higher age (age effect) or whether the results are distorted because of the sample (sample effect) and whether older drug users remember the facts correctly (memory effect), is a topic for discussion.

Figure 12.3: Age at first use (median) of persons with opioids as their primary drug, who were clients in long-term outpatient or inpatient treatment in 2008, by age group



Note: As less than 20 persons were 60 years and older, this age group is not represented in the graph.

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Below, selected indicators describing **sociodemographic aspects and the social situation** reveal specific characteristics of older drug users who take opioids as their primary drug in long-term outpatient and inpatient treatment (see Table 12.2). The majority of drug users aged 40 and older is men, the share of women clients in this age group is approximately one fifth. In general, the share of women clients decreases with age (see Chapter 5.3). Regarding the **highest degree of school education** that drug users have obtained, the level of education tends to rise with age. It is debatable whether this is due to an age cohort effect (better quality of education in the generations of older opioid users), a selection effect (better educated opioid users survive for a longer period; see also Eisenbach-Stangl and Reidl 2009) or further education and training programmes (degrees are completed at a later stage). The high share of drug users younger than 19 who do not have a compulsory school-leaving certificate or higher education cannot be interpreted, as this group is still in the process of school education or training.

Table 12.2: Clients with opioids as their primary drug undergoing long-term outpatient or inpatient treatment and selected sociodemographic and social indicators, by age, 2008

Variables	Age (years)				
	younger than 19 (n = 449)	between 20 and 29 (n = 3 212)	between 30 and 39 (n = 1 384)	between 40 and 49 (n = 699)	between 50 and 59 (n = 142)
Women	49%	31%	25%	22%	23%
Treatment based on court order	19%	24%	18%	14%	15%
Living in Vienna	27%	37%	40%	34%	19%
Gainfully employed	29%	27%	26%	23%	21%
Unemployed	28%	42%	38%	29%	14%
Receiving welfare assistance	7%	12%	12%	14%	18%
Doing military service / alternative service / on parents leave / retired	1%	4%	10%	23%	37%
No compulsory school degree	14%	6%	4%	3%	1%
No higher degree of education except compulsory school leaving certificate	76%	60%	58%	59%	48%
Stable housing situation	94%	91%	90%	92%	94%
Living alone	12%	23%	34%	43%	45%

Note: As less than 20 persons were 60 years and older, this age group is not represented here.

Source: GÖG/ÖBIG 2009a, DOKLI analysis client year 2008; representation by GÖG/ÖBIG

As to the **housing situation** a high share in all age groups indicate stability (e.g., clients have their own apartment). The share of persons living alone rises continually with age and is 45% among the age group between 50 and 59. Based on the available data it is not evident whether this is a sign of isolation. An interesting aspect is that the percentage of drug users living in Vienna has risen among the younger age groups and is declining among drug users aged 40 and older. Vienna seems to be less attractive as a place to live for older drug users; it is not clear whether this is also a trend in the general population or whether there are other determining factors. Results on the **means of subsistence** show that the category indicating retirement has sharply risen among older drug users. Still, the extremely low percentage of employed drug users may be interpreted as indicating problems regarding integration into the labour market, especially for older drug users. Older drug users receive social benefits more frequently than drug users younger than 40. Based on a total population of all persons who were undergoing long-term inpatient or outpatient treatment, most of the differences between age groups described above are similar or somewhat less marked (see Table A34 in Annex A).

The CONTACT hospital connection service (Vienna) has found differences between older and younger clients which coincide with the analyses of DOKLI data described above. Examples for factors that distinguish older from younger clients are: social exclusion (especially among men); inability to live alone; no access to medical, addiction-related and social services because of bad physical or psychological condition and resulting limitations of mobility; lack of future perspectives; few or no opportunities to enter the job market; no daily structure; few options for sparetime activities (Sucht- und Drogenkoordination Wien 2009b). At the Association of Psychosocial Centres (PSZ) in Lower Austria, the group of older clients falls into two categories. One group is in a relatively stable situation in opioid substitution treatment (partly on a low maintenance dose, frequently methadone is administered) and socially inte-

grated to some extent (employed or having a family of their own) or suffering from a chronic disease (e.g., infectious disease), whereas members of the other group frequently show poly-drug use patterns (opioids, alcohol, benzodiazepines), have social contacts mainly within the drug scene, have been through several attempts of drug-free treatment and other forms of therapy and have experienced several periods of imprisonment and/or long years of prostitution (Werner, personal communication).

Regarding **drug-related health problems** the situation in the group of clients older than 29 is generally considered to be much worse than that of younger clients. By and large, the prevalence of infectious diseases rises with age, which is in line with expectations. In this context it has to be taken into account that the share of clients who inject drugs rises with age (GÖG/ÖBIG 2009a). Based on the reports of clients of BADO Vienna it becomes apparent that nearly all drug users over 40 are confronted with a number of serious health problems. In the order of frequency, the diseases indicated were chronic hepatitis C, dental problems, gastrointestinal problems, psychiatric conditions, skin problems and vascular problems, convulsions or epileptic attacks (ÖBIG 2005). The B.I.T. counselling unit (Tyrol) reports to have diagnosed manifest depression or other comorbid disorders in a majority of clients aged over 40 (GÖG/ÖBIG 2008c). Older clients of PSZ (Lower Austria) often show psychiatric dual diagnoses (personality disorders, depression, panic attacks; Werner, personal communication).

There is some evidence that older drug users are underrepresented in the services that communicate data to DOKLI. This may be concluded especially from comparisons with other EU countries and with data relating to opioid substitution treatment. The reasons for this discrepancy are a matter of speculation. On the one hand, older clients undergoing opioid substitution treatment may be stable and integrated enough as not to require other drug help services. On the other hand, the results could be interpreted in the sense that there are no adequate interventions available for the target group. According to another assumption, the specific needs of older OST clients are covered by services outside the drug help system. On the basis of routine monitoring data it is impossible to decide which of the three views actually applies. To provide conclusive evidence in this respect is a task for further research (GÖG/ÖBIG 2008a).

12.3 Treatment, management and care of older drug users

A number of regulations at federal and provincial levels are relevant for the treatment and care of older drug users in Austria (see Chapter 1). In principle, the same legal provisions apply to drug users of all ages. In existing regulations and services, drug users are mentioned as being excluded (e.g., non-eligibility for unemployment benefits, restrictions in the house rules of care homes etc.) (Spirig et al. 2009).

Many benefits of the **social system** are hard to obtain for most older drug users. All applicants encounter administrative obstacles when trying to gain access to benefits, but older drug users are especially disadvantaged in this situation. In addition to suffering from health impairments (e.g., limited mobility) this age group is confronted by obstacles which often result from social deprivation (Spirig et al. 2009). (Re-)integration into the job market is especially hard for older drug users (see Chapter 8.2).

Older drug users are rarely mentioned in **addiction plans** (see Chapter 1). As an example, in its current binding framework plan for the further expansion of the Carinthian addiction help system the Province of Carinthia pursues the aim to build up a medium-term care programme for older citizens in danger of addiction who show problem use of illicit drugs and/or alcohol. In this context it is interesting to note that the target group of older drug users was not defined according to a fixed age limit (Preshlauer, personal communication). The drug strategy of Vorarlberg (Amt der Vorarlberger Landesregierung 2002) mentions the need for a specific treatment programme for users between 30 and 50 years of age who have started using drugs as mature adults. This need should not be covered by a separate unit, but rather by specific services in existing institutions; at Maria Ebene hospital, a corresponding treatment programme has already been created for this target group. The addiction plans of the other provinces make no specific mention of older drug users.

Spirig et al. (2009) state that currently **no specific treatment programmes** for older drug users exist. Individual drug help centres have reported an increased use of their services by this group, e.g., B.I.T. (Tyrol; GÖG/ÖBIG 2008c) and VWS in Vienna (2009a). The specific care needs of older drug users (see Chapter 12.2) pose a great challenge to the drug help system. According to reports from Carinthia, there are no adequate care services available for older drug users suffering from a psychiatric primary disease and showing problem drug use patterns. As a result, clients move back and forth between emergency departments and rehabilitation facilities, which entails substantial costs; in this sense, care is insufficient (Land Kärnten 2006).

Especially in the area of care for older citizens, specific strategies should be designed to meet the needs of older drug users (GÖG/ÖBIG 2009a). According to the drug strategy of Vorarlberg (Amt der Vorarlberger Landesregierung 2002) the situation of older drug users requires specific interventions in which members of all care professions dealing with older citizens as well as friends and relatives of those concerned should be included. Experience from Vorarlberg has shown that the state of health of addiction patients can be raised to a satisfying level of stability in care facilities (Neubacher, personal communication). By contrast, Musalek and Preinsperger report that the massive additional substance use by part of the target group is hardly tolerated in geriatric facilities. Moreover, there are problems of acceptance of the target group by non-users in such facilities. Programmes providing a daily structure for older drug users are considered useful, as they are often unemployed and have few social contacts. In addition, assisted housing and specific care is required. The treatment of older drug users calls for a consideration of the specific aspects of aging, especially comorbidities[45].

Regarding the development of **policies for assistance and care** for older drug users, the EU project SDD-Care is of key significance for Austria[46]. As part of this project, currently basic information on the social situation and health status of older drug users (women and men) and their objective and subjective care needs is collected. In addition, it is planned to draw up strategies and guidelines for practical implementation of outpatient and inpatient depart-

[45] www.geriatrie-online.at/dynasite.cfm?dsmid=96679&dspaid=744846 (15 April 2009)
[46] www.sddcare.eu (7 August 2009)

ments for the target group of persons over 35 with drug problems. At provincial level, under the drug plan in Carinthia (see above) currently a strategy for assisting older drug users is designed by the OIKOS association for drug patients, which is soon to be completed and implemented (Land Kärnten 2006).

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BGBl II 2009/6 v. 7. 1. 2009. Verordnung des Bundesministers für Gesundheit, Familie und Jugend betreffend das Inverkehrbringen, den Import und das Verbringen von Räuchermischungen, die Naphthalen-1-yl-(1-pentylindol-3-yl)-methanon/JWH-018 enthalten.

BGBl II 2009/58 v. 3. 3. 2009. Verordnung des Bundesministers für Gesundheit betreffend das Inverkehrbringen, den Import und das Verbringen von Räuchermischungen, die cannabinomimetisch wirksame Stoffe enthalten.

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BGBl II 2009/174 v. 15. 6. 2009. Verordnung des Bundesministers für Gesundheit, mit der die Suchtgift-Grenzmengenverordnung geändert wird.

Personal communications, alphabetical order

Name and page	Organisation or function
Anderwald, DGKS Christine (p. 43)	Caritas Marienambulanz outpatient clinic, Graz
Bauer, Prim. Dr. Bernhard (p. 43)	Caritas Marienambulanz outpatient clinic, Graz
Duspara, Vinko (p. 43)	Lukasfeld therapy department, Maria Ebene foundation, Vorarlberg
Ederer, DSA Klaus Peter (pp. 27, 30)	Addiction Coordinator of Styria
Frossard, OA Dr. Martin (p.71)	emergency medicine clinic, General Hospital Vienna
Haltmayer, Dr. Hans (p. 43)	VWS (Vienna Social Projects Association)
Hörhan, Mag. Dr. Ursula (pp. 8, 30, 31, 52, 57)	Addiction Coordinator of Lower Austria
Kahl, DSA Walter (p. 66)	Federal Ministry of Justice, Dept. V/1
Kern, Harald (pp. 8, 31, 64)	Addiction Coordinator of the Tyrol
Mader, ADir. Christian (p. 79)	Federal Ministry of the Interior / Federal Criminal Agency
Mahnert, OA Dr. Franz Alfons (p. 30)	Walkabout therapy department
Mellish, Sadiya Petra (pp. 17, 19)	Addiction Prevention, Coordination and Counselling Unit of Lower Austria
Nagy, Mag.[a] Constanze (p. 71)	ChEck iT!, Vienna Social Projects Association
Neubacher, Thomas (pp. 29, 90)	Drug Coordinator Vorarlberg
Prehslauer, Dr. Brigitte (pp. 26, 30)	Drug Coordinator Carinthia
Rögl, Nicole (pp. 16, 19)	Akzente Addiction Prevention Unit in the Province of Salzburg
Schäfer, Mag. Silke (p. 45)	Komfüdro, Tyrol
Springer, Univ.-Prof. Dr. Alfred (p. 75)	Ludwig Boltzmann Institute for Addiction Research
Stolz-Gombocz, OA Dr. Ingrid (p. 43)	Anton Proksch Institute, long-term therapy department for drug addicts with personality disorders, Mödling, Lower Austria
Werner, Dr. Wolfgang (p. 89)	Association of Psychosocial Centres (PSZ)
Zeder, Dr. Ulf (p. 52)	Addiction Coordinator Graz

DATABASES

Best practice portal –Examples for evaluated measures: EDDRA = Exchange on Drug Demand Reduction Action [47]

Internet database of the EMCDDA: http://eddra.emcdda.europa.eu/html.cfm/index45497EN.html

Austrian projects in the EDDRA database respectively Best practice portal of the EMCDDA (as of August 2008):

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

Addiction information in schools supported by experts
(kontakt+co - Suchtpräventionsstelle, Tyrol)

Addiction prevention within the apprenticeship of the Austrian Federal Railways
(Institut für Suchtprävention, Vienna)

Addiction prevention within the Styrian Soccer Association
(VIVID – Fachstelle für Suchtprävention, Styria)

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

Become Independent: education programme for prevention in schools
(SUPRO - Werkstatt für Suchtprophylaxe, Vorarlberg)

Being a parent can be beautifully difficult sometimes
(Fachstelle für Suchtvorbeugung, Koordination und Beratung, Lower Austria)

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

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)

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

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, Carynthia)

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

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

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

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

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

"Guat beinand'!": Addiction prevention in communities and city districts
(Akzente Salzburg – Suchtprävention, Salzburg)

Health Promotion and Addiction Prevention in the Workplace
(SUPRO - Werkstatt für Suchtprophylaxe, Vorarlberg)

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

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

In motion: A multiplier project for addiction prevention at schools
(Institut Suchtprävention - eine Einrichtung von pro mente, Upper Austria)

Job assistance - subproject of the Vienna Job Exchange in the context of the Equal development partnership
(Wiener Berufsbörse, Vienna)

Living together in the 2nd district. Program for the prevention of addiction in schools, children and youth social work in urban areas.
(Institut für Suchtprävention, Vienna)

Local Capital for Social Purposes (a pilot action of the DG V of the EU) Programme: "Socially Innovative 2000" (EU regional management Eastern Styria)
(Volkshilfe Steiermark, VIVID Fachstelle für Suchtprävention, Regionalbüro Oststeiermark, Styria)

Log In: Measures for the integration and health promotion of former drug users
(Anton Proksch Institute, Lower Austria)

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

Long-term therapy facility CARINA
(Stiftung Maria Ebene, Vorarlberg)

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

Low threshold service Ganslwirt
(Verein Wiener Sozialprojekte, Vienna)

Lukasfeld: A short term therapy for young illegal drug addicts
(Stiftung Maria Ebene hospital, Vorarlberg)

Making kids strong through Sports
(SUPRO - Werkstatt für Suchtprophylaxe, Vorarlberg)

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

Medico-psycho-social Sanatorium „Schweizer Haus Hadersdorf“
(Evangelisches Haus Hadersdorf - WOBES, Vienna)

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

Needles or Pins: Occupational reintegration of (former) drug addicts.
(Beratungsstelle DIALOG, Vienna)

Peer education project
(Fachstelle für Suchtvorbeugung, Koordination und Beratung, Lower Austria)

Pib – prevention in companies
(kontakt+co - Suchtpräventionsstelle, Tyrol)

Pilot projekt: Addiction prevention in Trofaiach
(b.a.s. (betrifft alkohol und sucht) – steirischer Verein für Suchtkrankenhilfe, Styria)

Probation assistance for prisoners at Vienna Favoriten prison provided by voluntary staff
(Verein für Bewährungshilfe und soziale Arbeit – Bewährungshilfe, Vienna)

Scientific project: ChEckiT!
(Verein Wiener Sozialprojekte, Vienna)

Social medicine counselling centre Ganslwirt
(Verein Wiener Sozialprojekte, Vienna)

Socio economical company: Fix und Fertig (“All ready”)
(Verein Wiener Sozialprojekte, Vienna)

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

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

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

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

Supervised housing
(Verein Wiener Sozialprojekte, Vienna)

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

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

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

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

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

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

Vienna Job Exchange
(Wiener Berufsbörse, Vienna)

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

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

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, Styria)

Websites

Please find below websites of relevant institutions and associations 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.oebig.at under Activities/ Prevention/ Illegal drugs/ Links

Provincial Drug or Addiction Coordinators:

Addiction Coordinators for the Province of Burgenland
http://www.psd-bgld.at/suchtkoordination/index.html

Drug Coordinators for the Province of Carinthia
http://www.gesundheit-kaernten.at/gesundheitsserverhtml/page.asp?MEN_ID=42

Addiction Coordinators of the Province of Lower Austria
http://www.suchtvorbeugung.at/suchtkoordination/

Drug and Addiction Coordinators of the Province of Upper Austria
http://www.land-oberoesterreich.gv.at/cps/rde/xchg/SID-3DCFCFC3-8C8F5206/ooe/hs.xsl/554_DEU_HTML.htm

Drug Coordinators of the Province of Salzburg
http://www.salzburg.gv.at/themen/gs/soziales/leistungen_und_angebote/abhaengigkeit/abhaengigkeit_drogenkoordination.htm

Addiction Coordinators of the Province of Styria
http://www.drogenberatung-stmk.at/

Addiction Coordinators of the Province of the Tyrol
http://www.tirol.gv.at/themen/gesellschaft-und-soziales/soziales/suchtkoordination/

Addiction Coordinators of the Province of Vorarlberg
http://www.vorarlberg.at/vorarlberg/gesellschaft_soziales/gesellschaft/suchtkoordination/start.htm

Addiction and Drug Coordinators Vienna (SDW),
http://www.drogenhilfe.at

Provincial Addiction Prevention Units:

Burgenland: Fachstelle für Suchtprävention Burgenland
http://www.psd-bgld.at/suchtpraevention/index.html

Carinthia: Landesstelle für Suchtprävention Kärnten
http://www.gesundheit-kaernten.at/gesundheitsserverhtml/page.asp?MEN_ID=77

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

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

Salzburg: AKZENTE Suchtprävention – Fachstelle für Suchtvorbeugung Salzburg
http://www.akzente.net/Suchtpraevention.7.0.html

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

Tyrol: Kontakt&co – Suchtprävention. Jugendrotkreuz, Tirol
http://www.kontaktco.at

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

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

Federal Ministries:

Federal Ministry for Health
http://www.bmg.gv.at

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

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

Federal Ministry for Education, the Arts and Culture
http://www.bmukk.gv.at

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

Federal Ministry for Labour, Social Affairs and Consumer Protection
http://www.bmsk.gv.at

Federal Ministry for Transport, Innovation and Technology
http://www.bmvit.gv.at

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

Monitoring and research:

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

Institut für Suchtforschung der Universität Innsbruck mit Sitz am Krankenhaus Maria Ebene
(Addiction Research Institute of the University of Innsbruck, based at the hospital Maria Ebene)
http://www.suchtforschung.at

Ludwig Boltzmann Institute of Addiction Research at Anton Proksch Institute
http://www.api.or.at/lbi/index.htm

ÖBIG – Österreichischer Suchthilfekompass (Austrian Addiction Help Compass)
http://suchthilfekompass.oebig.at

ÖBIG – Einheitliches Dokumentationssystem der Klienten und Klientinnen der Drogenhilfe
(Uniform documentation and reporting system of clients of Austrian drug help centres)
http://tdi.oebig.at

Suchtforschung und Suchttherapie an der Medizinischen Universität Wien
(Addiction Research at the Medical University of Vienna)
http://www.sucht-addiction.info

European Centre for Social Welfare Policy and Research
http://www.euro.centre.org/

Other websites:

AIDS assistance
http://www.aidshilfen.at

Allgemeines Krankenhaus in Wien (General Hospital Vienna)
http://www.meduniwien.ac.at

ARGE Suchtvorbeugung (Working Group for Addiction Prevention)
http://www.suchtvorbeugung.net

Anton Proksch Institute
http://www.api.or.at

Auftrieb – youth and addiction counselling
http://jugendundkultur.at

b.a.s. – Styrian society for addiction issues
http://www.bas.at

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

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

Carina – Therapiestation (treatment centre)
http://www.mariaebene.at/carina/

Caritas Innsbruck
http://www.caritas-innsbruck.at

Caritas Graz – Kontaktladen (contact point)
http://caritas-steiermark.at

ChEck iT! – Vienna Social Projects Association (VWS)
http://checkyourdrugs.com

CONTACT – hospital connection service
http://www.drogenhilfe.at/rathilfe/skh/r-s-contact.htm

dialog – counselling and care centre
http://www.dialog-on.at

Do it yourself – low-threshold centre for drug users
http://www.doit.at

Drogenberatung des Landes Steiermark (Drug Counselling Centre of the Province of Styria)
http://www.drogenberatung-stmk.at

ENCARE Austria
http://www.encare.at

Ex und Hopp – drug counselling
http://www.exundhopp.at

Fachzeitschrift für Online-Beratung und computervermittelte Kommunikation (Magazine for online counselling and computer-aided communication)
http://www.e-beratungsjournal.net

Fonds Gesundes Österreich
http://www.fgoe.org/startseite

Ganslwirt – Verein Wiener Sozialprojekte (low-threshold centre; Vienna Social Projects Association)
http://www.vws.or.at/ganslwirt

Grüner Kreis – Society for the rehabilitation and integration of addicted persons
http://www.gruenerkreis.at

Haus am Seespitz (short-term therapy centre for drug patients)
http://sogis.i-med.ac.at/ich-brauche-hilfe/einrichtungsdaten.cfm?eid=47

H.I.O.B. – (drug counselling centre)
http://www.caritas-vorarlberg.at

Jugendstreetwork Graz (youth street work)
http://caritas-graz.at/home.php?cakt=einr&id=2&einrakt=&narchiv=&armonat=&arjahr=&suche=&einrid=&ibhid=&mitid

Klinische Abteilung für Allgemeine Psychiatrie; Universitätsklinik für Psychiatrie in Wien (Clinical department of general psychiatry, Vienna University Hospital of Psychiatry)
http://www.medizin-medien.info/dynasite.cfm?dssid=4263

Komfüdro – communication centre for drug users
http://www.caritas-innsbruck.at/einrichtungen.cfm?mode=showseite1&e_id=15

Kontaktstelle in Suchtfragen – contact and information centre for addiction prevention in schools, Salzburg
http://www.landesschulrat.salzburg.at//service/kis/index.php

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

Verein LOG IN Association
http://www.login-info.at

Lukasfeld – (therapy centre)
http://www.mariaebene.at

Marienambulanz (outpatient centre)
http://www.caritas-graz.at/home.php?cakt=einr&id=68

MDA basecamp – (mobile drug prevention in the Tyrol)
http://www.mdabasecamp.com

MDA basecamp – (online counselling)
http://www.onlinedrogenberatung.at

Needles or Pins – dialog
http://www.dialog-on.at/article_69.html

Neustart – Bewährungshilfe, Konfliktregelung, Soziale Arbeit (probation assistance, conflict management, social work)
http://www.neustart.at/

Oikos – Association for drug addicts
http://www.oikos-klagenfurt.at

Otto-Wagner-Spital – drug institute
http://www.wienkav.at/kav/ows/medstellen_anzeigen.asp?suchstring=912

Österreichische Caritaszentrale – (Caritas social integration enterprise)
http://www.esf.at/projekte/arbeitslose/projekte_ida.html

Österreichischer Verein für arzneimittelgestützte Behandlung von Suchtkranken (Austrian Association for pharmacologically assisted treatment of drug addicts
http://www.oegabs.at/index.php

Österreichischer Verein für Drogenfachleute (Austrian Association of Experts in the Field of Drugs)
http://www.oevdf.at

Österreichisches Netzwerk Gesundheitsfördernde Schulen (Austrian Network of Health-Promoting Schools)
http://www.schule.at/gesundheit

Plattform Drogentherapien – information on opiate addiction
http://www.drogensubstitution.at

pro mente Oberösterreich (psychosocial care association)
http://www.promenteooe.at

Schulpsychologie Bildungsberatung (school psychology, education counselling)
http://www.schulpsychologie.at

Schultüte (FSW/ISP Vienna; school project)
http://schultuete.at

Schweizer Haus Hadersdorf (counselling and treatment centre)
http://www.shh.at

Stadt Wien - City of Vienna
http://www.magwien.gv.at

Stiftung Maria Ebene (foundation, hospital)
http://www.mariaebene.at

Streetwork Graz (street social work)
http://caritas-steiermark.at

Substanz – Verein für suchtbegleitende Hilfe (association for accepting drug assistance)
http://www.substanz.at

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

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

Therapiestation Walk about (treatment centre)
http://www.barmherzige-brueder.at/walkabout/

Tiroler JugendWeb – Drogen, Sucht, Hilfe (Tyrolean youth network for drug assistance)
http://www.startblatt.net/at/jugend/jugend-tirol/tiroler-jugendweb

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

Verein PASS (prevention and drug counselling)
http://www.pass.at/start.htm

VIVA (drug counselling centre)
http://www.gesundheit-kaernten.at/gesundheitsserverhtml/page.asp?MEN_ID=109&SEI_ID=99&LST_ID=48

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

VWS (Vienna Social Projects Association)
http://www.vws.or.at

Verein Jugend & Kultur Wiener Neustadt (youth and culture association)
http://www.jugendundkultur.at

Wiener BerufsBörse (Vienna Job Exchange)
http://www.berufsboerse.at

ANNEX

A. Tables, Map

B. List of Abbreviations

C. Standard Tables & Structured Questionnaires

ANNEX A

Tables, Map

Table A1: Overview of selected general population surveys on drug experience among the Austrian population from 2004 to 2008

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

Summarised by GÖG/ÖBIG

Table A2: Overview of selected youth surveys on drug experience among young people in Austria from 2001 to 2008

Study (author(s), year of publication)	**Area covered year of data collection** (period covered)	**Target group** (sample)	**Drug types surveyed**	**Percentage of respondents with drug experience** Age group	%
Schulstudie Burgenland / school survey, Burgenland (Schönfeldinger 2002)	Burgenland 2001 (lifetime)	Students in their 7th to 13th school years (n = 1 899)	Cannabis Ecstasy Cocaine Heroin Speed Hallucinogenic drugs Solvents and inhalants Biogenic drugs	12–19 12–19 12–19 12–19 12–19 12–19 12–19 12–19	20 4 2 1 3 3 20 8
HBSC-Studie / HBSC-study (Dür und Mravlag 2002)	Austria 2001 (lifetime)	Students aged 15 (n = 1 292)	Cannabis	15	14
ESPAD Österreich / ESPAD Austria (Uhl et al. 2005b)	Austria 2003 (lifetime)	Students aged 14 to 17 (n = 5 281)	Cannabis Ecstasy Cocaine Crack Heroin Amphetamines GHB LSD Solvents and inhalants Magic Mushrooms	14–17 14–17 14–17 14–17 14–17 14–17 14–17 14–17 14–17 14–17	22 3 2 2 1 5 1 2 15 4
Berufsschulstudie Steiermark / vocational school survey, Styria (Hutsteiner, Seebauer, Auferbauer 2005)	Styria 2005 (lifetime)	Trainees at vocational school aged 15 to 19 (n = 3 919)	Cannabis Party drugs Cocaine Crack Opioids Amphetamines Hallucinogenic drugs Solvents and inhalants Magic Mushrooms	15–20 15–20 15–20 15–20 15–20 15–20 15–20 15–20 15–20	27.1 4.8 2.0 1.1 1.4 3.1 1.8 11.4 8.9
HBSC-Studie / HBSC study (Dür und 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)	Adolescents and young adults aged 15 to 24 (n = 669)	Cannabis Ecstasy Heroin Morphine Amphetamines Cocaine LSD Solvents and inhalants Biogenic drugs	15–24 15–24 15–24 15–24 15–24 15–24 15–24 15–24 15–24	36.9 12.3 7.7 8.5 12.3 10.0 9.0 16.5 13.0
Schulstudie Burgenland / school study Burgenland (Falbesoner und Lehner 2008)	Burgenland 2007 (lifetime)	Students in their 7th to 13th school years (n = 1 213)	Cannabis Ecstasy Cocaine Heroin Speed Solvents and inhalants Biogenic drugs	12–19 12–19 12–19 12–19 12–19 12–19 12–19	11 2 2 2 3 15 4
ESPAD Österreich / ESPAD Austria (ESPAD-Austria 2007)	Austria 2007 (lifetime)	Students aged 15 to 16 (n = 4 574)	Cannabis Ecstasy Cocaine Crack Heroin Amphetamines GHB LSD Solvents and inhalants Magic Mushrooms	15–16 15–16 15–16 15–16 15–16 15–16 15–16 15–16 15–16 15–16	18.0 3.4 3.2 2.3 1.8 7.7 2.3 2.8 14.1 4.1

Summarised by GÖG/ÖBIG

Table A3: Development of AIDS cases in Austria by risk situation from 1999 to 2008

Risk situation	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Homo-/bisexual contact	27	13	21	19	7	16	14	16	19	12
Injecting drug use	28	24	28	22	14	13	14	6	14	16
Heterosexual contact	31	28	33	41	21	32	17	30	22	25
Other cause/unknown	16	23	11	15	10	10	14	11	17	12
Total	102	88	93	97	52	71	59	63	72	65

Source: BMG, calculations by GÖG/ÖBIG

Table A4: Distribution of reports of violations of the Narcotic Substances Act in Austria by first offenders and repeat offenders, development from 1990 to 2008

Reports	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total numbers of reports	17 597	18 125	21 862	22 422	22 245	25 215	25 892	24 008	24 166	20 043
First offenders	9 868	9 343	11.033	11.269	12.117	14 346	15 569	15 808	16 053	13 634
Repeat offenders	7 463	8 296	10 052	10 380	9 288	9 990	9 520	7 636	7 569	5 990

Difference between sum of individual figures and total figure = unknown

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

Source: BMI/.BK

Table A5: Distribution of reports of violations of the Narcotic Substances Act (narcotic substances only) in Austria from 1999 to 2008

Province	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Burgenland	603	843	712	805	984	967	923	1 033	1 008	871
Carinthia	1 208	1 088	1 758	1 676	1 659	1 464	1 529	1 190	1 408	1 153
Lower Austria	2 389	2 624	2 975	3 319	3 017	3 531	3 632	3 050	3 464	2 583
Upper Austria	1 946	1 887	2 677	3 054	2 782	3 521	3 769	3 209	3 786	3 245
Salzburg	840	718	1 471	1 384	868	1 077	1 092	1 001	1 116	1 015
Styria	1 367	1 305	1 601	1 910	1 570	1 705	1 516	1 435	1 929	1 372
Tyrol	2 152	2 687	2 449	2 229	2 102	2 695	2 775	2 607	2 454	1 982
Vorarlberg	1 848	1 183	1 447	1 265	1 146	1 044	1 008	1 240	1 153	976
Vienna	4 858	5 233	6 212	6 210	7 652	8 524	8 797	7 925	6 611	5 883
Total	17 211	17 568	21 302	21 852	21 780	24 528	25 041	22 690	22 929	19 080

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

Source: BMI/.BK

Table A6: Distribution of reports of violations of the Narcotic Substances Act in Austria by drug type from 1999 to 2008

Drug type	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Cannabis	17 236	17 001	19 760	19 939	17 706	20 252	20 900	19 021	19 063	15 063
Heroin and opioids	2 524	2 413	3 802	3 954	4 717	4 770	4 720	3 516	3 294	2 865
Cocaine +Crack	2 608	2 494	3 416	3 762	4 785	5 365	5 491	4 252	4 263	3 551
LSD	532	477	506	327	214	196	160	164	196	101
Ecstasy	1 517	2 337	2 940	2 998	2 473	2 362	2 106	1 763	1 889	1 127
Amphetamines	–	1 041	1 215	1 357	1 619	1 741	1 664	1 503	1 914	1 296
Psychotropic substances	750	780	822	736	603	903	1 085	1 701	1 555	1 198
Other drugs	–	–	1 288	1 524	1 311	1 826	2 471	3 299	3 237	2 678

– = not evaluated separately or not specified

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

Source: BMI/.BK

Table A7: Distribution of reports of violations of the Narcotic Substances Act in Austria by drug type and province in 2008

Drug type	B	C	LA	UA	S	ST	T	VB	V	Total
Cannabis	819	1 233	2 109	2 662	976	1 323	1 912	976	3 053	15 063
Heroin and opioids	90	58	429	508	39	105	70	237	1 329	2 865
Cocaine + Crack	151	194	400	572	89	129	313	164	1 539	3 551
LSD	13	1	24	26	3	8	12	6	8	101
Ecstasy	68	87	313	291	74	96	82	37	79	1 127
Amphetamines	80	34	298	434	96	118	47	51	138	1 296
Psychotropic substances	24	3	94	66	23	36	67	17	868	1 198

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

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

Source: BMI/.BK

Table A8: Convictions under the Narcotic Substances Act (SMG) and total number of convictions in Austria from 1999 to 2008

Year	Total number of convictions under the SMG	Convictions under Section 28 SMG resp. Section 28 a SMG	Convictions under Section 27 SMG	Convictions in Austria	
				Total number	Under the SMG (percentages)
1999	3 359	1 022	2 230	61 954	5.4
2000	3 240	933	2 245	41 624	7.8
2001	3 862	1 141	2 671	38 763	10.0
2002	4 394	1 108	3 243	41 078	10.7
2003	4 532	1 161	3 318	41 749	10.9
2004	5 706	1 441	4 229	45 185	12.6
2005	6 128	1 357	4 702	45 691	13.4
2006	5 795	1 464	4 246	43 414	13.3
2007	5 437	1 387	3 956	43 158	12.6
2008	4 291	1 332	2 899	38 226	11.2

Until 2007: Section 28 SMG = trafficking, possession etc. of large quantities of narcotic drugs (commercial trafficking)
Section 27 SMG = trafficking, possession etc. of small quantities of narcotic drugs

As of 2008: Section 27 SMG = illicit handling of narcotic substances
Section 28 SMG = preparation of trafficking of narcotic substances
Section 28a SMG = trafficking of narcotic substances

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

Source: Statistics Austria (criminal court statistics)

Table A9: Final convictions under the Narcotic Substances Act (SMG) in Austria by age, gender and basis of conviction in 2008

Basis of conviction		14–19 years	20–24 years	25–29 years	30–34 years	> 34 years	Total
SMG total	Men	585	1 365	727	432	731	3 840
	Women	71	171	73	43	93	451
Section 28 SMG / Section 28 a SMG	Men	108	366	216	158	347	1 195
	Women	13	41	23	17	43	137
Section 27 SMG	Men	476	994	501	269	354	2 594
	Women	57	128	48	26	46	305

Until 2007: Section 28 SMG = trafficking, possession etc. of large quantities of narcotic drugs (commercial trafficking)
Section 27 SMG = trafficking, possession etc. of small quantities of narcotic drugs

As of 2008: Section 27 SMG = illicit handling of narcotic substances
Section 28 SMG = preparation of trafficking of narcotic substances
Section 28a SMG = trafficking of narcotic substances

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

Source: Statistics Austria (criminal court statistics)

Table A10: Final convictions under the Narcotic Substances Act (SMG), young people and adults, basis of conviction and type of punishment in 2008

Basis of conviction		Fine	Prison sentence			Other punishment[1]	Total
			Probation	No probation	Partial probation		
SMG total	Young people	76	92	28	14	20	230
	Adults	997	1.272	1.219	414	159	4 061
Section 28 SMG / Section 28 a SMG (felonies)	Young people	2	13	10	3	2	30
	Adults	38	344	635	236	49	1 302
Section 27 SMG (misdemeanours)	Young people	74	79	18	11	18	200
	Adults	949	907	560	174	109	2 699

Young people = person younger than 18 at the time of the offence

Until 2007: Section 28 SMG = trafficking, possession etc. of large quantities of narcotic drugs (commercial trafficking)
Section 27 SMG = trafficking, possession etc. of small quantities of narcotic drugs

As of 2008: Section 27 SMG = illicit handling of narcotic substances
Section 28 SMG = preparation of trafficking of narcotic substances
Section 28a SMG = trafficking of narcotic substances

[1] Other punishment: partial probation (Section 43(2) StGB), referrals to institutions (Section 21(1), 21(2), 22 and 23 StGB), no additional punishment (Section 40 StGB) and, only in the case of young people, conviction with punishment reserved (Section 13 JGG) and conviction without punishment (Section 12 JGG).

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

Source: Statistics Austria (criminal court statistics)

Table A11: Development of alternatives to punishment applied in Austria from 1999 to 2008

Waiving of reports/ suspension of proceedings	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total	6 989	8 049	8 145	8 974	9 023	9 666	11 660	10 379	10 175	9 384
Section 35 SMG (waiving of reports)	5 979	6 924	7 346	7 817	7 902	8 599	10 668	9 173	9 008	8 399
Of these: Section 35 (4) SMG (cannabis)	1 330	1 410	1 570	1 876	1 499	2 016	2 697	1 895	1 841	2 249
Section 37 SMG (dismissal of proceedings)	1 010	1 125	799	1 157	1 121	1 067	992	1 206	1 167	985

Until 2007: Section 35 SMG = temporary waiving of reports by the public prosecutor
Section 35 (4) SMG = waiving of reports in the case of small quantities of cannabis for personal use
Section 37 SMG = temporary dismissal of proceedings by the court

As of 2008: § 35 SMG = temporary deferment of charge by the public prosecutor's office
Section 35 (4) SMG = waiving of reports in the case of small quantities of cannabis for personal use
Section 37 SMG = temporary dismissal of proceedings by the court

Note: data on Section 39 of the SMG (suspension of sentence – therapy instead of punishment) are not available at present.

Source: BMG, calculations by GÖG/ÖBIG

Table A12: Number of seizures of narcotic drugs/substances in Austria from 1999 to 2008

Narcotic drug/substances	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Cannabis	5 079	4 833	5 249	5 294	5 422	6 202	6 012	5 770	5 732	5 050
Heroin	452	478	895	836	1 263	1 383	1 371	883	765	673
Cocaine	519	554	768	863	1 271	1 475	1 507	1 044	1 087	936
Amphetamines	–	141	161	202	294	324	312	299	319	262
LSD	56	42	32	20	33	29	20	20	39	20
Ecstasy	215	330	352	308	276	286	295	248	250	181
Psychotropic substances	74	65	1	0	6	5	2	2	10	1
Psychotropic medicines	517	501	566	515	432	678	823	1 300	1 019	843

– = not evaluated separately or not specified

Source: BMI/.BK

Table A13: Seizures of narcotic drugs/substances in Austria by quantity from 1999 to 2008

Narcotic drug/substances	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Cannabis (kg)	451	1 806	456	743.1	925.9	1 680.9	819.9	1 880.4	1 276.0	873.6
Heroin (kg)	78	230	288	59.5	42.8	235.0	282.2	34.3	117.0	104.0
Cocaine (kg)	63	20	108	36.9	58.3	75.5	244.9	61.8	78.1	78.38
Amphetamines (kg)	–	1	3	9.4	54.2	25.7	8.9	38.17	17.5	13.00
LSD (trips)	2 811	865	572	851	298	2 227.5	2 108.5	10 831.5	1 058	225.50
Ecstasy (number of pills)	31 129	162 093	256 299	383 451	422 103	122 663	114 104	30 855	66 167	45 335
Psychotropic substances (kg)	4.00	1.29	0.00	0.00	0.20	0.10	0.00	0.03	0.21	0.00003
Psychotropic medicines (units)	36 437	38 507	31 377	20 081	15 649	21 119	27 104	44 416	26 289	24 675

– = not evaluated separately or not specified

Source: BMI/.BK

Table A14: Ingredients of samples bought as ecstasy and analysed by the ChEck iT! Project at parties and clubbing from 1999 to 2008

Ingredients	Samples bought as ecstasy (percentages)									
	1999 (n=152)	2000 (n=319)	2001 (n=268)	2002 (n=269)	2003 (n=143)	2004 (n=93)	2005 (n=53)	2006 (n=134)	2007 (n=117)	2008 (n=146)
MDMA	86.2	83.4	77.2	68.0	83.2	72.0	67.9	74.6	60.7	61.6
MDMA + MDE		3.1	2.2	14.1	7.7	9.7		1.5		
MDMA + MDA		0.9	1.5	6.7				0.7		
MDE and/or MDA	0.7	1.3	7.1	0.4		7.5				1.4
MDMA + caffeine	1.3	1.6		0.7	0.7	1.1	5.7	5.2	0.9	0.7
MDMA + amphetamines	0.7	0.6	0.4		0.7		1.9	1.5		
MDMA + various combinations*	3.9	2.2	0.4		3.5	1.1	13.2		6.0	7.5
PMA/PMMA		1.3	0.4		0.7					
Amphetamines	3.3			1.9	1.4		1.9	4.5		0.7
Methamphetamine		0.6	2.6	1.5				0.7		
Caffeine		0.9		1.5		1.1		0.7	1.7	
Chinine/chinidine		0.6	1.1							
mCPP/mCPP + various combinations**								1.5	16.2	17.8
Various combinations*	3.9	3.4	7.1	5.2	2.1	7.5	9.4	9.0	14.5	10.3

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

** mCPP/and various combinations: mCPP and one or more additional substances

Source: Vienna Social Projects Association (VWS)

Table A15: Ingredients of samples bought as speed and analysed by the ChEck iT! Project at parties and clubbing from 1999 to 2008

Ingredients	Samples bought as speed (percentages)									
	1999 (n=67)	2000 (n=93)	2001 (n=51)	2002 (n=87)	2003 (n=57)	2004 (n=41)	2005 (n=33)	2006 (n=75)	2007 (n=129)	2008 (n=99)
Amphetamines	53.7	57.0	60.8	46.0	35.1	22.0	33.3	24.0	22.5	15.2
Amphetamines + caffeine	4.5	9.7	9.8	8.0	15.8	19.5	6.1	29.3	10.1	27.3
Amphetamines + methamphetamine	1.5									2.0
Amphetamines + various combinations*	20.9	7.5	3.9	17.2	29.8	39.0	24.2	24.0	31.8	34.3
Methamphetamine	7.5	3.2	2.0	3.4	1.8	2.4	3.0		10.1	1.0
Caffeine	1.5	3.2	11.8	8.0		4.9	9.1	1.3	1.6	3.0
MDMA	3.0	3.2		1.1			6.1	4.0		1.0
Ephedrine total										
Various combinations*	7.5	16.1	11.8	16.1	17.5	12.2	18.2	17	23.3	14.1
mCPP/mCPP + various combinations**									0.8	2.0

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

** mCPP/and various combinations: mCPP and one or more additional substances

Source: Vienna Social Projects Association (VWS)

Table A16: Number of persons currently registered for substitution treatment in Austria in the BMGFJ monitoring system by treatment/continued treatment and province in 2008

Treatment	B	C	LA	UA	S	St	T	VB	V
Continued treatment	155	306	1.175	716	401	963	453	458	4.883
First Treatment	36	90	228	261	71	123	53	93	592
Total	191	396	1 403	977	472	1.086	506	551	5 475

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

Note: **Continued treatment** means treatment started before the respective year, or repeated treatment of persons who have already undergone substitution treatment before. **First treatment** means treatment of persons who have never undergone substitution treatment before. The figures relate to treatments reported to the BMGFJ and in part differ considerably from the figures collected at provincial level.

The total number of substitution treatments in Austria is higher than the sum of substitution treatments by province since records of the provinces are incomplete in some cases.

Source: BMG, calculations by ÖG/ÖBIG

Table A17: Persons starting drug-specific treatment or assistance in 2008, by age and gender; percentages

Age	Short-term contacts			Low-threshold assistance			Long-term out-patient treatment			Long-term in-patient treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
0 to 4	0	0	0	0	0	0	0	0	0	0	0	0
5 to 9	0	0	0	0	0	0	0	0	0	0	0	0
10 to 14	1	2	1	4	6	5	1	1	1	0	0	0
15 to 19	18	25	20	15	18	16	14	25	16	8	17	11
20 to 24	29	28	29	23	27	24	32	33	32	36	34	35
25 to 29	19	17	18	26	25	26	22	20	21	24	27	25
30 to 34	12	9	11	15	12	14	12	9	11	13	10	12
35 to 39	8	7	8	9	5	8	8	5	8	9	5	8
40 to 44	7	6	7	5	4	4	6	4	5	6	4	6
45 to 49	4	4	4	3	2	3	3	2	3	3	1	3
50 to 54	2	1	2	1	0	1	2	1	1	1	1	1
55 to 59	1	1	1	0	0	0	1	0	0	0	1	0
60 to 64	0	0	0	0	1	0	0	0	0	0	0	0
65 to 69	0	0	0	0	0	0	0	0	0	0	0	0
70 to 74	0	0	0	0	0	0	0	0	0	0	0	0
75 to 79	0	0	0	0	0	0	0	0	0	0	0	0
80 or older	0	0	0	0	0	0	0	0	0	0	0	0
Valid indications	4 022	1 107	5 129	477	214	691	2 946	1 013	3 959	1 002	350	1 352
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Missing	–	–	–	–	–	–	–	–	–	–	–	–

Note: all lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Sampled population: all clients

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A18: Persons starting drug-specific treatment or assistance in 2008, by gender and livelihood; percentages

Livelihood/employment	Short-term contacts			Low-threshold assistance			Long-term out-patient treatment			Long-term in-patient treatment		
	Age			Age			Age			Age		
	< 20	20–29	> 29	< 20	20–29	> 29	< 20	20–29	> 29	< 20	20–29	> 29
Gainful employment	–	–	–	22	19	6	40	35	27	15	12	13
Registered as unemployed	–	–	–	10	29	34	23	36	36	20	50	42
Welfare assistance	–	–	–	2	10	11	4	11	15	11	12	13
Child, school student, university student	–	–	–	43	1	0	16	4	2	14	3	3
Military service, alternative military service, parenthood leave, retired	–	–	–	1	2	9	3	3	9	1	7	14
Housework, (re)training, other	–	–	–	1	2	1	6	3	3	4	2	2
No gainful employment, no other form of livelihood	–	–	–	6	9	7	5	3	3	5	2	2
No gainful employment, other form of livelihood unknown	–	–	–	15	28	32	3	4	5	30	12	11
Valid indications	–	–	–	136	282	171	653	2 043	1 098	138	777	377
Unknown	–	–	–	3	56	28	20	60	49	3	18	18
Missing	–	–	–	2	7	6	6	21	9	1	17	3

Note: all lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Sampled population: all clients

The corresponding data are not collected for short-term contacts

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A19: Persons starting drug-specific treatment or assistance in 2008, by place of residence and gender; percentages

Place of residence	Short-term contacts			Low-threshold assistance			Long-term out-patient treatment			Long-term in-patient treatment		
	Age			Age			Age			Age		
	< 20	20-29	> 29	< 20	20-29	> 29	< 20	20-29	> 29	< 20	20-29	> 29
Burgenland	–	–	–	–	–	–	2	2	2	3	2	2
Carinthia	–	–	–	–	–	–	12	8	6	6	3	0
Lower Austria	–	–	–	–	–	–	13	9	5	18	9	2
Upper Austria	–	–	–	–	–	–	10	9	6	13	12	5
Salzburg	–	–	–	–	–	–	3	5	6	6	2	4
Styria	–	–	–	–	–	–	7	5	4	15	12	9
Tyrol	–	–	–	–	–	–	12	11	9	6	9	15
Vorarlberg	–	–	–	–	–	–	19	12	9	14	9	10
Vienna	–	–	–	–	–	–	22	38	52	20	42	53
Foreign country	–	–	–	–	–	–	0	1	1	0	0	1
Valid indications	–	–	–	–	–	–	661	2 048	1 117	140	777	379
Unknown	–	–	–	–	–	–	13	50	32	2	31	16
Missing	–	–	–	–	–	–	5	26	7	0	4	3

Note: all lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Sampled population: all clients

The corresponding data are not collected for short-term contacts and low-threshold assistance.

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A20: Persons starting drug-specific treatment or assistance in 2008, by present housing situation and gender; Percentage

Present housing situation	Short-term contacts			Low-threshold assistance			Long-term care outpatient			Long-term care inpatient		
	Age			Age			Age			Age		
	< 20	20–29	> 29	< 20	20–29	> 29	< 20	20–29	> 29	< 20	20–29	> 29
Stable (e.g., flat of one's own)	–	–	–	71	27	35	90	87	83	83	79	80
Unstable (e.g., homeless)	–	–	–	19	54	43	5	8	8	11	13	10
In institution, plus stable housing situation	–	–	–	5	7	15	3	4	7	3	6	10
In institution, plus unstable housing situation	–	–	–	5	12	8	2	1	2	3	3	1
Valid indications	–	–	–	132	296	172	646	2 043	1 106	138	779	376
Unknown	–	–	–	8	42	27	29	61	46	1	31	20
Missing	–	–	–	1	7	6	4	20	4	3	2	2

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 variable „present housing situation" is not surveyed for short-term contacts.

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A21: Persons starting drug-specific treatment or assistance in 2008, by primary drug and gender; percentages

Primary drug (multiple indications admissible)	Short-term contacts			Low-threshold assistance			Long-term out-Patient treatment			Long-term in-patient treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Opioids	35	41	36	55	61	57	54	67	58	78	86	80
Heroin	28	29	28	35	35	35	36	43	38	54	52	54
Methadone	3	3	3	2	0	1	6	6	6	14	18	15
Other substitution substances	11	14	12	27	31	28	26	34	28	51	58	53
Other opioids, or opioids not specified	1	1	1	2	1	2	3	3	3	4	3	4
Cocaine group	9	8	9	10	10	10	12	9	11	25	21	24
Cocaine	9	8	9	10	10	10	12	9	11	25	21	24
Crack	0	0	0	0	0	0	0	0	0	0	1	0
Cocaine not specified	0	0	0	0	0	0	0	0	0	0	0	0
Stimulants	3	4	3	1	1	1	4	5	4	8	8	8
Amphetamines (e.g., speed)	2	3	3	0	1	0	3	3	3	7	6	7
MDMA (ecstasy), other derivatives	1	2	2	1	1	1	2	3	2	4	6	5
Stimulants not specified	0	0	0	0	0	0	0	0	0	0	0	0
Tranquillisers/hypnotics	10	14	11	14	18	15	10	14	11	19	24	20
Benzodiazepines	9	14	10	14	18	15	10	14	11	19	24	20
Barbiturates	0	0	0	0	0	0	0	0	0	0	0	0
Other hypnotics/tranquillisers	0	1	0	0	2	0	0	0	0	0	0	0
Hallucinogenic	0	1	0	0	0	0	1	1	1	2	3	3
LSD	0	1	0	0	0	0	1	1	1	2	3	2
Hallucinogenic drugs not specified	0	0	0	0	0	0	0	0	0	1	0	0
Cannabis	28	22	27	19	14	17	35	22	32	30	21	27
Solvents and inhalants	0	0	0	0	0	0	0	0	0	0	0	0
Alcohol	5	6	5	7	5	6	7	5	6	10	9	9
Biogenic drugs	0	0	0	0	0	0	0	0	0	1	0	0
Other drugs	0	0	0	0	0	0	0	0	0	0	1	0
Only use not relevant for treatment	35	31	34	9	8	9	4	5	4	0	0	0
Additional drug only	3	2	3	12	10	11	9	7	8	4	4	4
Valid indications	4 937	1 317	6 254	586	263	849	3 953	1 355	5 308	2 067	696	2 763
Number of persons with valid indications	3 618	957	4 575	424	196	620	2 537	865	3 402	909	306	1 215
Unknown	340	122	462	45	16	61	202	77	279	36	23	59
Missing	64	28	92	8	2	10	207	71	278	57	21	78

Note: all lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.

Bold type indicates main categories

Sampled population: all clients

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A22: Persons starting drug-specific treatment or assistance in 2008, by injecting drug use and age; percentages

Injecting drug use	Short-term contacts			Low-threshold assistance			Long-term out-patient treatment			Long-term in-patient treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
No	70	62	68	28	23	26	57	49	55	24	21	23
Yes	30	38	32	72	77	74	43	51	45	76	79	77
Valid indications	3 502	923	4 425	352	175	527	2 718	925	3 643	949	319	1 268
Unknown	444	161	605	89	29	118	178	72	250	43	24	67
Missing	76	23	99	36	10	46	50	16	66	10	7	17

Note: all lines except Valid indications, Unknown and Missing give percentages that relate to the number of valid indications. Unknown means that the field 'unknown' was indicated and Missing means that no indication was made.
Sampled population: all clients

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A23: Nationwide standardised interventions for addiction prevention implemented in schools, 2008

Programme: Eigenständig werden (Become independent)
Direct target group: children aged 6 to 10
Indirect target group: teachers in elementary schools

Province	Number of implemented workshops/ events, 2008	Number of lessons/ hours of training for multipliers, 2008	Number of accredited teachers, 2008	Percentage of teachers reached in 2008	Number of elementary schools reached in 2008	Percentage of elementary schools reached in 2008	Total number of teachers reached by end of 2008	Percentage of total number of teachers reached by end of 2008	Total number of elementary schools reached by end of 2008	Percentage of total number of elementary schools reached by end of 2008
B	0	0	0	0	0	0	101	12.62	55	27.23
C	1	24	12	0.6	9	0.4	143	6.43	61	24.01
LA	6	24	105	1.80	21	3.19	328	5.61	105	15.93
UA	12	n. v.	239	n. a.	46	n. a.	n. a.	n. a.	n. a.	n. a.
S	5	24	68	3.2	34	18	200	9.4	71	37.76
St	3	24	55	1.14	13	2.51	187	4.61	111	21.43
T	3	24	42	1.62	31	8.01	270	10.71	139	35.9
VB	6	24	110	6.76	15	9.03	155	9.53	28	16.86
V	7	24	171	3.19	18	2.97	836	15.61	200	74.35

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg; St = Styria, T = Tyrol, VB = Vorarlberg, V = Vienna, n. a. = not available

Note: the programmes „Step by Step“ and „feel.ok” are also implemented on a nationwide level, but only few trainings are currently organised. Therefore the corresponding numbers are not included here.

Sources: Akzente Suchtprävention - Fachstelle für Suchtvorbeugung Salzburg; Fachstelle für Suchtprävention Burgenland; Fachstelle für Suchtvorbeugung, Koordination und Beratung, Lower Austria; VIVID – Fachstelle für Suchtprävention, Styria; Institut Suchtprävention, Upper Austria; Kontakt+co – Suchtprävention Jugendrotkreuz, Tyrol; SUPRO – Werkstatt für Suchtprophylaxe, Vorarlberg; ISP Vienna; Landesstelle für Suchtprävention, Carinthia

Table A24: Selected, approved and continuously implemented interventions for addiction prevention

Setting	Name of the project/ programme (province)	Direct target group (age)	Indirect target group (multipliers)	Short description
Kindergarten	Spielzeugfreier Kindergarten (B); Toy-free kindergarten	Children aged 3 to 6	Kindergarten teachers	Over a period of around 3 months all prefabricated toys are removed from the groups. This is a period of intensive learning, in which children can make self-determined experience, develop social competence and find collective solutions to problems in the group. Children, parents and kindergarten teachers are carefully prepared for this period. The role of the kindergarten teachers changes from giving instructions for games to watching and supporting the group process.
Family	Elternvorträge (LA); Lectures for parents	Children and adolescents	Parents	Especially children, but also adolescents, are oriented towards the role models of adults and learn from their behaviour. If addiction prevention starts early in life, better protection factors can be developed against the emergence of addiction and the related risk factors can be reduced. The lectures for parents focus on ways to promote life skills in the family and on other issues of addiction prevention that matter in education.
Elementary school	Kinder stark machen – erlebnispädagogischer Workshop (VB); Strengthening our children - experience-based workshop	Children	Teachers	This intervention highlights joint group action in an exciting and challenging way in order to expand the children's own action competence, . Teachers jointly try out experience-based games and exercises that they can use as activities for the children without a lot of work input and special knowledge. They are shown how they can strengthen the personalities of the children, who learn how to observe boundaries and rules, how to handle success, disappointment and conflicts, to help someone and be helped by someone, and also to express feelings and needs. It is demonstrated how attractive activities will enhance the creativity and imagination of the children.
School (lower level)	plus (T)	School students aged 10 to 14	Teachers	The programme is aimed at the development of cognitive, social and emotional skills in order to facilitate coping with the tasks of adolescence, which reduces the probability of developing socially maladjusted and harmful behaviour, and especially of addiction risks and problems.
School (advanced level)	Suchtvorbeugung in der Schule als Entwicklungsaufgabe (C); Addiction prevention in school as development task	School students aged 15 to 19	Teachers, educators, parents	Since 2007 the Carinthian Tourism College has worked with a team of teachers and educators, in cooperation with the Landesstelle Suchtprävention (provincial agency for addiction prevention). In addition to strengthening the life skills of students, the aim is to critically examine organisational structures in schools that influence the daily work of teachers and students. The result is a package of interventions oriented towards various target groups. All activities are continually evaluated and improved upon suggestion. In the parallel working group, new themes can be discussed and adapted to current demands.
Vocational schools	LIZ – Lehrlinge im Zentrum (S); Apprentices in the centre	Apprentices	Teachers, trainers	This programme includes interventions for trainees as well as trainers and vocational schools. Its aim is early detection and intervention as well as distribution of knowledge regarding substances and addiction, and also the reflection about one's personal handling of substances (alcohol, cannabis etc.).
Youth social work in associations	Suchtprävention in Vereinen (St); Addiction prevention in associations	Youth	Youth commissioners, coaches …	In rural areas, fire brigades and football clubs are important partners in youth social work and thus also in addiction prevention. The programme *Brennpunkt Suchtprävention* (Addiction Prevention In Focus) addresses local youth commissioners, interested fire-fighters and football trainers as multipliers. In addition to the causes and development of addiction, the functions of role models and specific ways to achieve prevention are discussed within the association in question. In 2008 the district of Liezen (Styria) was included in the project as the 12th fire brigade district. Also in 2008, evaluation of the feedback on the project for addiction prevention in football associations yielded the best results since the start of the project in 2003.
Youth social work in recreational settings	Lehrgang Suchtprävention in der Jugendarbeit (V); Training programme: Prevention of addiction in youth social work	Youth	Youth workers in recreational settings	The programme is aimed at promoting professional attitude towards young drug users, developing skills and initiating addiction prevention projects as well as communicating practical approaches and methods of addiction prevention.
Federal Armed Forces	Lehrgang für Schlüsselpersonen im österreichischen Bundesheer (UA); Training courses for key actors in the Austrian army	Conscripts	Key actors in the Austrian army	During one week of special training, addiction and drug-related information is communicated, which includes causes, substances and their effects, prevention, early detection and drug help system.

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

Note: Only such projects/programmes have been selected, which meet the criteria of this report (see chapter 3), have continuously been implemented for more than one year and can serve as an example for different settings.

Sources: Akzente Suchtprävention - Fachstelle für Suchtvorbeugung Salzburg; Fachstelle für Suchtprävention Burgenland; Fachstelle für Suchtvorbeugung, Koordination und Beratung, Lower Austria; VIVID – Fachstelle für Suchtprävention, Styria; Institut Suchtprävention, Upper Austria; Kontakt+co – Suchtprävention Jugendrotkreuz, Tyrol; SUPRO – Werkstatt für Suchtprophylaxe, Vorarlberg; ISP Vienna; Landesstelle für Suchtprävention, Carinthia

Table A25: Duration of treatment of clients with opioids as primary drugs, who were in long-term inpatient or outpatient treatment in 2008, by age group

	Age (years)					
Duration of treatment	**19 or younger (n = 145)**	**between 20 and 29 (n = 1 093)**	**between 30 and 39 (n = 406)**	**between 40 and 49 (n = 172)**	**between 50 and 59 (n = 24)**	**60+ (n = 0)**
Up to 1 month	27.6%	20.8%	20.0%	16.3%	12.5%	0.0%
1 to 3 months	32.4%	27.7%	24.6%	23.8%	8.3%	0.0%
4 to 6 months	12.4%	14.9%	11.8%	12.8%	33.3%	0.0%
7 to 12 months	17.9%	16.0%	13.7%	15.7%	8.3%	0.0%
13 to 24 months	6.9%	13.1%	15.8%	14.0%	16.7%	0.0%
25 to 36 months	2.1%	4.5%	4.2%	7.0%	12.5%	0.0%
37 to 48 months	0.7%	0.9%	2.0%	1.7%	4.2%	0.0%
more than 48 months	0.0%	2.1%	4.9%	8.7%	4.2%	0.0%

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A26: Main impulse for contacting a drug help unit among clients with opioids as primary drugs, who were in long-term inpatient or outpatient treatment in 2008, by age group

	Age (years)					
Source of main impulse	**19 or younger (n = 422)**	**between 20 and 29 (n = 3 163)**	**between 30 and 39 (n = 1 362)**	**between 40 and 49 (n = 683)**	**between 50 and 59 (n = 141)**	**60+ (n = 4)**
Client's own initiative	38.9%	41.1%	48.6%	51.7%	55.3%	75.0%
Family	15.4%	10.4%	5.5%	3.8%	1.4%	0.0%
Drug help centre	9.3%	9.4%	9.7%	8.3%	12.1%	0.0%
General practitioner	3.4%	3.4%	4.5%	7.5%	7.8%	0.0%
Hospital	4.3%	4.1%	2.6%	4.2%	4.3%	0.0%
Social welfare office	5.2%	4.4%	4.9%	5.4%	5.7%	0.0%
Public Employment Service	0.7%	1.5%	1.7%	0.9%	0.0%	0.0%
Court order or obligation	11.5%	15.4%	11.5%	11.7%	9.9%	25.0%
School	0.7%	0.2%	0.0%	0.0%	0.0%	0.0%
Other	10.6%	10.1%	10.9%	6.4%	3.5%	0.0%

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A27: Main impulse for contacting a drug help unit among clients who were in long-term inpatient or outpatient treatment in 2008, by age group

Source of main impulse	Age (years)					
	19 or younger (n = 1196)	between 20 and 29 (n = 5 640)	between 30 and 39 (n = 2 297)	between 40 and 49 (n = 1 107)	between 50 and 59 (n = 257)	60+ (n = 14)
Client's own initiative	21.3%	32.7%	42.7%	43.9%	44.4%	42.9%
Family	14.9%	8.8%	5.7%	4.1%	3.1%	7.1%
Drug help centre	4.7%	8.1%	9.1%	10.2%	12.5%	7.1%
General practitioner	2.0%	3.2%	4.1%	6.0%	5.4%	7.1%
Hospital	3.6%	3.7%	3.0%	4.3%	3.1%	0.0%
Social welfare office	18.8%	9.6%	5.7%	6.0%	7.4%	0.0%
Public Employment Service	0.8%	1.1%	1.8%	1.4%	0.4%	0.0%
Court	22.7%	23.8%	17.2%	17.1%	16.3%	35.7%
School	3.8%	0.3%	0.0%	0.1%	0.0%	0.0%
Other	7.3%	8.7%	10.6%	7.0%	7.4%	0.0%

Source: GÖG/ÖBIG 2009a. DOKLI analysis of client year 2008

Table A28: Predominant form of heroin use among clients with opioids as primary drugs, who were in long-term inpatient or outpatient treatment in 2008, by age group

Form of use	Age (years)					
	19 or younger (n = 402)	between 20 and 29 (n = 2 924)	between 30 and 39 (n = 1 223)	between 40 and 49 (n = 622)	between 50 and 59 (n = 126)	60+ (n = 2)
Unknown	1.5%	2.7%	3.8%	4.5%	6.3%	0.0%
Injecting	31.8%	43.2%	61.4%	68.0%	69.8%	100%
Smoking	9.5%	7.1%	5.0%	3.2%	4.8%	0.0%
Oral	0.7%	0.9%	0.7%	1.9%	2.4%	0.0%
Snorting	56.5%	46.1%	28.9%	22.3%	16.7%	0.0%
Other	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A29: Predominant form of heroin use among clients who were in long-term inpatient or outpatient treatment in 2008, by age group

Form of use	Age (years)					
	19 or younger (n = 507)	between 20 and 29 (n = 3 606)	between 30 and 39 (n = 1 520)	between 40 and 49 (n = 749)	between 50 and 59 (n = 153)	60+ (n = 5)
Unknown	1.6%	2.7%	4.3%	4.5%	5.9%	0.0%
Injecting	28.2%	39.5%	56.8%	64.9%	66.7%	40.0%
Smoking	9.3%	7.8%	5.9%	4.7%	6.5%	20.0%
Oral	1.0%	1.1%	1.1%	1.6%	2.0%	20.0%
Snorting	60.0%	48.7%	31.9%	24.3%	19.0%	20.0%
Other	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%

Source: GÖG/ÖBIG 2009a. DOKLI analysis of client year 2008

Table A30: Predominant form of cocaine use among clients with opioids as primary drugs, who were in long-term inpatient or outpatient treatment in 2008, by age group

	Age (years)					
Form of use	**19 or younger (n = 358)**	**between 20 and 29 (n = 2 576)**	**between 30 and 39 (n = 1 024)**	**between 40 and 49 (n = 503)**	**between 50 and 59 (n = 92)**	**60+ (n = 2)**
Unknown	0.8%	2.9%	5.5%	5.2%	6.5%	0.0%
Injecting	20.4%	27.4%	36.2%	36.8%	30.4%	0.0%
Smoking	0.6%	1.6%	1.7%	1.2%	3.3%	0.0%
Oral	2.2%	1.6%	2.3%	2.6%	5.4%	0.0%
Snorting	76.0%	66.5%	54.3%	54.3%	54.3%	100%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A31: Predominant form of cocaine use among clients who were in long-term inpatient or outpatient treatment in 2008, by age group

	Age (years)					
Form of use	**19 or younger (n = 566)**	**between 20 and 29 (n = 3 629)**	**between 30 and 39 (n = 1 485)**	**between 40 and 49 (n = 689)**	**between 50 and 59 (n = 129)**	**60+ (n = 8)**
Unknown	1.6%	2.9%	5.3%	4.4%	6.2%	0.0%
Injecting	14.7%	23.3%	29.9%	32.2%	29.5%	0.0%
Smoking	1.4%	1.6%	2.1%	1.6%	2.3%	12.5%
Oral	2.8%	1.8%	2.4%	2.2%	4.7%	0.0%
Snorting	79.5%	70.4%	60.3%	59.4%	57.4%	87.5%
Other	0.0%	0.1%	0.1%	0.3%	0.0%	0.0%

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A32: (Median) age at first use of clients with opioids as primary drugs, who were in long-term inpatient or outpatient treatment in 2008, by age group

	(Median) age at first use		
Age group	**Heroin**	**Cocaine**	**Cannabis**
19 or younger	16	16	14
between 20 and 29	18	17	15
between 30 and 39	20	20	16
between 40 and 49	20	24	16
between 50 and 59	20	23	16
60+	42	42	30

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A33: (Median) age at first use of clients who were in long-term inpatient or outpatient treatment in 2008, by age group

	(Median) age at first use		
Age group	**Heroin**	**Cocaine**	**Cannabis**
19 or younger	16	16	14
between 20 and 29	18	18	15
between 30 and 39	20	20	16
between 40 and 49	20	24	16
between 50 and 59	20	24,5	16
60+	42	40	30

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A34: Clients in long-term inpatient or outpatient assistance in 2008 and selected sociodemographic and social indicators, by age

Variables	**Age (years)**				
	19 or younger (n = 1 232)	**between 20 and 29 (n = 5 804)**	**between 30 and 39 (n = 2 389)**	**between 40 and 49 (n = 1 149)**	**between 50 and 59 (n = 264)**
Women	39%	26%	23%	21%	21%
Treatment based on court order	42%	35%	24%	20%	23%
Living in Vienna	19%	32%	40%	37%	32%
Gainfully employed	39%	35%	30%	28%	22%
Unemployed	20%	36%	36%	29%	18%
Receiving welfare assistance	3%	9%	12%	12%	19%
Doing military service / alternative service / on parents leave / retired	2%	4%	8%	19%	29%
No compulsory school degree	14%	6%	5%	4%	4%
No higher degree of education except compulsory school leaving certificate	75%	56%	53%	56%	52%
Stable housing situation	94%	91%	90%	92%	94%
Living alone	11%	25%	35%	46%	54%

Note: As only 15 persons were 60 years and older, this age group is not represented here.

Source: GÖG/ÖBIG 2009a, DOKLI analysis of client year 2008

Table A35: Austrian population statistics by age group and gender in 2008

Age group	Men	Women	Total
0 to under 4 years	202 913	193 570	396 483
5 to under 9 years	210 277	199 475	409 752
10 to under 14 years	237 190	226 131	463 321
15 to under 19 years	256 937	244 180	501 117
20 to under 24 years	262 561	257 038	519 599
25 to under 29 years	274 626	271 012	545 638
30 to under 34 years	269 210	269 924	539 134
35 to under 39 years	320 249	320 497	640 746
40 to under 44 years	362 237	353 097	715 334
45 to under 49 years	339 206	332 301	671 507
50 to under 54 years	278 545	282 967	561 512
55 to under 59 years	241 273	250 651	491 924
60 to under 64 years	213 163	229 435	442 598
65 to under 69 years	224 524	251 910	476 434
70 to under 74 years	134 313	164 898	299 211
75 to under 79 years	114 675	161 503	276 178
80 to under 84 years	73 463	144 501	217 964
85 years or older	43 273	124 824	168 097
Total	**4 058 635**	**4 277 914**	**8 336 549**
0 to 14 years	650 380	619 176	1 269 556
15 to 29 years	794 124	772 230	1 566 354
30 to 44 years	951 696	943 518	1 895 214
45 to 59 years	859 024	865 919	1 724 943
60 to 74 years	572 000	646 243	1 218 243
75 years or older	231 411	430 828	662 239
Total	**4 058 635**	**4 277 914**	**8 336 549**

Source: Statistics Austria, 30th of June 2009, calculations by GÖG/ÖBIG

Map A1: Overview of provinces, provincial capitals and districts

Scale 1:2 500 000

ANNEX B

List of Abbreviations

ADHD	attention deficit hyperactive disorder
Aids	Acquired Immune Deficiency Syndrome
AKH	Vienna General Hospital
AMS	Public Employment Service
API	Anton-Proksch-Institut
ASK	drug outpatient clinic
BADO	(Vienna) Basic Documentation
BBRZ	Labour Training and Rehabilitation Centre
BDF	Federal Drug Forum
BGBl	Federal Collection of Statutes
BMASK	Federal Ministry of Labour, Social Affairs and Consumer Protection
BMeiA	Federal Ministry for European and International Affairs
BMF	Federal Ministry of Finance
BMG	Federal Ministry for Health
BMGFJ	Federal Ministry for Health, Family and Youth
BMI	Federal Ministry of the Interior
BMI/.BK	Federal Ministry of the Interior / Federal Criminal Agency
BMJ	Federal Ministry of Justice
BMLFUW	Federal Ministry of Agriculture, Forestry Environment and Water Management
BMLV	Federal Ministry of Defence
BMUKK	Federal Ministry for Education, the Arts and Culture
BMVIT	Federal Ministry for Transport, Innovation and Technology
BMWF	Federal Ministry for Science and Research
BZP	Benzylpiperazine
COFOG	Classification of Functions of Government
CRC	capture-recapture
CSR	Corporate Social Responsibility
DC	Drug Coordinator
DR	Drug Representative
DRD	drug-related deaths
DOKLI	nationwide documentation system of clients of drug help units in Austria
DTA	low threshold therapeutic centre for drug addicts
EDDRA	Exchange on Drug Demand Reduction Action
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMS	Epidemiological detection system
ENCARE	European Network for Children Affected by Risky Environments within the Family
ESPAD	European School Survey Project on Alcohol and other Drugs
EU	European Union

FGÖ	Health Austria Fund
g	gramme
GBL	gamma butyrolacetone
GHB	gamma hydroxybutyric acid
GÖG	Health Austria
GÖG/ÖBIG	Health Austria / Austrian Health Institute
GÖG/FGÖ	Health Austria / Healthy Austria Fund
HAV	hepatitis A virus
HBV	hepatitis B virus
HBVcAb	hepatitis B core antibody (= HBc-Ab)
HBVeAg	hepatitis B e antigen (= HBc-Ab)
HBVsAb	hepatitis B surface antibody (= HBs-Ab)
HBVsAg	hepatitis B surface antigen
HCV	hepatitis C virus
HCV-Ab	HCV antibody
HCV-RNA	RNA (ribonucleic acid) of the hepatitis C virus
HIV	human Immunodeficiency Virus
ICD-10	International Classification of Diseases and Related Health Problems
IFES	Institute for Empirical Research
ISD	Institute for Addiction Diagnostics
ISP	Addiction Prevention Institute
ITM	International College of Tourism and Management
i. v.	intravenous
JGG	Juvenile Court Act
JWH-018	Naphthalene-1-yl-(1-pentylindol-3-yl)-methanone
kg	kilogramme
l	litre
LSD	d-lysergic acid diethylamide
MA	Municipal Department
mCPP	meta-chlorophenyl piperazine
MDA	3,4-methylenedioxyamphetamine
MDE	3,4-methylenedioxy-N-ethylamphetamine
MDMA	3,4-methylenedioxy-methylamphetamine
mg	milligramme
NÖ	Lower Austria
ÖBIG	Austrian Health Institute
ÖGABS	Austrian Society of Pharmacologically Assisted Treatment of Addiction
OÖ	Upper Austria
OST	opioid substitution treatment

PCR	polymerase chain reaction
PMA	Paramethoxyamphetamine
ppm	parts per million
PSD	Psychosocial Services
PTBS	posttraumatic stress disorders
REITOX	European Information Network on Drugs and Drug Addiction (Réseau Européen d'Information sur les Drogues et les Toxicomanies)
SAM	Social, Safe, Active and Mobile
SDW	Addiction and Drug Coordination Vienna
SMG	Narcotic Drugs Act
SMZ	Centre of social medicine
SQ	Structured Questionnaire
ST	Standard Table
StGB	Criminal Code
TB	tuberculosis
THC	Tetrahydrocannabinol (main psychoactive ingredient of cannabis)
TILAK	Association of Tyrolean community hospitals
UNODC	United Nations Office on Drugs and Crime
VWS	Verein Wiener Sozialprojekte (Vienna Social Projects Association)
WBB	Wiener BerufsBörse
WGKK	Wiener Gebietskrankenkasse
WHO	World Health Organization

ANNEX C

Standard Tables & Structured Questionnaires

List of Austrian Standard Tables and Structured Questionnaires of 2009

The following list gives an overview of all Standard Tables and Structured Questionnaires drawn up for Austria in 2009 and submitted to the EMCDDA. Here, all Structured Questionnaires referred to in the text are mentioned, also those that were updated in previous years. If you are interested in obtaining any table or questionnaire please contact Ms Monika Löbau: monika.loebau@goeg.at

STANDARD TABLES 01: BASIC RESULTS AND METHODOLOGY OF POPULATION SURVEYS ON DRUG USE (Vienna)

STANDARD TABLE 02: METHODOLOGY AND RESULTS OF SCHOOL SURVEYS ON DRUG USE (ESPAD)

STANDARD TABLES 03: CHARACTERISTICS OF PERSONS STARTING TREATMENT FOR DRUGS (DOKLI)

STANDARD TABLES 03: CHARACTERISTICS OF PERSONS STARTING TREATMENT FOR DRUGS (Substitution treatments)

STANDARD TABLE 05: ACUTE/DIRECT DRUG-RELATED DEATHS

STANDARD TABLE 06: EVOLUTION OF ACUTE/DIRECT DRUG-RELATED DEATHS

STANDARD TABLE 07: NATIONAL PREVALENCE ESTIMATES ON PROBLEM DRUG USE

STANDARD TABLE 08: LOCAL PREVALE4NCE ESTIMATES ON PROBLEM DRUG USE

STANDARD TABLE 09: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (Anton Proksch Institute: HBV, HCV, HIV)

STANDARD TABLE 09: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (Lukasfeld short-term therapy department: HBV, HCV, HIV)

STANDARD TABLE 09: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (Marienambulanz drug outpatient department, Graz: HBV, HCV, HIV)

STANDARD TABLE 09: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (Vienna Social Projects Association (VWS) – Ganslwirt: HBV, HCV, HIV)

STANDARD TABLE 09: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (drug outpatient department of General Hospital Vienna: HCV, HIV) (latest update: 2008)

STANDARD TABLE 09: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (drug-related deaths: HCV, HIV) (latest update: 2008)

STANDARD TABLE 09: PREVALENCE OF HEPATITIS B/C AND HIV INFECTION AMONG INJECTING DRUG USERS (DOKLI: HBV, HCV, HIV)

STANDARD TABLE 10: SYRINGE AVAILABILITY (latest update: 2008)

STANDARD TABLE 11: ARRESTS/REPORTS FOR DRUG LAW OFFENCES

STANDARD TABLE 12: DRUG USE AMONG PRISONERS

STANDARD TABLE 13: NUMBER AND QUANTITY OF SEIZURES OF ILLICIT DRUGS

STANDARD TABLE 14: PURITY AT STREET LEVEL OF ILLICIT DRUGS

STANDARD TABLE 15: COMPOSITION OF ILLICIT DRUG TABLETS

STANDARD TABLE 16: PRICE AT STREET LEVEL OF ILLICIT DRUGS

STANDARD TABLE 18: OVERALL MORTALITY AND CAUSES OF DEATHS AMONG DRUG USERS

STANDARD TABLE 24: ACCESS TO TREATMENT (latest update: 2008)

STANDARD TABLE 34: TREATMENT DEMAND INDICATOR (TDI) DATA

STRUCTURED QUESTIONNAIRE 22/25: UNIVERSAL PREVENTION (latest update: 2007)

STRUCTURED QUESTIONNAIRE 23/29: PREVENTION AND REDUCTION OF HEALTH-RELATED HARM ASSOCIATED WITH DRUG USE (latest update: 2008)

STRUCTURED QUESTIONNAIRE 26: SELECTIVE PREVENTION (latest update: 2007)

STRUCTURED QUESTIONNAIRE 27: Part 1: TREATMENT PROGRAMMES (latest update: 2008), Part 2: QUALITY ASSURANCE TREATMENT (latest update: 2008)

STRUCTURED QUESTIONNAIRE 28: SOCIAL REINTEGRATION (latest update: 2006)

STRUCTURED QUESTIONNAIRE 31: TREATMENT AS AN ALTERNATIVE TO IMPRISONMENT APPLICABLE FOR DRUG USING OFFENDERS IN THE EUROPEAN UNION (latest update: 2006)

STRUCTURED QUESTIONNAIRE 32: POLICY AND INSTITUTIONAL FRAMEWORK (latest update: 2006)