

2017 Report on the Drug Situation

On behalf of the European Monitoring Centre for Drugs and Drug Addiction, Lisbon
and the Austrian Federal Ministry of Health and Women's Affairs

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Executive Summary

The Report on the Drug Situation in Austria primarily deals with the illicit drug situation and serves as both a national report to the Austrian Federal Ministry of Health and Women's Affairs and as Austria's contribution to the report on the drug situation in the European Union.

Drug Policy

Both the Austrian Addiction Prevention Strategy and the provincial addiction and drug strategies and plans pursue an all-encompassing approach, and distinguish between addiction as a disease and drug trafficking. The reporting period saw the adoption of the new framework plan 2016–20 of the province of Salzburg, which includes the step-by-step establishment of integrated service structures at the regional level. The term 'integrated services' refers to all-encompassing holistic care services for people addicted to different substances, with links between different types of service, measures, and care areas (specialised services, hospitals and related psychosocial services) along standard treatment paths.

The new 2017 *federal health target control agreement* also mentions the issue of addiction. For instance, the agreement states that addiction diseases must be taken into account – in accordance with Health Target 9 (promotion of psychosocial health in all population groups) – in the process of expanding the psychosocial health care structures in line with concrete needs. Another aim is to set up less complicated funding structures for addiction support services

Legal Framework

In May 2017, a set of measures for quality and safety in opioid substitution treatment was submitted by the Ministry of Health for examination in the context of the general evaluation procedure. The adoption process had not been completed at the time of drawing up the present report. Essentially, these measures constitute a treatment guideline, which permits the revocation of a number of provisions that have so far affected medical treatment. In addition, the guideline provides a more precise definition of the tasks of public health officers with regard to opioid substitution treatment, and it improves the cooperation between pharmacies, doctors and public health officers.

In the reporting period, the manual on the uniform enforcement of SMG Section 12 has been evaluated. Regional differences in the individual provinces with regard to enforcement practices, as well as with regard to views on the roles and tasks of public health officers have again become apparent. The manual has been revised, but an intensified regional exchange appears to be necessary in order to arrive at consistent approaches.

In 2016, the proportion of convictions due to violations of the SMG saw a decrease, as against the previous year, to slightly below the level of 2014. The number of diversionary measures adopted

in the context of criminal proceedings rose in 2016 compared to 2015; in particular, diversion in accordance with the SMG was offered much more frequently.

Drug Use

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, around 2% to 4% of the population have experience of ecstasy, cocaine and amphetamine, and between 1% and a maximum of 2% have experience of opioids. In recent years, the range of substances taken in the context of experimental use has been found to be widening, and in certain scenes and groups of young people, it also includes biogenic drugs, as well as solvents and inhalants. However, in most cases, use of illicit substances is limited to a short period in life.

A clear distinction must be made between experimental or intermittent drug use that involves low risks, and problem/high-risk drug use. In Austria, polydrug use involving opioids plays an important role in this context. In the present day, Austria has between 29 000 and 33 000 high-risk drug users of opioids (mostly combined with use of other illicit drugs, alcohol or psychopharmaceuticals). Between 12 000 and 17 000 persons are estimated to lean towards injecting drug use. Almost all available drug monitoring data indicate a decline in high-risk opioid use in the age group under 25. It is not yet certain whether this indicates a decrease in illicit drug use as such, or a shift towards other substances such as cannabis or methamphetamine. With regard to high-risk drug use, several deaths connected with (high-potency) ecstasy pills have been recorded. Even though the patterns of ecstasy use do not appear to have changed, the use of ecstasy appears to have become more dangerous due to pills containing very high doses.

Prevention

The current focus is on expanding the training programmes for multipliers, i.e. on supporting persons who have contact with children and young people and who can influence their beliefs and patterns of behaviour. These programmes include, for instance, Vorarlberg's life skills project *Gesundes Aufwachsen in Vorarlberg* [Growing up healthy in Vorarlberg], *startklar* [Ready to go] in Salzburg, or *Kleiner Leuchtturm* [Small lighthouse] in Vienna. A study investigated endeavours undertaken in Upper Austria to intensify addiction prevention in line with the provincial health goals, by conducting an online survey among multipliers. It became apparent that it has become harder to motivate towns and young people to take an active part in prevention activities.

Addiction Treatment

In outpatient treatment settings, a decrease in opioids as the primary drug was registered until 2013, whereas cannabis as the primary drug was increasing. This particularly applies to people taking up outpatient treatment for the first time. Drugs such as cocaine or stimulants have also become more relevant in quantitative terms. From 2013 to 2016, the above trend has, in fact, not continued or has not been as obvious. A positive development is that the in-treatment rate among problem users of opioids has significantly risen over time, to more than 60%.

Support and treatment services have increasingly been oriented towards integrative approaches, and focused on establishing regional networks. The existing services have been further developed in all areas, e.g. in order to ensure the availability of opioid substitution treatment in the long run, to improve contact with people with an immigration background or to enable appropriate social reintegration measures. In Upper Austria, a survey was conducted to investigate clients' satisfaction with opioid substitution treatment, and has confirmed that, as a rule, OST does work well. Recommendations for improvement have been made with regard to the option of injecting use, easier take-home regulations, and attitudes towards clients.

Harm and Harm Reduction

In 2016, a total of 146 fatal drug overdoses were recorded in the context of autopsies. Another 19 deaths, for which no autopsies were performed, are also most likely to have resulted from overdoses. A total of 165 fatal overdoses is thus assumed. The number of drug-related deaths has therefore been higher than in the past three years. The proportion of persons aged under 25 (15%) has moderately decreased as against the past few years (2015: 21%, 2014: 19%; 2013: 18%), but is significantly smaller than in the period from 2005 to 2011.

With regard to infection rates, hepatitis C continues to be a massive problem among injecting drug users. The proportion of hepatitis C infections in this group has been high for many years – up to 83% in 2016, depending on the source of data. However, the HIV prevalence rates have remained at a low level in the past 10 years (2016: 0–4%). The hepatitis B prevalence rates among injecting drug users have been fairly constant for many years (2016: 12% to 29%). The treatment options for drug users with HCV infections have been developed further: treatment is available both in hospitals (Vienna, Graz Innsbruck) – usually in cooperation with low-threshold centres – and also directly in low-threshold settings, as a directly observed therapy combined with opioid substitution treatment. The criteria for cost coverage by the health insurance funds of treatment with new, direct-acting antiviral agents have also been eased continually, by further lowering the degree of fibrosis that is required for cost coverage. However, there are still patients who are not eligible for cost coverage.

Drug Markets

The growing importance of virtual drug markets is increasingly influencing the behaviour of dealers and users. Drug manufacturing (of cannabis and synthetic drugs) plays a minor role in Austria. In 2016, a total of 35 857 crime reports in Austria concerned narcotic drugs, and the majority of those (30 184) related to cannabis or cannabis combined with other narcotic drugs. The number of crime reports relating to misdemeanours (33 704) was by far higher than the number of reports concerning felonies (2 153). Any changes in the number of crime reports may also be connected to the amendment to the SMG that entered into force in 2016. The development of the past 10 years shows an increase in crime reports relating to ecstasy and cannabis, and the number of seizures of these two substances has also risen. The number and quantities of medicines seized that contain narcotic drugs (including substitution medicines) have declined.

In 2016, a total of 27 896 reports concerned driving under the influence of alcohol, compared to 1 491 reports relating to impaired ability to drive due to narcotic drugs.

Prison

No information on illicit substance use during imprisonment has been made available. By the reference date of 1 April 2017, almost 10% (872) of inmates were in opioid substitution treatment, which represents a small increase compared to the previous reporting period.

Neither needle and syringe exchange programmes nor systematic hepatitis B vaccinations for all seronegative inmates are available in Austrian prisons. It has, however, been reported that particular attention is increasingly being paid to infectious diseases in prison. Upon commencing a prison sentence, all prisoners are tested for HIV, TB, HBV and HCV, and HCV genotype testing is conducted. In addition, treatment with new, direct-acting antiviral agents has been intensified in the prisons.

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Abbreviations

3-MMC	3-methylmethcathinone
4-MEC	4-methylethcathinone
6-MAM	6-monoacetylmorphine
A	Austria
AB-FUBINACA	N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide
abs.	absolute
AC	Addiction Coordinator
ADB-FUBINACA	N-[(1S)-1-(aminocarbonyl)-2,2-dimethylpropyl]-1-[(4-fluorophenyl)methyl]-1H-indazole-3-carboxamide
ADHS	attention deficit hyperactivity disorder
AGES	Austrian Agency for Health and Food Safety
AHIVCOS	Austrian HIV Cohort Study
AIDS	acquired immune deficiency syndrome
amph.	amphetamine(s)
AMS	Public Employment Service
ÄndG	amending act
AR	Addiction Representative
ART	antiretroviral treatment
ARV	antiretroviral
ATHIS	Austrian Health Interview Survey
b	billion
B	Burgenland
BADO	basic documentation of clients of drug services in Vienna
BASG	Austrian Federal Office for Safety in Health Care
BAST	Austrian Working Committee of Social Streetwork
BGBI	Federal Collection of Statutes
BMASK	Federal Ministry of Labour, Social Affairs and Consumer Protection
BMB	Federal Ministry of Education
BMBF	Federal Ministry of Education and Women's Affairs
BMEIA	Federal Ministry for Europe, Integration and Foreign Affairs
BMF	Federal Ministry of Finance
BMFJ	Federal Ministry of Families and Youth
BMG	Federal Ministry of Health
BMGF	Federal Ministry of Health and Women's Affairs (as of July 2016)
BMI	Federal Ministry of the Interior
BMI/.BK	Federal Ministry of the Interior/Federal Criminal Agency
BMJ	Federal Ministry of Justice
BMLV	Federal Ministry of Defence and Sports
BMUK	Federal Ministry of Education and Cultural Affairs
BMUKK	Federal Ministry of Education, Arts and Culture
BMVIT	Federal Ministry of Transport, Innovation and Technology

BMWF	Federal Ministry of Science, Research and Economy
BÖP	Professional Association of Austrian Psychologists
C	Carinthia
COFOG	Classification of Functions of Government
DAA	direct-acting antiviral agents
DC	Drug Coordinator
DLD	diagnosis and performance documentation of Austrian hospitals
DOKLI	nationwide documentation system of clients of Austrian drug services
DR	Drug Representative
e.g.	for example
EC	European Community
ed.	editor(s)
EDDRA	Exchange on Drug Demand Reduction Action
EDPQS	European Drug Prevention Quality Standards
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and other Drugs
et al.	and others
etc.	et cetera
EU	European Union
excl.	excluding
f	and following
FGÖ	Fonds Gesundes Österreich [Health Austria Fund]
FSG	Driving Licences Act
GBL	butyro-1,4-lactone
gGmbH	non-profit private limited company
GHB	γ-hydroxybutanoic acid
GÖG	Gesundheit Österreich [Health Austria]
GSpG	Gambling Act
HAART	highly active antiretroviral therapy
HAV	hepatitis A virus
HBSC	Health Behaviour in School-Aged Children [WHO survey]
HBV	hepatitis B virus
HBVc	hepatitis B virus core
HBVs	hepatitis B virus surface
HCV	hepatitis C virus
HCV-Ab	HCV antibody
HCV-PCR	HCV polymerase chain reaction
HCV-RNA	RNA (ribonucleic acid) of the hepatitis C virus
HiaP	Health in all Policies
HIV	human immunodeficiency virus
i.e.	that is
I.K.A.	interdisciplinary contact point
ICD-10	International Classification of Diseases and Related Health Problems
IFES	Institute for Empirical Social Studies
incl.	including

inp.	inpatient
ISD	Institute for Addiction Diagnostics
ISP	Addiction Prevention Institute
IVV	integrated prison administration system
JGG	Juvenile Court Act
kg	kilogram
LA	Lower Austria(n)
LBI	Ludwig Boltzmann Institute
LISA	list of doctors qualified to deliver opioid substitution treatment
LSD	d-lysergic acid diethylamide
m	million
max.	maximum
MDA	3,4-methylenedioxyamphetamine
MDE	3,4-methylenedioxy-N-ethylamphetamine
MDMA	3,4-methylenedioxy-methylamphetamine
MDMB-CHIMICA	(MDMB = N-[[1-(cyclohexylmethyl)-1H-indol-3-yl]carbonyl]-3-methyl-valine, methyl ester)
mg.	milligram
min.	minimum
MMC	4-methylmethcathinone
n.a.	not available
NGO	non-governmental organisation
no.	number
NÖGKK	Lower Austrian health insurance fund
NÖGUS	Lower Austrian health and social care fund
NPS	new psychoactive substance(s)
NPSG	Act on New Psychoactive Substances
NPSV	Regulation on New Psychoactive Substances
ÖAKDA	Austrian Working Group for Communicative Drug Work
ÖBIG	Österreichisches Bundesinstitut für Gesundheitswesen [Austrian Health Institute]
ÖGABS	Austrian Society of Pharmacologically Assisted Treatment of Addiction
ÖGAM	Austrian Society of General Practice and Family Medicine
ÖGKJP	Austrian Society of Child and Adolescent Psychiatry
ÖGPB	Austrian Society of Neuropsychopharmacology
OST	opioid substitution treatment
outp.	outpatient
ÖVDF	Federation of Austrian Professionals Working in the Field of Drug Abuse
para.	paragraph
PMA	paramethoxyamphetamine
PMMA	parametoxymethamphetamine
PSD	Psychosocial Services
PSZ	Psychosocial Centres
QGIS	Quantum geoinformation system
RARHA	Reducing Alcohol Related Harm Alliance

REITOX	European Information Network on Drugs and Drug Addiction (Réseau Européen d'Information sur les Drogues et les Toxicomanies)
S	Salzburg
SAG	Prevention as a Community Task
SDW	Vienna Addiction and Drug Coordination
SHH	Schweizer Haus Hadersdorf treatment centre
SHW	Vienna Addiction Services
SMG	Narcotic Substances Act
SQ	Structured Questionnaire
ST	Standard Table
St	Styria
StGB	Criminal Code
StPO	Code of Criminal Procedure
StVG	Execution of Sentence Act
StVO	Road Traffic Act
SV	Narcotic Drugs Regulation
SVR rate	sustained virological response rate
SY	school year
T	Tyrol
Tb	tuberculosis
TDI	Treatment Demand Indicator
TEDI	Trans European Drugs Information
THC	tetrahydrocannabinol
TP-IgM-AB ELISA	Treponema pallidum immunoglobulin M-antibody enzyme-linked immuno- sorbent assay
TPHA	Treponema pallidum particle agglutination assay
UA	Upper Austria
V	Vienna
v.	versus
Vb	Vorarlberg
VDRL	venereal disease research laboratory
VIDRO	Virtual drug trafficking project
VSSS	Verona Service Satisfaction Scale
WHO	World Health Organization
WPI	Viennese pati

Introduction

This is the 22nd time that the REITOX Focal Point at GÖG (Gesundheit Österreich GmbH), ÖBIG business unit (GÖG/ÖBIG), is presenting its annual report to the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) and the Austrian Federal Ministry of Health. The REITOX Focal Point is a central link in Austria's data and information network for drug-related matters and cooperates very closely with the relevant federal and provincial authorities in the field, as well as with addiction and drug treatment and support services.

The Report on the Drug Situation in Austria primarily deals with the illicit drug situation and serves as both a national report to the Austrian Federal Ministry of Health and as Austria's contribution to the report on the drug situation in the European Union. Similar reports are being submitted by the REITOX Focal Points of all EU Member States and by the EU candidates, in accordance with guidelines issued by the EMCDDA. They form an essential basis for the EMCDDA's European Drug Report.

Since 2015, instead of the chapters-based structure of prior reports, the report has consisted of independent workbooks, in accordance with the new EMCDDA guidelines. Each workbook includes a table of contents, a summary, bibliographic references, and in some cases, an annex. Their main part consists of three sections: current situation (national profile), trends, and new developments. Whereas the information in the section on new developments – as in the prior reports – relates to the previous year, this does not apply to the other subchapters. The first section attempts to provide an overview of the current political framework, structures and measures, as well as the present epidemiological situation (routine data from statistics for the previous year). The section on trends describes developments over the past 10 years wherever possible. Each main part is followed by a section on sources and methodology, in which the sources used and the studies and surveys quoted are described in more detail. For the Austrian national report, the workbooks have been compiled to form a single report, in order to continue the tradition of past years.

The present report is based on the previous reports on the drug situation, and makes repeated reference to them for further details. In addition to the report on the drug situation in Austria, standard tables are provided, which are integrated into the EMCDDA's Statistical Bulletin¹. In order to illustrate the Austrian structures and the great variety of measures taken, specific examples have been consistently selected. Whenever possible, they have been oriented towards the EDDRA database of the EMCDDA or specific measures of interest to the EMCDDA, and do not claim to constitute a ranking.

This report is based on a large volume of varied data and information communicated to GÖG by numerous experts in the field of drugs. In this respect, the reports on the drug situation in the

¹

Please visit <http://www.emcdda.europa.eu/data/stats2016> (accessed on 8 June 2016).

individual Austrian provinces drawn up by the drug and Addiction Coordination offices are especially significant. In addition, a number of experts have contributed background information and specific data for individual chapters of the present report. We would like to express our gratitude for their cooperation. We are especially indebted to the members of the advisory working group of the REITOX Focal Point Austria for their helpful comments and invaluable input.

Drug policy

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1 Drug Policy

1.1 Summary

National profile

Austria's addiction/drug policy is primarily governed by laws and regulations, as well as drug/addiction strategies and plans. Even though it aims at a society as free of addiction as possible, addiction is regarded as a disease, and is thus distinguished from pure drug trafficking. In this context, the goal to reduce to a minimum the negative consequences for the population that result from behavioural addictions and use of psychotropic substances has played an increasingly important role. Both the Austrian Addiction Prevention Strategy – Strategy for coherent prevention and addiction politics, as well as the provincial addiction and drug strategies and plans, pursue an all-encompassing approach, in which different forms of addiction are taken into account. In addition to the addiction/drug strategies or plans, other strategies in the health and social care sector are relevant – for instance, the Health Targets Austria at the federal level, as well as specific strategies concerning alcohol at the provincial level.

Outcome orientation is regarded as a key public management principle in Austria, but external evaluations of strategies or laws – and thus also of addiction/drug policy legislation – are not often conducted. As a rule, working groups are convoked, which focus on specific aspects and draw up recommendations for the further development of addiction prevention and support services, based on the existing documentation systems, as well as on practical experience.

At the federal level, the main drug policy actors are the *Federal Drug Coordination Office* and the *Federal Drug Forum*, and at the provincial level, the *addiction/drug coordination offices* and the *addiction/drug representatives or advisory boards*. The Federal Drug Forum coordinates the federal and provincial levels, as well as different sectors. The Provincial Conference of Drug Coordination Offices is another body worthy of mention. *ARGE Suchtvorbeugung* is a key coordinating body at the national level.

Systematic information on public expenditure for the implementation of drug policy measures cannot be given for Austria as the COFOG classification², use of which is encouraged by the European Union (EU), has not been fully implemented, and drug- or addiction-related expenditure is not often explicitly specified in the relevant budgets.

2

The COFOG Classification of Functions of Government comprises 10 divisions, which are further divided into groups and classes.

In Austria, only figures on expenditure broken down by COFOG divisions are available, but not by groups and classes.

New developments

The new federal health target control agreement (*Zielsteuerung-Gesundheit 2017*) is the first one ever to mention the issue of addiction. For instance, the agreement says that addiction diseases must be taken into account – in accordance with Health Target 9 (promotion of psychosocial health in all population groups) – in the process of expanding the psychosocial health care structures in line with concrete needs, and another aim is to set up less complicated funding structures for addiction support and treatment services. Apart from this, addiction is only mentioned in a sentence referring to the implementation of the Austrian Addiction Prevention Strategy.

Salzburg's new *framework plan for addiction support and treatment services* (Land Salzburg 2016) provides the basis for the step-by-step establishment of integrated service structures at the regional level in the province of Salzburg. In this context, the term 'integrated service structures' refers to all-encompassing services for addicted patients, across different substances, which link the available support and treatment services and service providers.

1.2 National profile

1.2.1 Addiction and drug strategies

The Narcotic Substances Act (SMG; BGBl. I 1997/112), as well as the corresponding supplementary regulations (see chapter 2) and the Austrian Addiction Prevention Strategy (BMG 2015), constitute the main framework of **Austria's drug policy**. They form the basis for the key principles of Austria's drug policy: they are characterised by having the declared goal of a society as free of addiction as possible; while accepting addiction as a disease, they distinguish between dependence on the one hand and drug trafficking on the other. The principle of treatment instead of punishment, which is applied all over Austria, has been referred to as the 'most noticeable element of Austrian drug policy' by the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction; EMCDDA 2014). In 1971, this principle was integrated into the then Narcotic Drugs Act and has since then been expanded.

The Austrian Addiction Prevention Strategy relates to both legal and illicit drugs, as well as to non-substance-related forms of addiction and – in addition to the Austrian *child and adolescent health strategy* (BMG 2011), as well as the federal *Health Targets Austria* (BMGF 2017) – constitutes a further national strategy that follows the principle of health in all policies. Taking into account the existing provincial addiction/drug strategies, it provides a framework for orientation with regard to all addiction-related activities undertaken in Austria, as well as their advancement. In contrast to an action plan, it does not include detailed individual measures, but rather defines a common societal approach to addiction and the corresponding positions towards persons suffering from addiction. It is oriented towards a health perspective and presents an all-encompassing approach to prevention (which includes not only prophylactic measures but also treatment and harm reduction), and underlines the importance of a wide range of available measures. With regard to *illicit*

drugs, the strategy emphasises that advice, as well as medical treatment, psychological and social counselling, are given priority to criminal prosecution. Persons who traffic in illicit drugs on a commercial basis should be prosecuted, whereas illicit drug users, rather than being punished, need to have access to a diversified range of services, from prevention, advice, emergency services/harm reduction and treatment to health-related rehabilitation, as well as occupational and social integration. In addition to traditional security interventions to control drug trafficking, measures need to be taken at the levels of social policy, health policy and infrastructure in order to enhance public security and ensure that people feel safe.

Due to the federal structure of Austria's health and social care system, the **provinces** play important roles in the formulation and implementation of drug policy measures. All nine provinces have drawn up their own addiction/drug strategies in which their addiction/drug policy goals and areas of intervention have been laid down. The first provincial drug strategy was adopted in Vorarlberg in 1980, and the last province to prepare one was Upper Austria, in 2002. Several provincial strategies have seen updates and additions in recent years (see Table 1.1); for instance, in 2016 Salzburg adopted a new framework plan (see section 1.3). In Vorarlberg, the issue of addiction is examined in *Vorarlberg's psychiatry strategy 2015–25*; no update of the current drug strategy is currently planned.

Table 1.1:
Addiction/drug strategies of the Austrian provinces

PRO V.	(First version), updated in	Title	By (responsible editor)	Focus on drugs/on addiction	Main areas/structure
B	2002	Burgenländisches Suchtkonzept [Burgenland addiction plan]	Office of the Provincial Government of Burgenland	Illicit substances, alcohol	Prevention, health-related measures, social interventions, security
C	(1995) 2011	Landessuchtplan Kärnten 2011-16 [Carinthian provincial addiction plan 2011-16]	Office of the Carinthian Provincial Government	Illicit substances, legal substances, behavioural addictions	Service structures, young people, old age, quality
LA	(2000) 2016	NÖ Suchtstrategie 2016 [Lower Austrian addiction strategy of 2016]	Lower Austrian Addiction Prevention Unit	Illicit substances, legal substances, non-substance-related forms of addiction	Basic concepts, goals, measures (by type of addiction, fields of intervention such as advice, treatment and harm reduction, as well as specific target groups)
UA	2002	Oberösterreichisches Sucht- und Drogenkonzept [Upper Austrian addiction and drug plan]	Expert group on behalf of the Addiction Advisory Board	Illicit substances, legal substances, non-substance-related forms of addiction, psychoactive substances	Prevention, health-related measures, social interventions, security
S	(1999) 2016	Suchthilfe im Land Salzburg. Rahmenplan 2016 bis 2020 [Addiction services in the Province of Salzburg - framework plan 2016-20]	Working group with health and social care experts	Illicit substances, legal substances, medicines, gambling and other behavioural addictions	Addiction prevention; integrated addiction services in the areas of low-threshold liaison, advice, treatment and rehabilitation as well as aftercare; integrated services in the individual regions
St	(2000) 2012	Die neue Steirische Suchtpolitik [new Styrian addiction policy]	Office of the Styrian Provincial Government	Illicit substances, legal substances, psychoactive medicines, non-substance-related forms of addiction and patterns of behaviour, products for enhancing motivation and performance	Prevention of addiction, support and treatment services, steering
T	(1993) 2012	Tiroler Suchtkonzept 2012 [Tyrolean addiction plan of 2012]	Office of the Tyrolean Provincial Government / Gesundheit Österreich Forschungs- und Planungs GmbH	Illicit substances, legal substances, non-substance related forms of addiction	Prevention of addiction; advice, treatment and aftercare; structural reorientation of support and treatment services; cooperation with national actors; research and further training
Vb	(1980) 2002	Vorarlberger Drogenkonzept 2002 [Vorarlberg drug plan of 2002]	Addiction Coordinator and Drug Representative	Illicit substances	Prevention, treatment services, substitution, rehabilitation, educational initiatives
V	(1999) 2013	Wiener Sucht- und Drogenstrategie 2013 [Viennese addiction and drug strategy of 2013]	Vienna Addiction and Drug Coordination Office	Illicit substances, legal substances, non-substance related addictive behaviour	Prevention of addiction; advice, treatment and care; labour market policy measures; social (re)integration; public spaces; security

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

Sources: ÖBIG 2000, SDW 2013, Amt der Steiermärkischen Landesregierung (2011), Amt der Tiroler Landesregierung / Gesundheit Österreich Forschungs- und Planungs GmbH (2012), Amt der Burgenländischen Landesregierung (2002), Land Salzburg (2016), Amt der Kärntner Landesregierung (1995), Amt der Vorarlberger Landesregierung (2002), Fachstelle für Suchtprävention NÖ (2016), Suchtbeirat des Landes OÖ (2002)

The provincial strategies are structured in different ways – most of them tend to be organised by individual areas of intervention, and some of them also by target groups and/or structures. They therefore list different main areas. While quality assurance and (further) training are treated as a separate main area in several strategies, only one strategy specifies documentation as a main area and one, research.

At first, the provincial plans or strategies were oriented primarily towards illicit substances, but meanwhile most of them have adopted a broader view of addiction, and thus encompass both illicit and legal substances, as well as other forms of addictive behaviour. Only Vorarlberg still focuses on illicit substances. However, certain aspects of addiction have meanwhile been integrated into Vorarlberg's psychiatry strategy, where they are treated in an all-encompassing way. The revisions of the original strategies – irrespective of the forms of addiction covered – generally include a reorientation towards all-encompassing approaches that integrate both the individual level and also social environments, and aim at improving the quality of life of all persons concerned. The goal of reducing to a minimum the negative consequences for the population that result from the use of psychotropic substances and behavioural addictions has thus played an increasingly important role.

For further details on goals and priorities in the individual areas of intervention (prevention, treatment, etc.) please consult chapters prevention, treatment and harms. Generally speaking, all strategies are oriented towards a balanced approach combining health policy interventions and interventions aimed at reducing supply and demand. Prevention plays a key role in all provinces; e.g. Salzburg has adopted a specific framework plan for prevention (see ÖBIG 2001).

In addition, a number of **strategies at the federal and provincial levels** that do not specifically focus on addiction or drugs but on general health and social care matters, as well as the various government policy statements, are also relevant. The child and adolescent health strategy (BMG 2011) and the Health Targets Austria (BMGF 2016, BMGF 2017), the health target control system³ (see section 1.3), as well as the federal health promotion strategy (BMG 2014) are a few examples of papers at the federal level, out of the large number of strategies in this field. For instance, the child and adolescent health strategy includes the top area of healthy development, and mentions the furthering of life skills among children and young people as one of its goals. The Health Targets Austria include the target 'to promote psychosocial health in all population groups'. General health goals have been adopted in several provinces (e.g. Vienna), as well as at the local level (e.g. for Linz, Upper Austria): some of them include clearly defined measures for the area of addiction services (see chapter 5). The structural and psychiatric plans at the federal and the provincial levels are further documents with particular relevance for the area of treatment. For instance, *Vorarlberg's psychiatry strategy 2015–25* emphasises the need for orienting the provision of support services towards specific social spaces by establishing regional contact points for clients with

3

For further information please visit https://www.bmgf.gv.at/home/Gesundheit/Gesundheitsreform/Zielsteuerung_Gesundheit_ab_2017 (accessed 10 July 2017).

psychological, health and social problems, with clearly defined competences (Amt der Vorarlberger Landesregierung 2014).

Apart from the Austrian Addiction Prevention Strategy and the provincial strategies (see also chapter 4), the relevant framework with regard to legal drugs is also defined by laws (see chapter 2).

1.2.2 Evaluation of national drug strategies

Only a small number of addiction/drug strategies explicitly stipulate an evaluation of strategies or of the measures listed in them; however, outcome orientation is a central public management principle in Austria. Therefore, monitoring systems – of differing scope and degree of detail – have been established at the federal and political levels to, for instance, keep track of the drug situation and to help advance the existing system of addiction/drug support services and strategies. Internal evaluations are also carried out to this effect, and in addition, external evaluations are commissioned in certain cases. The Austrian Addiction Prevention Strategy also mentions evaluation and quality assurance as key instruments of planning and control (BMG 2015).

Internal evaluations are usually carried out by working groups which analyse the existing data and field experience and derive recommendations for further development from them. For instance, Salzburg evaluated its drug and addiction services system in recent years in order to prepare a more comprehensive framework plan on this basis (see Weigl et al. 2014). The members of the evaluation working groups came from the service providers involved, and focused on the areas of addiction prevention, advice/support/treatment, as well as (re)integration. They assessed the existing activities with regard to both quality and quantity, and drew conclusions for further development. It was decided to plan an integrated addiction support and treatment system on this basis (Schabus-Eder, personal communication).

Tyrol saw an environmental analysis of the current epidemiological situation, as well as of the available support and treatment services. The environmental analysis was conducted by ÖBIG Forschungs- und Planungsgesellschaft, drawing on the results of a provincial working group (ÖBIG Forschungs- und Planungsgesellschaft 2009). The recommendations that have been derived from it include the expansion of the drug plan towards an addiction plan, preserving the flexibility of the support and treatment services to enable appropriate responses to, for instance, changing patterns of use, as well as taking holistic approaches into account when planning and funding support and treatment services.

The most recent evaluation report is on the Lower Austrian addiction plan and was drawn up the Addiction Prevention Unit (see also Weigl et al. 2016). From the evaluation, numerous recommendations have been derived and integrated into the new addiction strategy. They include both responsible approaches to nicotine and alcohol, with regard to role model functions, as well as measures aimed at destigmatising addiction and dependence (Fachstelle für Suchtprävention NÖ 2016).

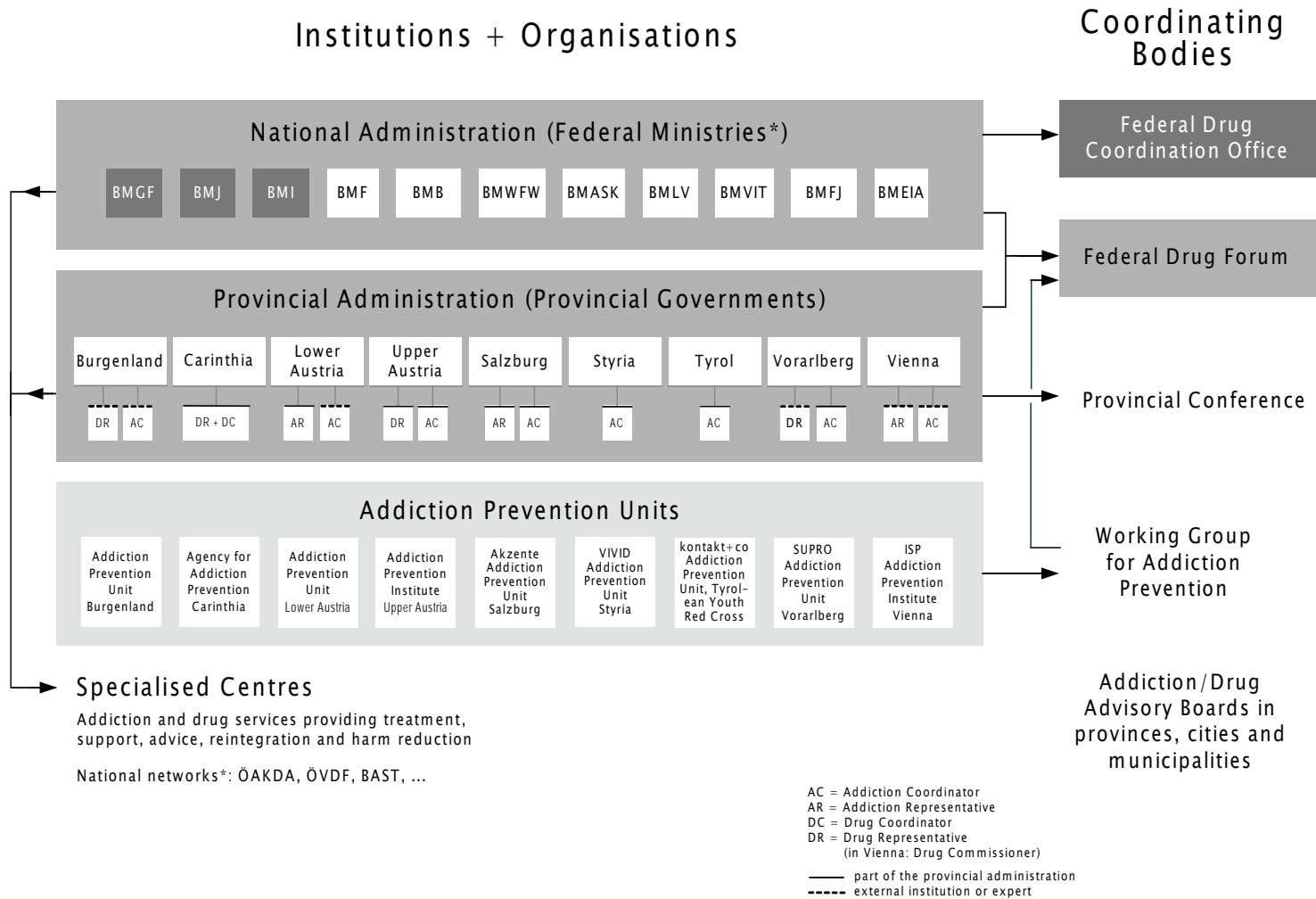
1.2.3 Drug policy coordination

At the federal level, the central actors in the field of drug policy are the *Federal Drug Coordination Office*, the *Federal Drug Forum*, the body that coordinates policies with the provinces (see Figure 1.1), as well as the *Committee on Quality and Safety in Substitution Treatment* (see also chapter 5). These bodies focus exclusively on illicit substances and the problems related to their use, as laid down in the Narcotic Substances Act or the New Psychoactive Substances Act. The main responsibility for coordinating the federal drug policy, i.e. cooperation at the federal level and with the provinces, rests with the Federal Ministry of Health, which also chairs the Federal Drug Coordination Office. Representatives of the Federal Ministries of the Interior and of Justice are permanent members of the *Federal Drug Coordination Office*, and additional ministries can be involved on an ad-hoc basis. The Ministry of Health also chairs the Federal Drug Forum, in which other federal ministries and the provinces, as well as the Local Governments Federation, GÖG and ARGE Suchtvorbeugung (the coordinating body of the addiction prevention units), are represented, and further experts and academics can be invited as well.

All provinces nominate addiction/drug coordinators who plan, coordinate and link addiction/drug policies, as well as support and treatment measures, at the provincial level. Furthermore, they provide expert consultancy to the provincial governments and draw up statements for bills, and they are in charge of public relations work in their field of expertise. The coordinators liaise with the federal authorities and are therefore represented in the *Federal Drug Forum*.

The Provincial Conference of Drug Coordination Offices, where joint positions and statements are prepared, is another networking body linking the individual provinces. The majority of provinces have also nominated addiction or drug representatives. In Tyrol, a special *addiction advisory board* has instead been established for expert consultancy, and in Styria this task is taken over by the *Addiction Policy Forum*. Other provinces have also nominated additional addiction advisory boards.

Figure 1.1:
The organisational structure of drug policy in Austria



* see List of Abbreviations.

Expert commissions for substitution treatment for opioid users exist in all provinces (see chapter 5). Additional networking bodies at the provincial level cooperate with the relevant authorities and with support and treatment services, either separately or jointly (e.g. in the Styrian SAG working group⁴ – see chapter 4 – and the Board of Drug Experts). Furthermore, drug advisory boards or similar bodies have been established at local or district levels. For instance, Salzburg has steering groups for prevention in specific settings (school, families, including childcare outside families, as well as young people at work and in recreational settings) that plan prevention measures in cooperation with the Addiction Coordination Office. Once a year, an exchange across different settings takes place. The steering group is composed of members of the relevant organisations – which either represent specific target groups or provide prevention services in the respective setting – as well as the Addiction Coordination Office.

Each province runs an addiction prevention unit, which is linked with the other units in the coordinating body *ARGE Suchtvorbeugung*. The first unit was founded in Vorarlberg in 1993.

Other processes at the federal and provincial levels are also relevant with regard to both strategic directives and coordination and cooperation structures. Since 2013, they have included the joint health target control system of the federal and provincial governments as well as the social insurance funds, and the monitoring that is conducted parallel to the implementation of the Health Targets Austria and the federal health promotion strategy⁵. For instance, the *Provincial Psychiatry Advisory Board of Vorarlberg* functions as a coordination and information body for all partners in the psychosocial care system, and is composed of members of the coordination committee as well as the permanent working groups (Amt der Vorarlberger Landesregierung 2014). One of the working groups focuses on *care for addicted patients, and support and treatment services*.

1.2.4 Drug-related (public) expenditure

Drug policy measures are funded primarily by the provinces (through the health, social care and education budgets), the social insurance funds and the federal government (funding, by the Federal Ministry of Justice, of the treatment instead of punishment programme and funding, by the Ministry of Health, of services established under Section 15 of the Narcotic Substances Act; see chapter 2 and 5). In Austria, the COFOG classification, use of which is encouraged by the EU, has not been fully implemented, and besides, drug- or addiction-related expenditure is not usually specified in the respective budgets (see GÖG/ÖBIG 2007). Therefore, no conclusive and systematic statements on addiction-related public expenditure can be made for Austria. At the federal level,

4
SAG = Prevention as a Community Task.

5
For further information please visit http://www.gesundheitsziele-oesterreich.at/wp-content/uploads/2014/10/rah-mengesundheitsziele_english.pdf (accessed 18 July 2016).

only expenditure for health-related measures (treatment) incurred by the Federal Ministry of Justice (BMJ), particularly in the context of diversion in accordance with SMG Sections 35 and 37, as well as due to suspension of sentence in accordance with SMG Section 39, has been announced. Under SMG Section 41, the Federal Government is legally required to provide subsidiary cost coverage for the above measures (see chapter 2). Table 1.2 represents the development of this expenditure, which has slightly decreased in 2016 as against the previous year. The effects of the cost reduction resulting from the change in the BMJ directives in 2011 (see chapter 2) are still being felt, but in 2016, the cost incurred was only approximately 4% below the 2011 figures. The provinces, in turn, have since 2011 more often been ready to bear the cost of long-term inpatient treatment. This, however, also means that the administration of financing is getting more complicated. Less complicated structures for funding addiction-related advice and treatment would thus be very helpful for all stakeholders (see also section 1.3).

Table 1.2:
Expenditure of the Austrian Ministry of Justice for addiction treatment in accordance with SMG Sections 35, 37 and 39; from 2007 to 2016

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Expenditure (million EUR)	5.86	6.48	7.03	8.54	8.77	8.46	7.71	7.71	8.44	8.41

Source: BMJ 2017; graphic representation: GÖG

In addition, individual reports from the provinces and studies on drug-related expenditure have been repeatedly made available (see also Weigl et al. 2014). According to the most recent study, public expenditure in the area of addiction prevention in Austria amounted to EUR 7.0 million in 2012 (BMG 2016 and Weigl et al. 2016).

1.3 New developments

The new Austrian Addiction Prevention Strategy (BMG 2015) has been discussed in detail in the previous report (Weigl et al. 2016). The Ministry of Health is in charge of coordinating the implementation of the Strategy. As prevention is a cross-sectional matter, it is necessary to coordinate with other ministries or policy areas at the federal and the provincial levels, as well as with European and international bodies. The coordination mechanism established in 1997 (consisting of the Federal Drug Coordination Office and the Federal Drug Forum, see Figure 1.1) will be used and expanded to this end. The Federal Ministry of Health commissioned GÖG to draft a new coordination structure, in cooperation with representatives of the federal and provincial governments. The new structure will be implemented from 2018.

In October 2016, Salzburg's new strategy for addiction services in the province of Salzburg (framework plan 2016–20) was adopted, which also encompasses different substances. In addition, the former *Drug Policy Advisory Board* has been remodelled and now operates under the name *Addiction Policy Advisory Board* (Schabus-Eder, personal communication). The framework plan already incorporates the available results of the 2020 regional structural plan on health, the Austrian

Addiction Prevention Strategy, as well as the results of the psychosocial care/new planning project (Land Salzburg 2016). The framework plan provides the basis for the step-by-step development of integrated service structures at the regional level in the province of Salzburg. The term ‘integrated services’ refers to all-encompassing holistic care services for people addicted to different substances, with links between different types of service, measures, and care areas (office-based doctors and psychotherapists, specialised addiction services, hospitals, and related psychosocial services) along the standard treatment paths. The individual fields of specialised services are organised as modules with clearly defined ranges of activity and conditions for access. In order to meet the goal of ensuring decentralised regional services, the strategy also specifies who is responsible for implementing the modules in the individual care regions. With regard to the prevention of addiction, it refers to the general prevention goals on the one hand and the Addiction Prevention Unit as the key networking body and competence centre on the other. The completion of a comprehensive addiction prevention strategy, in which Salzburg’s health goals are taken into account, has been scheduled for 2020. In December 2016, a steering group was established to provide expert input during the implementation of the framework plan. The steering group is composed of representatives of all four care areas mentioned, as well as providers of funding, health planning experts and addiction coordinators.

Further developments in the area of drug policy are discussed in chapter 2, which describes changes in the legal framework.

Apart from specialised addiction strategies, other strategies and strategic processes are also relevant (see section 1.2.1). A new development is that addiction and addiction-related interventions are mentioned, albeit only in passing, in the *2017 target control agreement*⁶. The individual provinces have drawn up provincial target control agreements in which strategic and operative targets have been set for the provincial level, and the measures that are necessary to achieve the goals have been defined. The agreements will then be broken down into federal annual working programmes and provincial target control contracts. Part C (on current activities) of the 2017 federal health target control agreement mentions that addiction diseases need to be taken into account when psychosocial health care structures are established in accordance with Health Target 9 (promotion of psychosocial health in all population groups). It also states that less complicated funding structures for addiction services need to be established. Apart from this, addiction is only mentioned in one sentence referring to the implementation of the Austrian Addiction Prevention Strategy. For monitoring the target control agreements, the current state of affairs is surveyed and documented in the context of various processes (see also chapter 5).

The revised Austrian Road Safety Programme, which has also seen an update, was presented in autumn 2016 (see also chapter 6). It is aimed at reducing traffic accidents in which people sustain (severe) injuries, as well as fatal accidents, and also includes a few references to the issue of drugs (BMVIT 2016). For instance, the Field of Action ‘Enforcement’ includes the statement that ‘from a

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For further information please visit https://www.bmgf.gv.at/home/Gesundheit/Gesundheitsreform/Zielsteuerung_Gesundheit_ab_2017 (accessed 5 July 2017).

legal, technical and logistics perspective, the provision of support to the police is a key priority.' Support with regard to drugs is explicitly mentioned in this context. In the 'Catalogue of Measures', a 3-pillar-approach is described, which makes the following distinctions:

- » zero tolerance in the case of drugs for which no meaningful prescriptive limits can be defined;
- » prescriptive limits for those drugs which can be assumed to impair the ability to drive;
- » impairment approach, i.e. sanctions only taken in the case of proven impairment of ability to drive (BMVIT 2016).

The programme does not specify, however, which drugs fall into which group. However, a variety of measures are recommended, e.g. acquisition of drug-pretesting devices (as soon as they become available). It also mentions measures such as an 'extension of the network of doctors used to identify drug use, by providing the necessary organisational and financial conditions, and regular training for the police to enable them to identify drivers under the influence of drugs. Another recommendation is the obligation on the part of doctors and pharmacists to explicitly warn patients when prescribing or dispensing medicines which could have negative effects on their fitness to drive and to implement the EMEA⁷ classification system for medicines.

In the field of action 'Databases and Accident Data Collection', the use of safety indicators is listed among the measures to be taken. For this purpose, data on 'drunk driving rates' need to be collected, as well as 'drug driving rates' – as soon as such rates can be measured and made available.

1.4 Sources and methodology

Most of the information given in this chapter comes from the addiction or drug strategy papers mentioned, as well as from previous reports on the drug situation, and input by the addiction/drug coordination offices.

2015 evaluation report on addiction activities in Lower Austria (Fachstelle für Suchtprävention NÖ 2015): Experts from various fields were involved in the evaluation, e.g. staff from Lower Austrian and Viennese addiction support centres, inpatient treatment centres, the Lower Austrian Medical Association, the Lower Austrian Health Insurance Fund, the NÖGUS health and social care fund, as well as decision-makers from various institutions in the province of Lower Austria. Based on a description of prevalence rates and addiction-related services provided in 2014, general as well as detailed recommendations for further developments were drawn up. The distribution of the existing services/activities in Lower Austria was assessed for the five care regions (Waldviertel, Weinviertel, Mostviertel, Thermenregion and NÖ Mitte).

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Former name: EMEA; present name: EMA (European Medicines Agency).

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1.6 Referenced Federal and Provincial Acts

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1.7 Personal communications (alphabetical order)

Name	Institution or function
Thomas Neubacher	Addiction Coordinator, Vorarlberg
Franz Schabus-Eder	Addiction Coordinator, Salzburg

Legal framework

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2 Legal framework

2.1 Summary

National profile

The Narcotic Substances Act (SMG) constitutes the main framework of Austria's drug policy. It focuses on quantities on the one hand and classes of substances on the other⁸. The use of narcotic substances as such is not punishable. However, the purchase, possession, production etc. of narcotic substances is a punishable offence. Drug use is thus indirectly covered through the aspect of drug possession. Limit quantities have been defined in separate regulations, and the exceeding of these quantities is threatened with severe punishment. The SMG distinguishes between misdemeanours and felonies⁹. For the misdemeanours, punishment is up to one year's imprisonment (or a fine), and in severe cases, up to three years' imprisonment; and for the felonies, it is imprisonment for up to five years, and in severe cases, up to 20 years. The SMG also offers a wide range of alternatives to punishment. The addicted patient's voluntary participation is a general requirement for treatment, and it is the task of the health authorities to motivate patients to undergo treatment.

In addition to the SMG, the Narcotic Drugs Regulation (SV) is important: it lays down further legal provisions, e.g. on the prescription of medicines containing narcotic substances, and on opioid substitution treatment of addicted patients.

The New Psychoactive Substances Act (NPSG) provides the basis for specific measures aimed at supply reduction to minimise the circulation of new psychoactive substances. It pursues a generic approach and lists diverse classes of substances.

In Austria, just over 10% of all convictions are related to the SMG, with the majority of convictions concerning misdemeanours. As far as statutory alternatives to punishment (diversionary options¹⁰

8

This classification is based on international conventions and distinguishes between narcotic drugs, psychotropic substances and precursor substances.

9

Misdemeanours relate to illicit handling of drugs (SMG Section 27) and felonies to preparation for drug trafficking (SMG Section 28), as well as drug trafficking itself (Section 28a). However, the offence described under Section 28, para. 1 cannot in fact be classified as a felony. In order to avoid unnecessary complications, here all crime reports relating to violation of Sections 28 and 28a of the SMG are referred to as 'felonies', and all crime reports relating to Section 27 are referred to as 'misdemeanours'.

10

Diversion: Under certain circumstances, the public prosecutor can decide to discontinue penal action provided that the defendant meets certain requirements defined by the public prosecutors, such as undergoing a 'health-related measure'.

under SMG Sections 35 and 37) are concerned, temporary discontinuation of penal action by the public prosecutors under SMG Section 35 has been recorded much more frequently than temporary dismissal of proceedings on the part of the courts (SMG Section 37). Suspension of sentence (SMG Section 39) is the alternative that has been applied least often.

Trends

The changes in the drug-related legislation that have taken place since 2000 have aimed at adapting its provisions to EU law or international requirements and at improving drug monitoring. Another aim has been to enhance the role of diversionary measures and the principle of treatment instead of punishment.

In 2016, the proportion of convictions due to violation of the SMG saw a decrease as against the previous year, to slightly below the level of 2014. The number of diversionary measures adopted in the context of criminal proceedings rose in 2016 compared to 2015; in particular, diversion in accordance with the SMG was offered much more frequently than in 2015.

New developments

In May 2017, a set of measures for quality and safety in opioid substitution treatment was submitted by the BMGF for examination in the context of the general evaluation procedure. Essentially, these measures constitute a treatment guideline drawn up by a large number of experts and adopted by four medical associations, which has now been completed and which the BMGF will refer to, rather than issue its own guideline. According to the draft guideline, those provisions of the Narcotic Drugs Regulation that have so far affected medical treatment are to be revoked, and thus the problem that medical intervention could constitute a drug-related offence under the above Regulation will automatically be solved. In addition, the amendment, which had not yet been adopted when the present report was drawn up, will more clearly define the tasks of the public health officers involved in opioid substitution treatment, as well as the cooperation between the public health officers and the doctors delivering OST. Further proposals for amendments in this context relate to the Regulation on Further Training in Oral Substitution and the Regulation on Psychotropic Substances. An amendment to the SMG, which has already entered into force (BGBl. I 116/2017), has particularly improved the possibilities for cooperation between pharmacies and health authorities on the one hand and OST doctors on the other.

In the reporting period, the manual on the uniform enforcement of SMG Section 12 has been evaluated. The evaluation has confirmed that differences in the individual provinces do exist with regard to enforcement practices, as well as with regard to views on the roles and tasks of public health officers in this context. The manual was then revised, but an intensified regional exchange seems to be necessary in order to arrive at consistent approaches.

Other obligations (e.g. community service) can also be imposed. For further details please consult the Austrian Code of Criminal Procedure (StPO, 11. Hauptstück, BGBl. 1975/631).

The reporting period has also seen modifications of the New Psychoactive Substances Regulation in order to respond to European requirements and to newly identified substances in Austria.

2.2 National profile

2.2.1 Legal framework

The Narcotic Substances Act (SMG; BGBl. I 1997/112) constitutes the main framework of Austria's drug policy. It focuses on quantities on the one hand and a classification of substances (narcotic substances, narcotic drugs¹¹ and psychotropic substances¹², as well as precursor substances¹³) on the other. The substances that come under the individual groups are listed in separate regulations. Furthermore, there are regulations that define limit quantities¹⁴, and exceeding these quantities is threatened with severe punishment. The SMG distinguishes between misdemeanours (SMG Section 27) relating to the illicit handling of narcotic drugs, felonies relating to the preparation for drug trafficking (SMG Section 28) and drug trafficking itself (SMG Section 28a). Separate provisions exist for cannabis and hallucinogenic mushrooms.

Austria's drug legislation is characterised by a balanced approach combining health policy interventions and interventions to reduce supply (see also chapter 1) as responses to drug use and drug addiction. This is reflected in a wide range of alternatives to punishment under the SMG, which include that, first of all, the health authorities are informed in order to assess the need for health-related measures (see also chapter 1). The use of narcotic substances is not punishable. However, the purchase, possession, production etc. of narcotic substances is a punishable offence.

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Narcotic drugs are substances and preparations which, under the *Single Convention on Narcotic Drugs* as well as the United Nations Convention on Psychotropic Substances, are subject to restrictions with regard to production, possession etc. and have been defined as narcotic drugs in regulations of the Federal Ministry of Health and Women's Affairs or are regarded as equal to narcotic drugs. Furthermore, the Ministry of Health and Women's Affairs can define additional substances and preparations as equal to narcotic drugs if they are comparable to narcotic drugs with regard to their risk potential.

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Psychotropic substances are substances and preparations which, under the United Nations Convention on Psychotropic Substances, are subject to restrictions with regard to production, possession, etc. and have been defined as psychotropic substances in regulations of the Federal Ministry of Health and Women's Affairs. Furthermore, the Federal Ministry of Health and Women's Affairs can define additional substances and preparations as equal to psychotropic substances if they are comparable to psychotropic substances with regard to their risk potential.

13

Precursor substances are substances which are covered by Regulations (EC) 2004/273 and 2005/111.

14

The limit quantity is the lower limit of the quantity of pure substance of an active ingredient, large quantities of which can pose a danger to the life and health of a human being. The potential of narcotic drugs to cause dependence is also taken into account.

Drug use is thus indirectly covered through the aspect of drug possession. It is the task of the health authorities to motivate addicted patients to undergo a reasonable health-related measure¹⁵ that is acceptable and appropriate in view of their situation and not obviously unlikely to be effective. The patient's voluntary participation is a general requirement for treatment, but non-cooperation on their part will have consequences in subsequent court proceedings. Addicted patients are free to choose between different treatment centres, provided that it is a recognised treatment centre under SMG Section 15 (see chapter 5) whenever the cost of treatment is to be covered by the judicial system. The SMG also legally requires the Federal Government to take over the cost of treatment, subject to the provisions of SMG Section 41, to avoid any non-treatment due to lack of funds on the part of the patient.

In addition to the SMG, the **Narcotic Drugs Regulation** (SV; BGBl. II 1997/374) is an important legal basis, which covers aspects such as the production, processing, conversion, purchase, possession and supply, import and export of narcotic substances, as well as provisions concerning documentation.

The SMG and the SV also regulate the manufacture of medicines containing narcotic substances and the growing of plants of the genus cannabis for the manufacture of medicines and for related scientific purposes (SMG Section 6a), as well as medical treatment with, and prescription of, medicines containing narcotic substances (SMG Section 8). The prescription of pure narcotic drugs and preparations from heroin, cannabis and coca leaves is prohibited (SV Section 14), with the exception of authorised pharmaceutical specialities made from cannabis extracts and dronabinol for pharmaceutical compounding. SV Sections 18 to 23 regulate the prescription of narcotic drugs (forms, handling, validity), including the prescription of opioid substitution medicines. The SMG requires the Federal Ministry of Health and Women's Affairs to maintain a database (substitution registry, results of medical examinations with regard to the need for health-related measures due to drug abuse, reports by the criminal police concerning suspicion of drug abuse). This database has been integrated into the common infrastructure for inter-administrative cooperation (public authorities portal group) and can be accessed by the health authorities. The Ministry of Health can retrieve pseudonymised data from a registry in order to obtain epidemiological information.

Since 2006, the general framework for opioid substitution treatment has been laid down in the Narcotic Drugs Regulation and the *Regulation on Further Training in Oral Substitution* (BGBl. II 2006/449; see also chapter 5). The latter defines the extent and organisation of further treatment that doctors have to complete to qualify for opioid substitution treatment (sections 2 to 4). The data of doctors who are permitted to deliver opioid substitution treatment are entered in a central online registry (section 5).

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Under SMG Section 11, para. 2, the available health-related measures include supervision of the state of health by a doctor, medical treatment including withdrawal and opioid substitution treatment, advice and support by a clinical psychologist, psychotherapy, as well as psychosocial advice and support.

With regard to offences and sanctions, a distinction is drawn between narcotic drugs, psychotropic substances and precursor substances, and between illicit handling and (preparation for) trafficking, and it is considered whether the quantity is above or below the limit quantity that has been defined (see Table 2.1). Under the 2007 amendment to the SMG, the provisions on offences and sanctions were harmonised with the EU Framework Decision (see GÖG/ÖBIG 2008). Different ranges of punishment for first-time offenders and repeat offenders only apply in the case of drug trafficking (SMG Section 28a). The daily rates for fines given in the table (see Table 2.1) are defined in Criminal Code Section 19 (BGBl. 1974/60) and are determined for each individual case, depending on the offender's financial situation.

Further relevant legal sources in addition to the SMG include the **New Psychoactive Substances Act** (NPSG; BGBl. I 2011/146), and the **New Psychoactive Substances Regulation** (NPSV; BGBl. II 2011/468) based on the NPSG, both of which entered into force in 2012. These aim to minimise the circulation of new psychoactive substances and the health hazards resulting from the use of these substances, by adopting specific control measures. In contrast to the SMG, the New Psychoactive Substances Act and Regulation rather pursue a generic approach and primarily relate to classes of substances¹⁶. It is a punishable offence to import and export new psychoactive substances, to make them available to, or to procure them for, others in order to derive benefit from this act and with the intention that others or third parties use said substances to achieve psychoactive effects. Punishment ranges from imprisonment for up to two years (Section 1, para. 1), to imprisonment between one and 10 years in the case of severe bodily harm or loss of life resulting from this offence (NPSG Section 4, para. 2).

In Austria, statutory alternatives to punishment exist in accordance with the principle of treatment instead of punishment¹⁷. As this principle constitutes an important aspect of Austria's drug policy, various **alternatives to punishment** are available for delinquent drug users.

An important element in this context is that the criminal police or administrative authorities report suspected violations of the SMG to the health authorities, who assess the need for health-related measures whenever there are indications of drug use (SMG Sections 13, para. 2b and Section 14, para. 2, and with regard to traffic offences, Section 5, para. 9 of the Road Traffic Act; BGBl. 1960/195). The examinations by the health authorities are also relevant in drug-related court

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According to the definition by the Ministry of Health and Women's Affairs, the term *new psychoactive substances* refers to substances which, due to their psychoactive effects, are likely to be circulated for the purpose of misuse and whose use involves a health risk for consumers, or if such a risk cannot be excluded.

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

proceedings, as an expert opinion confirming the need for health-related measures can be a prerequisite for diversionary¹⁸ measures. Since 2016, a new procedure has been in force for cases in which the initial suspicion of a drug-related offence (Code of Criminal Procedure Section 1, para 3; BGBl. 1975/631) does not (also) relate to drug trafficking but exclusively to the purchase/possession of drugs for one's own personal use or personal use by another person, without deriving benefit from this act (SMG Section 13, para. 2): the criminal police now only need to inform the public prosecutors (by means of a 'statement of assignment') that the case has been referred to the health authorities. Drug-related criminal proceedings have thus no longer been initiated parallel to the procedures started by the health authorities. This expansion of the principle of treatment instead of punishment underlines that drug use primarily calls for health-related measures and support whenever necessary, rather than punitive intervention. However, the purchase and possession of those substances continues, on principle, to be a punishable act: i.e. the new procedure does not involve legal decriminalisation but enables the health authorities to respond more quickly and public prosecutors to concentrate their resources on more severe drug offences (see section 2.4). The health authorities are only required to notify the public prosecutors if the person in question fails to appear for the examination that has been scheduled or refuses to undergo the health-related measure that the health authorities have deemed necessary, reasonable, acceptable and appropriate in view of the person's situation and not obviously unlikely to be effective. When drug-related criminal proceedings are initiated, the same diversionary options as before are available (SMG Section 14, para. 1).

In the case of lesser offences (e.g. possession and purchase of small quantities for one's private use), the available alternatives to conviction are *temporary discontinuation of penal action* (SMG Section 35) and *temporary dismissal of proceedings* (SMG Section 37; see Table 2.2).

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Diversionary = without recourse to formal proceedings.

Table 2.1

Offences and sanctions under the Narcotic Substances Act

Offence committed ¹⁹	Punishment	Increased punishment	Reduced punishment	Exception
Narcotic drugs SMG Section 27 (illicit handling): Purchase, possession, production, import, export, making available, procurement, transport and offering of narcotic drugs; growing of opium poppy, coca plants and cannabis plants; offering, making available, procuring and growing mushrooms containing psilocybin.	Max. 12 months' imprisonment (or fine of up to 360 daily rates)	Up to 2 years' imprisonment for offences committed in public spaces or offences liable to constitute an obvious nuisance when observed directly. Up to 3 years' imprisonment for adults who make narcotic drug use available to minors and are themselves more than two years older than said minor; and have committed the offence commercially or as a member of a criminal organisation.	Up to 6 months' imprisonment for offences committed solely for personal use (or fine of up to 360 daily rates). No increased punishment if the offenders are dependent on a narcotic substance themselves.	
SMG Section 28 (preparation for trafficking): Purchase, possession and transport of narcotic drugs, growing of opium poppy, coca and cannabis plants for obtaining narcotic drugs in quantities above the limit quantity, with the intention of putting said drugs into circulation.	Up to 3 years' imprisonment	Up to 5 years' imprisonment in the case of 'large quantities' (i.e. 15 times the limit quantity or more). Up to 10 years' imprisonment for members of a criminal organisation.	Punishment is reduced to no less than 1 year, and increased punishment is reduced to a sentence of no less than 3 or 5 years, respectively, in the case of offenders who are dependent on drugs themselves.	
SMG Section 28a (trafficking): Production, import, export, offering, making available and procurement of narcotic drugs in quantities above the limit quantity.	Up to 5 years' imprisonment	Imprisonment for 1–10 years in the case of commercial trafficking combined with a prior conviction, offence committed as a member of a criminal organisation or if 'large quantities' are involved. Imprisonment for 1–15 years if committed as a member of a criminal organisation combined with a prior conviction or as a member of a group of a larger number of persons, or if very large quantities of narcotic drugs are involved (25 times the limit quantity or more); imprisonment for 10–20 years or life imprisonment for heads of groups comprising a larger number of persons.	Punishment is reduced to no less than 3 years, and increased punishment is reduced to no less than 5 years in the case of offenders who are dependent on drugs themselves.	
Psychotropic substances SMG Section 30 (illicit handling): Purchase, possession, production, import, export, making available, procurement, transport and offering.	Up to 1 year's imprisonment (or fine of up to 360 daily rates)		Up to 6 months' imprisonment for offences committed solely for personal use (or fine of up to 360 daily rates).	No punishment for persons who commit offences with medicines that contain psychotropic substances in quantities below the limit quantity, for personal use or personal use by another person, without deriving benefit from this act.

Continued next page

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i.e. offence committed as an intentional violation of existing laws and regulations (e.g. persons who are entitled to possess narcotic drugs on the basis of a statutory regulation or permission by the relevant authorities are not committing an offence).

Table 2.1 continued

<p>SMG Section 31 (preparation for trafficking): Purchase, possession and transport of a psychotropic substance in quantities above the limit quantity, with the intention of putting said substance into circulation.</p>	<p>Up to 2 years' imprisonment</p>	<p>Up to 5 years' imprisonment in the case of 'large quantities' (i.e. 15 times the limit quantity or more). Up to 10 years' imprisonment for members of a criminal organisation.</p>	<p>Punishment is reduced to no less than 1 year, and increased punishment is reduced to a sentence of no less than 3 or 5 years respectively, in the case of offenders who are dependent on drugs themselves.</p>	
<p>SMG Section 31 (trafficking): Production, import, export, offering, making available and procurement in quantities above the limit quantity.</p>	<p>Up to 3 years' imprisonment</p>	<p>Imprisonment for up to 5 years if very large quantities are involved. Imprisonment for 1 to 10 years if committed by a member of a criminal organisation.</p>	<p>Punishment is reduced to no less than 1 year, and increased punishment is reduced to a sentence of no less than 3 or 5 years, respectively, in the case of offenders who are dependent on drugs themselves.</p>	
<p>Precursor substances SMG Section 32 (illicit handling): Production, transport and making available of precursor substances for use in the context of illicit production of narcotic substances.</p>	<p>Up to 1 year's imprisonment</p>	<p>Up to 2 years' imprisonment in the case of purchase or possession with the intention of use for the illicit production of narcotic substances in quantities above the limit quantity. Up to 5 years' imprisonment in the case of production, import, offering, making available and procurement with the intention of use for the illicit production of narcotic substances in quantities above the limit quantity.</p>		

Source: SMG (BGBl. I 1997/112) as amended; graphic representation: GÖG

Table 2.2:
Alternatives to punishment under the SMG

Section	Short name	Relevant passage	Authority in charge	Stage of proceedings
SMG Section 12	Health-related measures	<p>(1) If it is reasonable to assume, due to certain facts, that a person has abused narcotic drugs, the health authorities shall refer said person to a doctor who is sufficiently knowledgeable about questions of narcotic drug abuse, for the purpose of examination.</p> <p>(2) If the examination reveals that a health-related measure under SMG Section 11, para. 2 is required, the health authority shall motivate said person to undergo such a measure.</p> <p>(3) The health authorities can obligate said person to present a confirmation of the start and progress of the health-related measure.</p>	Health authority	Before report
SMG Section 13		<p>(1) If it is reasonable to assume, due to certain facts, that a school student has abused narcotic drugs, the head of school shall refer said student to the school medical officer for examination. Whenever necessary, school psychologists shall be involved. If the examination indicates the need for health-related measures under SMG Section 11, para. 2 and it cannot be ensured that said measure will be applied, or if the student, their parents or guardians refuse examination by the school medical officer or consultation with the school psychologist, then the head of school, rather than submitting a crime report, shall inform the district administration authorities in their function as health authorities.</p> <p>(2) If</p> <ol style="list-style-type: none"> 1. a pre-enlistment examination among conscripts; or 2. a medical examination of women in the context of a voluntary application for military training; or 3. a military medical examination of soldiers during compulsory service or training <p>gives reason to assume misuse of narcotic drugs, the recruitment commission or the army personnel office or the commander of the military unit in which the conscript is serving, rather than submitting a crime report, shall notify the district administration authorities of this fact in their function as health authorities.</p> <p>(2a) If a public authority or institution knows of an initial suspicion that a person has committed an offence under Section 27, paras. 1 and 2, for exclusively personal use or personal use by another person, without deriving benefit from this act, instead of filing a crime report, the said authority or institution shall notify the health authority.</p> <p>(2b) If investigations by the criminal police authorities exclusively corroborate the aforementioned suspicion, they shall communicate said suspicion to the health authorities and inform the public prosecutors on said referral to the health authorities, in the manner provided for under Section 24a, para 1.</p> <p>(3) In the above cases, the district administration authorities, in their function as health authorities, shall proceed in accordance with Section 12, provided that the case in question is not merely a case described under Section 35, para. 4.</p>	School army unit, public authority or office	Instead of informing the judicial authorities

Continued next page

Table 2.2 continued

<p>SMG Section 35</p>	<p>Temporary discontinuation of penal action</p>	<p>(1) Under certain prerequisites and conditions, the public prosecutors shall – by determining a probationary period of 1 to 2 years – temporarily discontinue penal action related to offences under Section 27, paras. 1 or 2 or Section 30, which have been committed solely for the defendant’s personal use or personal use by another person without the defendant deriving benefit from this act.</p> <p>(2) Under certain prerequisites and conditions, the public prosecutors shall also – by determining a probationary period of 1 to 2 years – temporarily discontinue penal action related to other offences under Sections 27 or 30 to 31a, or offences relating to Section 28 or 28a, provided that the defendant is dependent on narcotic substances, or in the case of an offence committed to support drug habits, provided that:</p> <ol style="list-style-type: none"> 1. the offence is not subject to the jurisdiction of a court with co-opted lay judges or jury members; 2. the defendant’s guilt is not deemed to be severe; 3. discontinuation of penal action is not less appropriate than a conviction with regard to preventing the defendant from committing such offences. <p>Such a course shall also be taken in the case of defendants who face prosecution for an additional offence under para. 1 committed during the probationary period fixed in accordance with para. 1.</p> <p>(9) Should the police inform the public prosecutors that a case has been referred to the health authorities (‘statement of assignment’; Section 13, para. 2b), the public prosecutors shall temporarily discontinue penal action immediately, provided that no further facts need to be ascertained. The defendant shall be informed of this situation, as well as of the grounds for a continuation of proceedings (Section 38, para. 1a).</p>	<p>Public prosecutors</p>	<p>Before initiation of prosecution/charge</p>
<p>SMG Section 37</p>	<p>Temporary dismissal of proceedings</p>	<p>After a charge has been brought, the court shall apply Section 35 mutatis mutandis, and proceedings shall be dismissed until the end of the trial with a decision to this effect, under the prerequisites that apply to the public prosecutors.</p>	<p>Courts</p>	<p>After initiation of prosecution/charge</p>
<p>SMG Section 38</p>	<p>Permanent discontinuation or dismissal</p>	<p>Provided that no grounds for a subsequent continuation of proceedings apply, the public prosecutors shall permanently discontinue penal action, after the probationary period has elapsed and any obligations imposed have been complied with. The court shall permanently dismiss criminal proceedings with a decision to this effect.</p>	<p>Public prosecutors, court</p>	
<p>SMG Section 39</p>	<p>Suspension of sentence</p>	<p>(1) After hearing the public prosecutors, the execution of a fine or a prison sentence of a maximum of 3 years for an offence under this Federal Act, with the exception of Section 28a, paras. 2, 4 and 5, or for an offence committed to support drug habits, shall be suspended for a maximum period of 2 years, even after the execution of the sentence has started (Execution of Sentence Act Section 3, para. 4):</p> <ol style="list-style-type: none"> 1. provided that the offender is dependent on narcotic substances and has stated their willingness to undergo a necessary and reasonable health-related measure that is acceptable and appropriate in view of their situation and not obviously unlikely to be effective, and which may include inpatient treatment for a maximum period of six months; 2. in the case of a prison sentence of more than 18 months for a criminal offence committed to support drug habits: provided that the execution of the prison sentence is not deemed necessary due to the dangerousness of the offender, particularly in the case of a conviction for a criminal act involving considerable violence against persons. <p>(3) The court can oblige the convicted offender to present a confirmation of the start and progress of the health-related measure.</p> <p>(4) The suspension of the sentence shall be revoked and punishment shall be imposed if the convicted offender:</p> <ol style="list-style-type: none"> 1. fails to undergo, or does not continue to undergo, the health-related measure to which they have agreed under para. 1(1); or 2. is again convicted for an offence under that Federal Act or an offence committed in connection with their dependence on narcotic substances; and execution of the prison sentence is deemed necessary in order to prevent the offender from committing further offences. 	<p>Courts</p>	<p>After conviction</p>

SMG Section 40	Subsequent non-execution on probation	<p>(1) If the suspension of the sentence is not to be revoked (Section 39, para. 4) or if an offender who is dependent on a narcotic substance has otherwise successfully undergone a health-related measure, the court shall not execute the sentence and shall define a probationary period of one year at least and three years at most.</p> <p>(3) In the case of a decision to revoke subsequent non-execution (StGB Section 53), the court can decide on full or partial non-revocation, provided that the offender has undergone a health-related measure which has constituted a considerable restriction of their control over their life.</p>	Courts	After conviction
SMG Section 41	Cost coverage	<p>(1) In cases that fall under SMG Sections 35 to 37 and 39, the Federal Government shall bear the cost of health-related measures in accordance with Section 11, paras. 2(1) to 4, as well as the cost of drug-free treatment ... of an offender who – on the occasion of a conviction connected with their dependence on narcotic substances – has been obliged by an order to undergo such treatment, provided that</p> <ol style="list-style-type: none"> 1. the said offender is to undergo the said measure in a treatment centre or support service in accordance with Section 15; 2. the said offender is not entitled to receive the corresponding support and treatment services on the basis of provincial laws or a legal social insurance fund; and 3. an obligation on the part of the offender to take over the cost themselves would constitute a hindrance to their livelihood. <p>(2) The Federal Government shall only cover costs to the extent to which the Social Insurance Fund for Civil Servants would cover costs if the offender were insured with the Social Insurance Fund for Civil Servants. Instead of charging treatment co-payment ... a lump sum shall be defined but only to an extent that does not jeopardise the necessary means of securing basic necessities of the offender and those persons to whom the offender has maintenance obligations. The said sum shall be defined with due regard to the type of measure, its necessity, its duration and its success, and in cases to which Section 39 applies, also with due regard to the reimbursement rate that the offender is obliged to contribute.</p> <p>(3) The cost taken over by the Federal Government shall be determined and the corresponding sum be transferred, based on a decision to this effect, by the court that would be competent for the investigation proceedings under Section 35; that has temporarily dismissed proceedings under Section 37; that has issued a directive under para. 1 above or Section 173, para. 5(9) of the Code of Criminal Procedure, or that has decided in favour of a suspension of sentence under Section 39.</p>	Courts	After conviction

Source: SMG (BGBl. I 1997/112) as amended; graphic representation: GÖG

For severe offences, suspension of sentence in accordance with SMG Section 39 is available as an alternative. This alternative is only open to offenders who are dependent on drugs and willing to undergo a necessary health-related measure. If the corresponding measure has been successful, the court will convert the sentence without probation to a probationary sentence. Table 2.2 provides a list of the available options. For a detailed presentation please consult ÖBIG 2004. Sections 38 and 40 of the SMG are also relevant in this context: they provide regulations for the subsequent continuation of criminal proceedings, the permanent discontinuation of penal action, as well as the permanent dismissal of proceedings, and subsequent non-execution of a sentence after a probationary period. SMG Section 41 covers the question of cost coverage (see also chapter 1).

The decision whether or not to apply an alternative to punishment continues to rest with the public prosecutors (before charges are brought) or the courts (after charges have been brought). It must be based on a statement issued by the district health authorities on the necessity for, and type of, health-related measures. The majority of available alternatives to punishment are regulated in peremptory provisions, i.e. the offender has a right to these alternatives. Only a small part has been laid down in optional provisions and is thus subject to discretion on the part of the judicial authorities.

The variety of available options are aimed at enabling a consequent implementation of the principle of treatment instead of punishment at all stages of (possible) proceedings in the case of persons suspected of a drug-related offence connected with drug use or drug addiction or persons already reported in connection with a drug-related offence.

In addition to the above options, general criminal law provisions on diversion are available in the case of drug offences. The relevant provisions have been laid down in the Code of Criminal Procedure (StPO; BGBl. 1975/631), the Criminal Code (StGB; BGBl. 1974/60) and the Juvenile Court Act (JGG; BGBl. 1988/599, see also chapter 8); however, these are of minor importance compared to the interventions in connection with drug users that are regulated in the Narcotic Substances Act. For instance, the Code of Criminal Procedure provides for a more lenient measure than pre-trial custody if the defendant agrees to undergo withdrawal treatment or a health-related measure in accordance with SMG Section 11, para. 2.

Regarding the execution of prison sentences without probation, the Execution of Sentence Act (StVG; BGBl. 1969/144) applies, as prisoners addicted to drugs must undergo withdrawal treatment if the prerequisites of StVG Section 68a are met. If the sentence is suspended on probation or prisoners are released on probation, the court must issue directives under StGB Section 50 in order to prevent the person concerned from committing further punishable offences. Under StGB Section 51, such a directive may also include treatment, provided that the relevant prerequisites are met and the person concerned agrees to treatment.

Relevant legislation outside the SMG includes, for instance, provisions on **drugs in road traffic**, laid down in the Road Traffic Act (StVO; BGBl. 1960/159), the Driving Licences Act (FSG; BGBl. I 1997/120) and the Driving Licences Health Regulation (FSG-GV; BGBl. II 1997/322). These have been discussed in detail in ÖBIG 2006. StVO Section 5 stipulates the course of action to be taken to identify the influence of alcohol or narcotic drugs and the subsequent procedure. Driving under

the influence of narcotic drugs is generally forbidden, whereas in the case of alcohol, limits have been defined. For the purpose of this report, it should suffice to mention that, in cases where traces of narcotic drugs are detected in the saliva or blood of a person found unfit to drive, instead of filing a crime report, the district administrative authorities are informed in their function as health authorities. In addition to an administrative fine, the driving licence can be temporarily withdrawn, and further measures (e.g. obtaining an expert opinion by a public health officer on fitness to drive) can also be imposed.

2.2.2 Implementation

Information on the implementation of the Austrian drug legislation is available through data on **convictions under the Narcotic Substances Act**. As in previous years, in 2016 the number of convictions for misdemeanours (SMG Section 27) was considerably higher than convictions for felonies (SMG Section 28): 2 479 v. 1 504 cases. The proportion of convictions for violation of the SMG out of the total number of convictions in Austria was 13.1% in 2016 (see also Table A2. 1).

As of 2012, data on all offences²⁰ on which a conviction is based have been made available. In 2016, a violation of the SMG was the main offence in the case of 3 993 convictions by Austrian courts²¹; and a total of 7 351 SMG offences led to convictions (see Table 2.3). According to an analysis by Statistics Austria, convictions relating to SMG Sections 27, 28 and 28a have been much more frequent than corresponds to their proportion as main offences, and a large number of convictions due to violation of the SMG related to several SMG offences. This particularly applies to the 5 095 offences due to SMG Section 27; with 4 740 of them committed by men.

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

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In Austria, the punishment imposed does not result from adding together the penalties for individual offences: instead, the main offence, which defines the severity of punishment, is determined based on the severity of the relevant offences. As of 2012, the **courts** have provided information on leading offences. Previously, **STATISTICS AUSTRIA** only determined the "leading offence", using an algorithm to calculate the offence with the highest range of punishment in cases where a defendant was found guilty of several offences; see Table A2. 2). This may have caused a break in the time series in 2012, so that it is only to a limited extent possible to compare new figures to those prior to 2012.

Table 2.3:

All offences resulting in a conviction under the Austrian Narcotic Substances Act (SMG), by gender and age group; in 2016*

Offence		Aged 14-19	Aged 20-24	Aged 25-29	Aged 30-34	34+	Total
SMG total	Men	1 051	1 956	1 385	953	1 464	6 809
	Women	53	143	145	84	117	542
SMG Section 28 or 28a	Men	159	484	414	334	649	2 040
	Women	8	43	54	27	47	179
SMG Section 27	Men	889	1 470	967	608	806	4 740
	Women	45	100	87	57	66	355

SMG Section 27 = illicit handling of narcotic drugs.

SMG Section 28 = preparation for trafficking in narcotic drugs.

SMG Section 28a = trafficking in narcotic drugs.

* Up to and including 2011, STATISTICS AUSTRIA only listed the leading offence.

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

In 2016, a total of 33 convictions related to psychotropic substances, and in the case of 10 convictions, an offence relating to psychotropic substances (SMG Sections 30, 31, 31a) was the main offence (see Table 2.4; STATISTICS AUSTRIA, judicial criminal statistics).

Table 2.4:

Convictions relating to psychotropic substances in Austria; 2011-16*

Type of conviction	Number of convictions					
	2011	2012	2013	2014	2015	2016
Convictions for which offences relating to psychotropic substances (SMG Sections 30, 31, 31a) were the main offence	117	47	30	21	5	10
All convictions connected with psychotropic substances (SMG Sections 30, 31, 31a)	-	195	116	85	63	33

* Up to and including 2011, STATISTICS AUSTRIA only listed the leading offence.

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

In 2016, approximately 75% of all persons convicted for SMG offences were punished by imprisonment, with prison sentences suspended on probation accounting for approximately 42% of all prison sentences. The proportion of young people sentenced to imprisonment (suspended on probation, with partial probation, without probation) accounted for around 71% of all convicted young people; approximately 49% of them were sentenced to imprisonment suspended on probation (see Table A2. 3).

For details regarding statistics on convictions in Austria, please consult the 2008 report (GÖG/ÖBIG 2008).

One goal of treatment instead of punishment is to apply diversion as a way of settling criminal proceedings. Under certain circumstances, the public prosecutors are legally required to discontinue penal action temporarily if the defendant needs to undergo a health-related measure **and**

agrees to this course of action. After the defined probationary period, penal action is discontinued permanently provided that the person concerned has not committed further drug-related crimes, has not persistently evaded the necessary health-related measure in the event that such a measure has been imposed, and provided that a continuation of criminal proceedings is not deemed reasonable and necessary to deter the offender from further wrongdoing (Rast 2013).

Regarding the implementation of the legal options in this field, the available information on the application of statutory alternatives to punishment is relevant (for details see ÖBIG 2004). The figures relating to 2016 refer to suspension of sentence (SMG Section 39: 561 cases), temporary dismissal of proceedings by the court (SMG Section 37: 1 857 cases) and temporary discontinuation of penal action by the public prosecutors (SMG Section 35: 23 809 cases; BMJ 2017; see Table A2. 4). Table A2. 2 provides additional information concerning final convictions under the SMG in 2016, broken down by basis of conviction, gender and age group.

The majority of diversionary settlements (93%) has been initiated by the public prosecutors, with diversion under SMG Section 35 playing the most important role in the case of adolescents, young adults and adults (56%, 51% and 31%, respectively, of all settlements by diversion). Their proportion has further increased in 2016 as against 2015. Regarding adults, the proportion of diversionary settlements combined with a probationary period without additional obligations is similar to the proportion of fines (29% v. 24%, respectively). A total of 81% of all diversion proceedings were settled successfully and penal action was discontinued permanently. Regarding the Narcotic Substances Act (SMG Sections 35 and 37), the corresponding percentage is 77.5% (women: 80.4%, men 76.9%, adolescents: 78.4%, young adults: 77.5%; BMJ 2017).

Table 2.5 below shows the number of **convictions under the New Psychoactive Substances Act** (NPSG; BGBl. I 2011/146) since its adoption. In 2016, 43 offences related to the NPSG; and in 13 cases it was the main offence (leading offence).

Table 2.5:
Offences relating to NPSG Section 4 (convictions by main offence and all offences); 2012-16

Year	All offences			Conviction based on main offence		
	Total	Men	Women	Total	Men	Women
2012	46	41	5	26	22	4
2013	66	59	7	37	32	5
2014	48	43	5	24	20	4
2015	34	33	1	20	19	1
2016	43	37	6	13	10	3

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

2.3 Trends

Since 2000, the **amendments to the existing legislation**, apart from revisions of the classification of substances (e.g. classification of 4-methylmethcathinone as a narcotic drug in 2010, and oropavin and benzylpiperazine (BZP) in 2009) have primarily been aimed at harmonising penal provisions with EU law or international agreements. The latest SMG amendment to this effect took place in 2007 (BGBl. I 2007/110), when the term ‘large amount’ was defined as an amount greater than 15 times the limit quantity. Under this amendment, the sanctions laid down in Section 27 were increased from six to 12 months’ imprisonment, and separate sections relating to preparation for drug trafficking and to drug trafficking were introduced. For further details on the 2007 amendment to the SMG please consult GÖG/ÖBIG 2008, which also describes the simultaneous enhancement of the principle of treatment instead of punishment. This enhancement was brought about by a change from optional to obligatory regulations.

The 2011 Act Accompanying the Budget (BGBl. I 2010/111) was aimed at reducing expenditure for inpatient treatment. Parallel to this, a separate medical unit was established in the judicial sector to assess the need for health-related measures. Another goal was to exclude the option of a suspended sentence in very severe cases of drug trafficking. The NPSG provides regulations specifically for *new psychoactive substances*, and particularly focuses on supply reduction. In 2014, the Criminal Code Amendment Act (BGBl. I 2014/71) was adopted, which provides for an easier procedure for seizing and destroying narcotic drugs (particularly cannabis plants) in accordance with SMG Section 34.

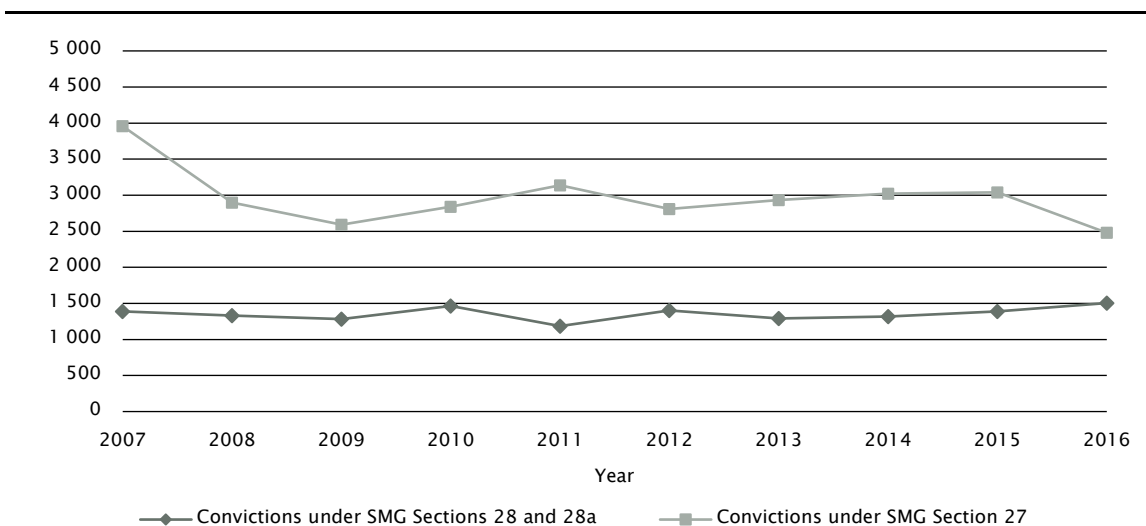
The changes to the SMG which entered into force in 2016 (see section 2.4) are aimed at advancing the principle of treatment instead of punishment, speeding up referral to the health authorities, as well as reducing the pressure on the judicial system and also arriving at uniform, less complicated and faster reporting procedures. The database that the BMGF had formerly been required to also maintain for the area of drug-related proceedings became obsolete when the *Judicial Proceedings Automation System* was introduced. In order to respond to the security needs of the population, *drug trafficking in public spaces* has been introduced as an additional offence.

Figure 2.1 below, which is based on the judicial criminal statistics, shows the **development of convictions** under SMG Sections 27 and 28 over the past 10 years, with regard to the leading offence. From 2006 to 2009, the number of convictions relating to SMG Section 27 saw a decline, and subsequently remained fairly constant. 2016 saw a considerable decrease in convictions. The convictions under SMG Sections 28 and 28a have remained at similar levels throughout the observation period. Due to the break in the time series²² described in section 2.2.2, the data from 2012 to 2016 may not be fully comparable to those from previous years (see also Table A2. 1).

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As of 2012, the courts have provided information on all offences leading to convictions, and all offences of persons receiving final convictions in the reporting year can be included in the statistics for the corresponding year. Previously, STATISTICS AUSTRIA determined the “leading offence”, using an algorithm to calculate the offence with the highest range of punishment

Figure 2.1:
Number of convictions in Austria under SMG Sections 27, 28 and 28a; 2007-16*



Until 2007:

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

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

As of 2008:

SMG Section 27 = illicit handling of narcotic drugs.

SMG Section 28 = preparation for trafficking in narcotic drugs.

SMG Section 28a = trafficking in narcotic drugs.

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

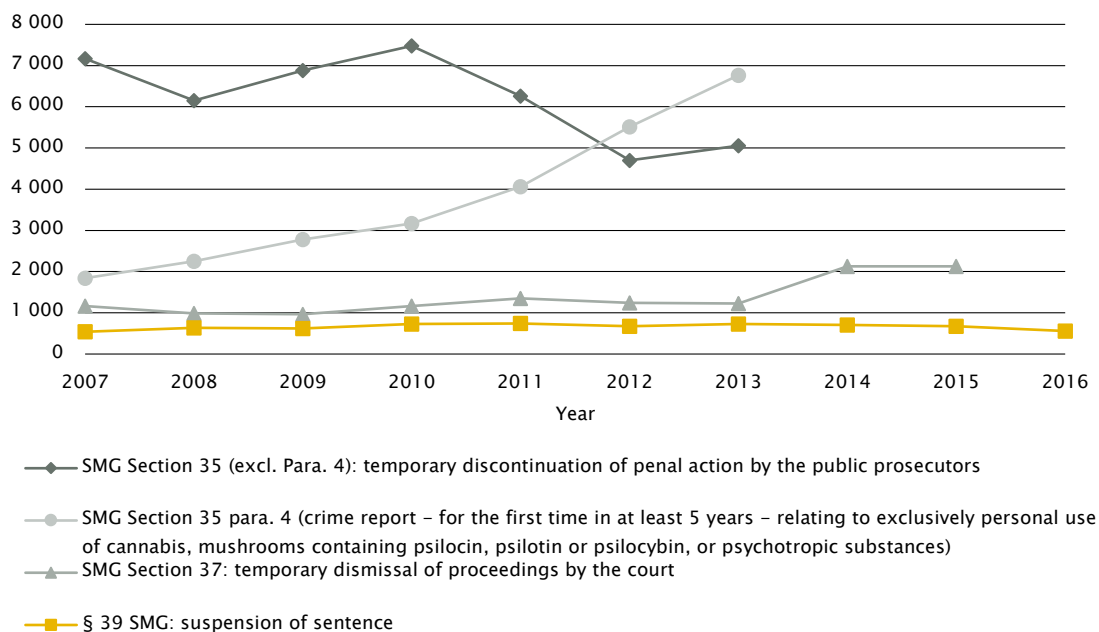
* As of 2012, data on the legal basis of conviction have no longer been compiled by STATISTICS AUSTRIA but by the courts.

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

In addition to the figures on convictions, Figure 2.2 and Table A2. 4 provide data on the **development of alternatives to punishment**, i.e. temporary discontinuation of penal action by the public prosecutors (SMG Section 35) and dismissal of proceedings (SMG Section 37), as well as suspension of sentence (SMG Section 39). The figures on SMG Sections 37 and 39 have mostly remained constant over the past 10 years – with the exception of an increase in temporary dismissals of proceedings by the courts in 2014, which remained at the same level in 2015. In 2016, slight declines in the application of SMG Sections 37 and 39 have become apparent. The figures for temporary discontinuation of penal action by the public prosecutors under Section 35, para. 4, have seen a considerable increase since 2007.

in cases where a defendant was found guilty of several offences. This may have caused a break in the time series in 2012 so that it is only to a limited extent possible to compare newer figures to those prior to 2012.

Figure 2.2:
Development of statutory alternatives to punishment applied in Austria; 2007-16

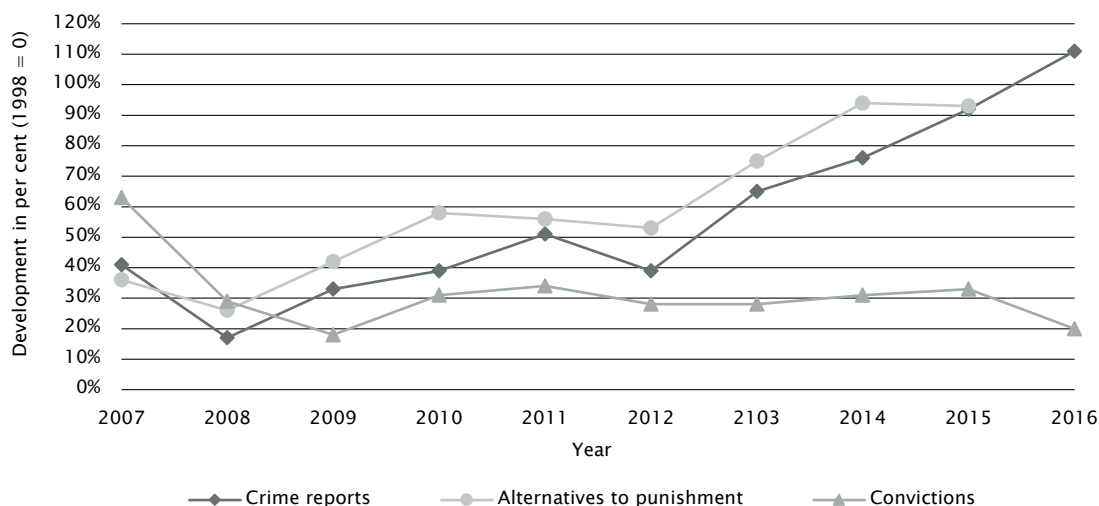


Until 2007: SMG Section 35 = temporary waiving of reports by the public prosecutors.
 As of 2008: SMG Section 35 = temporary discontinuation of penal action by the public prosecutors.
 Until 2013, the figures on SMG Sections 35 and 37 were communicated to the Ministry of Health by the public prosecutors and the courts.
 As of 2014, all data reported have been provided by the Federal Ministry of Justice (BMJ), which may result in a break in the time series; detailed figures on SMG Section 35, para. 4 cannot be made available as the entries in the BMJ database are not broken down by paragraph.

Sources: BMG, BMJ; as of 2014: only BMJ; graphic representation: GÖG

The developments in crime reports and convictions, as well as alternatives to punishment, present an interesting picture. Based on an index that was set at 100% for the year 1998, i.e. the year when the SMG entered into force, Figure 2.3 reveals that, from 2008 to 2015, the proportions of crime reports submitted and reports on the application of alternatives to punishment increased by roughly the same degree, whereas in the case of convictions, this only applies to the period from 2009 to 2012. In the reporting year 2016, the number of crime reports show an index-linked 19% increase as against 2015, whereas alternatives to punishment have increased markedly. This probably results from the modifications of the SMG following the adoption of the 2015 Criminal Code Amendment Act (BMJ 2017). Until 2015, convictions remained roughly at the level of 2010, and in 2016, a considerable decline has become apparent.

Figure 2.3:
Comparison of index-linked developments of reported drug offences, convictions and application of statutory alternatives to punishment in Austria; 2007–16*



Note: The calculations are based on the year 1998, i.e. the year in which the Narcotic Drugs Act was replaced by the Narcotic Substances Act.

The figures for convictions refer to the leading offence, i.e. the most serious offence with regard to the range of punishment. For instance, if a person who has committed several offences is convicted for robbery, an additional conviction under the SMG is not included in the statistics.

* As of 2012, data on the legal basis of conviction have no longer been compiled by STATISTICS AUSTRIA but by the courts. As of 2014, the data on the application of statutory alternatives to punishment have been provided by the Federal Ministry of Justice, which may result in a break in the time series.

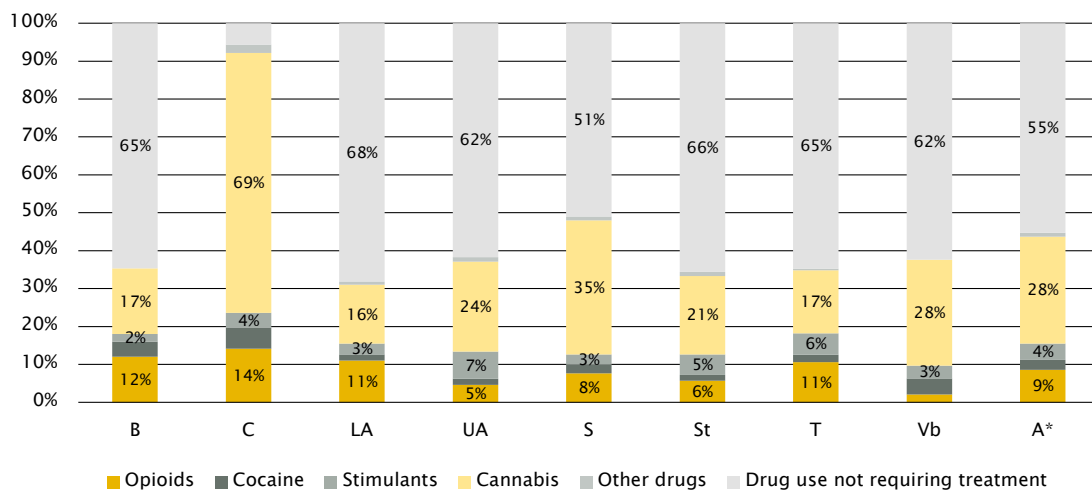
Sources: BMI/.BK, STATISTICS AUSTRIA, BMG, BMJ; calculation and graphic representation: GÖG

In 2016, the expenditure for health-related measures – particularly in the context of treatment instead of punishment – incurred by the Austrian Federal Ministry of Justice (BMJ; see also chapter 1) has decreased only slightly, and has thus remained roughly at the level of 2012 (BMJ 2017). As already discussed in GÖG/ÖBIG 2012, as of 2011 the maximum period of inpatient treatment in the context of treatment instead of punishment has been limited (to six months), and access to treatment instead of punishment has been generally restricted for repeat offenders. According to experts, this has led to a situation where expert opinions are issued stating that six months of treatment are insufficient for a person, and as a consequence, this person has to serve a prison sentence immediately – which runs counter to the intentions of the relevant provision. However, in certain cases, for which a need for treatment or funding beyond the limited resources granted by the court administration was identified, the provinces were willing to fund longer inpatient treatment (SHH 2014).

With regard to the implementation of the applicable provisions, **the new principle of giving priority to notifying the health authorities** and the corresponding application of health-related measures under SMG Section 11 are of specific interest. Figure 2.4 illustrates for which substances health-related measures were deemed necessary in 2016, and up to which extent drug use was not regarded as requiring treatment. Compared to previous years, the differences between individual provinces regarding decisions on the need for compulsory health-related measures seem to have

grown smaller (see also section 2.4). Carinthia continues to constitute an exception: in almost all cases of drug use, health-related measures have been deemed necessary.

Figure 2.4:
Health-related measures (by primary drug or drug use requiring treatment); in 2016



B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, St = Styria, T = Tyrol, Vb = Vorarlberg, V = Vienna; A* = Austria not counting Vienna.

Note: In the examinations carried out in Vienna, rather than substance-related statements on the need for further interventions, a more comprehensive addiction-related case history is provided, which focuses on the status of addiction disease and not on individual substances. No data are therefore available for Vienna.

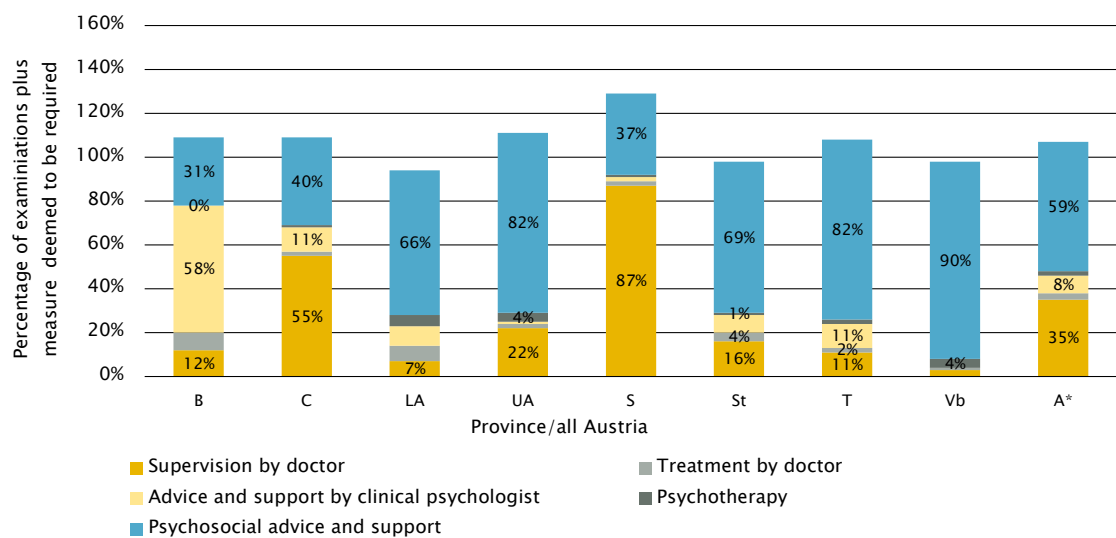
Source: eSuchtmittel; calculation and graphic representation: GÖG

2016 has seen a total of 5 465 examinations (of 5 222 persons) by the health authority in accordance with SMG Section 12; which represents a 27% reduction of examinations compared to the previous year. So far, one can only assume that this decline may result from a misinterpretation of the change in the legal framework that took place in 2016 (see Weigl et al. 2016). The revised manual on SMG Section 12 (see section 2.4) should enable further insight in this respect as well. More than half of the examinations were carried out due to notification by the police (61% under the SMG; 2% under the StVO), 26% of examinations were ordered to be performed by the courts or public prosecutors, 5% by army units, and 6% by other institutions (Anzenberger et al. 2017).

In Figure 2.5 it becomes apparent which type of health-related measure was regarded as appropriate in the case of exclusive use of cannabis in 2016. One has to bear in mind here that several health-related measures can be recommended simultaneously in each case. Figure 2.6 shows the type of health-related measure indicated in cases of opioid use (often in addition to the use of other drugs) that were regarded as requiring treatment. It has become apparent that the measures that are deemed adequate depend on the primary drug used. In the case of opioids, medical treatment (usually in the form of opioid substitution treatment) predominates, followed by psychosocial advice and support. For cannabis use, on the other hand, usually psychosocial advice and

support, and supervision by a doctor are recommended. The differences between individual provinces make it obvious that their approaches to SMG Section 12, and possibly also their documentation routines, continue to be divergent. However, differences with regard to the availability of individual types of measure also seem to be a relevant factor (see also section 2.4).

Figure 2.5:
Health-related measures for cannabis as the primary drug, by province; in 2016

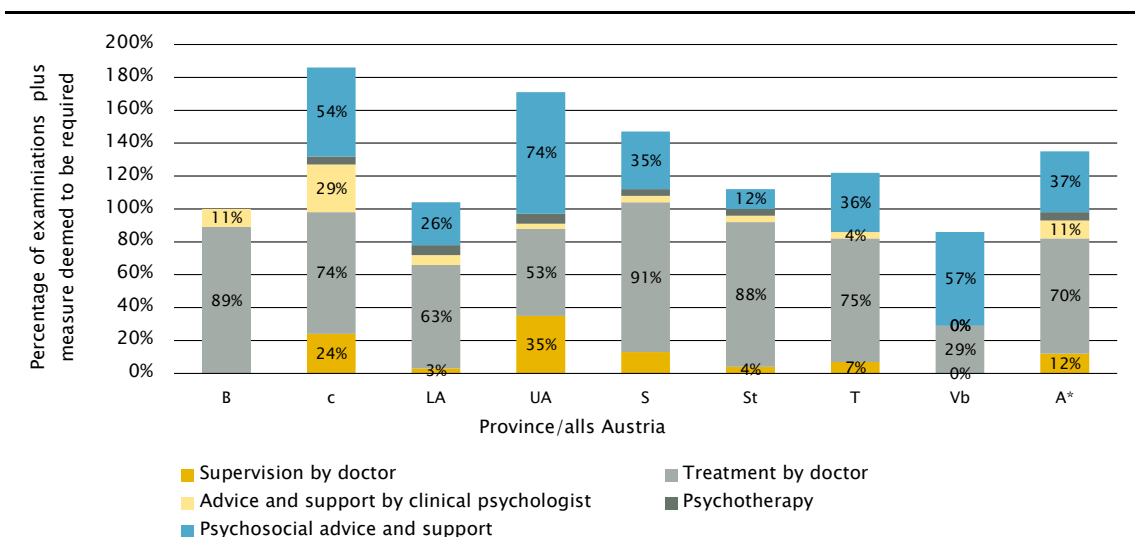


B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, St = Styria, T = Tyrol, Vb = Vorarlberg, V = Vienna; A* = Austria not counting Vienna.

Note: The reports by the district administration authorities only mention cannabis abuse. In each case, more than one health-related measure may be deemed necessary (indication of multiple measures is possible). Additional health-related measures can also be waived if the person concerned has already undergone a measure that has been deemed sufficient. Double counts of persons cannot be ruled out either. In the examinations carried out in Vienna, rather than substance-related statements on the need for further interventions, a more comprehensive addiction-related case history is provided, which focuses on the status of addiction disease and not on individual substances. No data are therefore available for Vienna.

Source: eSuchtmittel; calculation and graphic representation: GÖG

Figure 2.6:
Health-related measures for opioids as the primary drug, by province; in 2016



B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, St = Styria, T = Tyrol, Vb = Vorarlberg, V = Vienna; A* = Austria not counting Vienna.

Note: The reports by the district administration authorities mention opioid misuse, irrespective of whether other drugs have been indicated as well. In each case, more than one health-related measure may be deemed necessary (indication of multiple measures is possible). Additional health-related measures can also be waived if the person concerned has already undergone a measure that has been deemed sufficient. Double counts of persons cannot be ruled out either. In the examinations carried out in Vienna, rather than substance-related statements on the need for further interventions, a more comprehensive addiction-related case history is provided, which focuses on the status of addiction disease and not on individual substances. No data are therefore available for Vienna.

Source: eSuchtmittel; calculation and graphic representation: GÖG

2.4 New developments

A set of measures for quality and safety in opioid substitution treatment, which essentially constitutes a treatment guideline, was prepared by a large number of experts and adopted by four medical associations (see also chapter 5). In response, in May 2017 the Ministry of Health submitted amendments to the SMG, the Narcotic Drugs Regulation (SV), the Regulation on Psychotropic Substances (PV) and the *Regulation on Further Training in Oral Substitution (WbVO)* for examination in the context of general evaluation procedure. The reason for this is that since 2006 – unlike with other types of medical treatment – certain details of opioid substitution treatment provided by doctors have been laid down in regulations and thus affect the delivery of treatment. Normally, the 1998 Doctors' Act forms the legal basis for medical treatment, and legally requires doctors to treat their patients in line with the current state of the art and experience. However, the treatment criteria of the Narcotic Drugs Regulation that doctors must comply with when delivering OST have resulted in incompatibilities between the obligation to provide state-of-the-art treatment for individual patients on the one hand and the directives of the Narcotic Drugs Regulation on the other. Moreover, due to the structure of the rules, a violation of the directives also involves the risk of committing a punishable offence under the Narcotic Substances Act, which means that doctors

may face the risk of criminal prosecution. It has been confirmed by various studies that this is one of the reasons why doctors are reluctant to accept patients for opioid substitution treatment (see also chapter 5; Weigl et al 2016 and previous reports). The goal of the above set of measures is to assure the quality of treatment, in line with the medical state of the art and experience (treatment guideline), so that – as in the case of other types of treatment – doctors who provide OST are subject to the corrective provisions of medical law (and in the case of malpractice resulting in harm to patients, subject to criminal law) but do not run the risk of administrative or criminal proceedings under drug law as drug dealers do. Medical treatment has thus been exempted from the administrative sanctions defined in the SMG, with the exception of cases in which attending doctors have violated their documentation and information obligations towards the health authorities. This is punishable by a fine of up to EUR 7 500, and in the case of repeat offences, up to EUR 15 000 (SMG Section 44a). The new measures are aimed at ensuring therapy freedom by removing a recognised obstacle which impairs medical treatment, and also at contributing to the destigmatisation and normalisation of addiction treatment.

The planned **modifications of the Narcotic Substances Regulation** (SV) therefore include the withdrawal of

- » the treatment goals and the indication criteria (both in SV Section 23a);
- » the strict disciplinary criteria for the treatment contract or for exclusion from treatment, respectively (SV Section 23b);
- » the restrictions regarding the choice of substitution medicine by defining ‘medicines of choice’ (SV Section 23c); as well as
- » the differentiation according to active ingredient with regard to the mode of dispensing (SV Section 23e).

The amended Regulation, which had not yet been issued when the present report was drawn up, also includes a more precise definition and delineation of the tasks of doctors delivering OST on the one hand and public health officers involved in OST on the other. The task of the public health officers is – in the interest of public health – to check long-term prescriptions with regard to possible danger to third parties who may be involved in individual cases, especially if high daily doses are involved and take-home schemes are in place. The **treatment guideline** defines daily doses of the substances used for treatment, which are sufficient in most cases. In addition, the admissibility of take-home doses for a longer period is subject to medical and psychosocial stability criteria that must be met by the patient. The amended Narcotic Substances Regulation also relates to these provision as the treating doctor must give reasons for prescribing higher doses, and confirm the patient’s compliance with the stability criteria. The public health officer must check the corresponding parameters before the long-term prescription is made out (SV Sections 23b, 23c, 23e, 23g).

In addition, the **amendment to the SMG** (BGBl. I 116/2017), which has already entered into force, provides the basis, in terms of data protection, for a closer cooperation between pharmacies, health authorities and doctors delivering OST. The pharmacists are required to inform the attending doctor whenever they are aware of any behaviour on the part of the OST patient that indicates the risk of self-harm or harm to third parties, and they are required to inform other doctors if those doctors have prescribed additional psychotropic medicines to an OST patient. In addition,

the health authorities are allowed to notify the attending doctors of information supplied by the police that a patient is assumed to have violated drug laws (e.g. passing on of substitution medicines to other persons, purchase of drugs for additional use) whenever the authorities are notified of such a suspicion in the context of the enforcement of SMG Section 12 (examination of persons with regard to drug use). The doctors can then respond to this situation and whenever necessary adapt their treatment accordingly (amended SMG Section 8a, paras. 4 and 5).

The goal of the set of measures described – i.e. the treatment guideline for doctors, combined with the intensified cooperation under the SMG between pharmacists, health authorities and the attending doctors, as well as cooperation between doctors and public health officers with regard to prescription and authorisation – is thus to optimise opioid substitution treatment, while minimising the risk of harm to third parties in connection with take-home medicines.

Further **amendments**, some of which are also connected with the new measures for opioid substitution treatment, include the following:

- » Improvement of the data basis for the epidemiological key indicator or drug-related deaths and mortality of drug users (SMG):
 - » In the future, the Ministry of Health will also get the autopsy documents and confirmation-of-death certificates of those cases in which a definitive relationship between drug use and death could not safely be confirmed (SMG Section 24c).
 - » In the future, the Ministry of Health will be able to request from Statistics Austria those data that are needed for the calculation of mortality rates connected with drug use (SMG Section 24d).
- » **Proposals for amendments to the Further Training Regulation (WbVO):**
 - » Introduction of a multiple-choice test for completion of the basic module of the oral substitution further training programme, to test the knowledge that has been acquired (WbVO Section 4).
 - » Publication, as in the past, of the list of doctors who meet the quality criteria for delivering opioid substitution treatment (WbVO Section 5).
 - » Definition of the prerequisites for re-entry on the list after a previous removal from the list (WbVO Section 7a).

Further proposals for amendments to the Narcotic Substances Regulation (SV) that do not concern opioid substitution treatment of addicted persons:

- » Harmonisation with EU law of the provisions defining exceptions for industrial hemp (with a low THC content). It is, however, important to emphasise that it is not permitted to process the flowers and fruits to obtain cannabis extract for the purpose of producing medicines, dietary supplements or cosmetics (SV Annex I).
- » Implementation of new international regulations by including the substance of acetyl fentanyl in Annex I of the SV (plus definition of a limit quantity of 1.0 g in the SGV).

Proposals for amendments to the Psychotropic Substances Regulation (PV):

- » Implementation of Decision 59/7 of the CND by including phenazepam as a psychotropic substance in Annex 2 of the PV. The former Section 11, para. 2 of the Psychotropic Substances Regulation is to be withdrawn in connection with para. 4 of Section 8a of the SMG as amended.
- » The limit quantity for phenazepam in accordance with the PGV is to be 3.0 g.

Further changes to the legal framework concern the **New Psychoactive Substances Regulation** (NPSV). These have become necessary as several new psychoactive substances have been identified in the past few years which had not yet been covered by the NPSV, or which have meanwhile been subjected to control measures at the EU level. Thus, in October 2016, both the compounds listed in Annex II, as well as new substances (Annex I) and relevant structure examples (Annex III) were included in the NPSV.

- » New substances:
 - » AH-7921 (doxylam) or 3,4-dichloro-N-[(1-(dimethylamino)cyclohexylmethyl)benzamide
 - » U-47700 or trans-3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methylbenzamide.
- » Adapted compounds:
 - » arylcyclohexyl amine, pyrrolidine and piperidine compounds
 - » benzyl piperidine and benzyl pyrrolidine compounds
 - » 2-aminophenyl oxazole- and 2-aminophenyl oxazolone compounds

With regard to the **implementation of the 2016 SMG amendments**, several field reports have been made available. For instance, according to the Z6 drug support centre, now health has in fact become the key factor, as intended, and police activities have focused on combating drug trafficking (Z6/Drogenarbeit 2017). Fears of an increase in urinalyses have not played out. In contrast, the Tyrolean Addiction Advisory Service at Reutte reports that in the beginning fewer clients were referred to them by the health authorities to undergo health-related measures (Suchtberatung Tirol 2017), but that good networking and intensive cooperation have helped improve procedures so that, eventually, an even larger number of drug users could be reached.

The provisions of the SMG, according to which only AGES is permitted to grow cannabis plants to obtain drugs for the manufacture of medicines (SMG Sections 6 and 6a; see also Weigl et al. 2016), have given rise to legal proceedings on grounds of inadmissible restriction of the fundamental freedom to carry on a business. However, in November 2016, the Austrian Constitutional Court confirmed that the said provisions are constitutional (Verfassungsgerichtshof 2016).

The reporting period did not see any new **evaluations** of the legal framework; however, the Ministry of Health manual on the enforcement of SMG Section 12 was evaluated in 2016, and revised on

the basis of the results and the amendments to the SMG (BMGF 2017).²³ The evaluation has confirmed that differences between the provinces continue to exist with regard to both practical implementation and with regard to the views on the roles and tasks of public health officers as far as enforcement of SMG Section 12 is concerned (Tanios et al. 2017). Potential for improvement continues to exist as regards more uniform procedures for summons to appear for the examination, the examination itself and the selection of health-related measures. It has also become apparent in the evaluation that the manual is, in fact, well known and used as a guideline. Whereas certain recommendations of the evaluation have been taken into account and revisions have been integrated into the manual, in other cases, the existing text has been deemed sufficient. In response to the uncertainty that has been identified in some fields as regards the implementation of SMG Section 12, it has been recommended that exchange at the regional level should be intensified and that further training offers should be taken up.

The discussion of the **legal regulation of cannabis** has again intensified during the reporting period. A distinction between young people and adults is drawn here: for young people, the existing provisions shall remain in force, whereas for adults, regulated access to cannabis that enables quality assurance and maximum THC concentrations has been deemed reasonable (Z6/Drogearbeit 2017).

2.5 Sources and methodology

Sources

Drug-related database

The SMG legally requires the Ministry of Health (BMGF) to maintain a database with personal data (Sections 24ff). Until the end of 2015, it included notifications by both the BMI and the judicial authorities concerning crime reports submitted and concerning criminal proceedings under the SMG; the judicial authorities and a number of other authorities listed in the SMG had access to this database. When the *Judicial Proceedings Automation System* was introduced, it was no longer necessary to maintain a database on judicial data at the BMGF (see Weigl et al 2016); since the amendment to the SMG that entered into force on 1 January 2016, these data have no longer been entered in this database.

However, the data collected by the health authorities in the context of the enforcement of the SMG continue to be maintained at the database, i.e. the results of examinations carried out by the health authorities (under SMG Section 12) in cases of suspected drug abuse (SMG Section 24a,

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The German version of the manual can be downloaded under https://www.bmgf.gv.at/home/Gesundheit/Drogen_Sucht/Drogen/Leitlinie_fuer_die_Gesundheitsbehoerden_Handbuch_fuer_die_Vollziehung_des_sect_12_Suchtmittelgesetz (accessed 24 August 2017).

para. 3); as well as the data of the substitution registry (SMG Section 24b), which is aimed at identifying at the earliest possible stage, and at preventing, multiple prescriptions by the health authorities of substitution medicines to persons addicted to opioids. Since the adoption of the 2008 amendment to the SMG (BGBl. I 2008/143), the health authorities have gathered, and accessed, these data online, in a common inter-administrative infrastructure (*eSuchtmittel*), in line with the E-Government Act. The corresponding electronic infrastructure was established by the Ministry of Health in inter-administrative cooperation (public authorities portal group).

After their transfer to a pseudonymised statistics registry, the BMGF can use these data for epidemiological purposes. Due to the amendments to the SMG entering into force on 1 January 2016, the health authorities are informed by the BMGF, through *eSuchtmittel*, of notifications by the criminal police force (SMG Section 13, para. 2b, and Section 14, para. 2), as a basis for implementing SMG Section 12. The data of the pseudonymised statistics registry can thus also be made available for epidemiological purposes. Combined with the data that the BMI and STATISTICS AUSTRIA must report to the BMGF, in order to enable the recording and analysis of drug-related deaths, as well as the autopsy reports that must be communicated by the institutions performing the autopsies (Section 24c), the *eSuchtmittel* data form the basis for annual analyses, which have also been used for the purpose of this report (see chapter 3).

Data on crime reports, seizures, convictions and alternatives to punishment

The data on crime reports are based on BMI data (BMI 2017). They primarily reflect the intensity and focuses of police activities. All data on diversion have either been provided by the Ministry of Justice (BMJ) or come from the BMJ safety report (BMJ 20167. As has already been mentioned in section 2.2.2, with regard to data on convictions provided by STATISTICS AUSTRIA (judicial criminal statistics) as of 2012 the number of all drug-related offences on which convictions are based has been obtained.

Examinations by public health officers: see chapter 3

Information from parliamentary sources

Information on Parliamentary Citizen's Initiatives and drafts to be sent out for evaluation, as well as reports on committee meetings is given on the website of the Austrian Parliament (<http://www.parlament.gv.at/>); and information on amendments that have entered into force is provided by the legal information system of the Federal Chancellery (<https://www.ris.bka.gv.at/>).

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2.7 Referenced Federal Acts

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BGBl. 1969/144. Bundesgesetz über den Vollzug der Freiheitsstrafen und der mit Freiheitsentziehung verbundenen vorbeugenden Maßnahmen (Strafvollzugsgesetz – StVG)

BGBl. 1974/60. Strafgesetzbuch

BGBl. 1975/631. Strafprozessordnung 1975 (StPO)

BGBl. 1988/599. Bundesgesetz vom 20. Oktober 1988 über die Rechtspflege bei Jugendstraftaten (Jugendgerichtsgesetz 1988 – JGG)

BGBl. I 1997/112. Bundesgesetz über Suchtgifte, psychotrope Stoffe und Drogenausgangsstoffe (Suchtmittelgesetz – SMG)

BGBl. I 1997/120. Führerscheingesetz

BGBl. I 2007/110. Suchtmittelgesetz–Novelle 2007

BGBl. I 2008/143. Suchtmittelgesetz–Novelle 2008

BGBl. I 2010/111. Budgetbegleitgesetz 2011 (BBG)

BGBl. I 2011/146. Bundesgesetz über den Schutz vor Gesundheitsgefahren im Zusammenhang mit Neuen Psychoaktiven Substanzen (Neue–Psychoaktive–Substanzen–Gesetz, NPSG)

BGBl. I 2014/71. Strafprozessrechtsänderungsgesetz 2014

BGBl. II 1997/322. Verordnung des Bundesministers für Wissenschaft und Verkehr über die gesundheitliche Eignung zum Lenken von Kraftfahrzeugen (Führerscheingesetz–Gesundheitsverordnung – FSG–GV)

BGBl. II 1997/374. Verordnung der Bundesministerin für Arbeit, Gesundheit und Soziales über den Verkehr und die Gebarung mit Suchtgiften (Suchtgiftverordnung – SV)

BGBl. II 2006/449. Verordnung der Bundesministerin für Gesundheit und Frauen über die Weiterbildung zum/zur mit Fragen des Suchtgiftmissbrauchs hinreichend vertrauten Arzt/Ärztin für den Bereich der oralen Substitutionsbehandlung von opioidabhängigen Suchtkranken (Weiterbildungsverordnung orale Substitution).

BGBl. II 2011/468. Neue-Psychoaktive-Substanzen-Verordnung (NPSV)

2.8 Annex

Table A2. 1:
Convictions under the Narcotic Substances Act (SMG) and total number of convictions in Austria;
2007–16

Year	Total number of convictions under the SMG	Convictions under SMG Section 28 or 28a	Convictions under SMG Section 27	Convictions in Austria	
				total number	of those: under SMG (per cent)
2007	5 437	1 387	3 956	43 158	12.6
2008	4 291	1 332	2 899	38 226	11.2
2009	3 928	1 283	2 593	37 868	10.4
2010	4 363	1 466	2 838	38 394	11.4
2011	4 444	1 185	3 137	36 461	12.2
2012*	4 261	1 403	2 810	35 541	12.0
2013	4 252	1 289	2 933	34 424	12.4
2014	4 368	1 319	3 023	32 980	13.2
2015	4 435	1 389	3 041	32 118	13.8
2016	3 993	1 504	2 479	30 450	13.1

Until 2007:

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

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

As of 2008:

SMG Section 27 = illicit handling of narcotic drugs.

SMG Section 28 = preparation for trafficking in narcotic drugs.

SMG Section 28a = trafficking in narcotic drugs.

Note: The figures refer to the leading offence, i.e. the offence that is most severe with regard to the range of punishment, the table therefore does not include all convictions based on the SMG.

* As of 2012, a **break in the time series** has to be taken into account. Since that year, information on all offences leading to convictions has been provided by the **courts**. Until then, STATISTICS AUSTRIA determined the leading offence, using an algorithm to calculate the offence with the highest range of punishment in cases where a defendant was found guilty of several offences.

Due to this break in the time series, it is only to a limited extent possible to compare the new figures to those prior to 2012.

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

Table A2. 2:

Number of final convictions under the Austrian Narcotic Substances Act (SMG), leading offence, gender and age group; in 2016

Leading offence		Aged 14–19	Aged 20–24	Aged 25–29	Aged 30–34	34+	Total
SMG total	Men	576	1 101	767	512	758	3 714
	Women	34	78	77	42	48	279
SMG Section 28 or 28a	Men	120	350	292	220	405	1 387
	Women	7	29	38	17	26	117
SMG Section 27	Men	456	751	472	291	350	2 320
	Women	27	49	38	25	20	159

SMG Section 27 = illicit handling of narcotic drugs.

SMG Section 28 = preparation for trafficking in narcotic drugs.

SMG Section 28a = trafficking in narcotic drugs.

Note: The figures refer to the leading offence, i.e. the offence that is most severe with regard to the range of punishment, the table therefore does not include all convictions based on the SMG.

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

Table A2. 3:

Final convictions under the Austrian Narcotic Substances Act (SMG), disaggregated by young people and adults, leading offence and type of punishment; in 2016

Leading offence		Fine	Prison sentence			Other punishment ¹	Total
			Probation	No probation	Partial probation		
SMG total	Young people	55	136	34	27	24	276
	Adults	767	1 129	991	674	156	3 717
SMG Section 28 or 28a (felonies)	Young people	7	32	6	6	4	55
	Adults	33	333	585	401	97	1 449
SMG Section 27 (misdemeanours)	Young people	48	104	28	21	20	221
	Adults	732	788	406	273	59	2 258

Young people = persons aged under 18 at the time of the offence.

SMG Section 27 = illicit handling of narcotic drugs.

SMG Section 28 = preparation for trafficking in narcotic drugs.

SMG Section 28a = trafficking in narcotic drugs.

¹ Other punishment: partial probation (Criminal Code Section 43a, para. 2), i.e. combination of a fine without probation and prison sentence on probation; referral to an institution (Criminal Code Section 21, paras. 1 and 2); no additional punishment (Criminal Code Section 40); conviction with punishment reserved (Juvenile Court Act Section 13) and conviction without punishment (Juvenile Court Act Section 12).

Note: The figures refer to the leading offence, i.e. the offence that is most severe with regard to the range of punishment.

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

Table A2. 4:

Development of statutory alternatives to punishment applied in Austria; 2007-16

Temporary discontinuation of penal action/ dismissal of proceedings	2007	2008	2009	2010	2011	2012	2013	2014**	2015	2016
Total (SMG Sections 35 and 37)	10 175	9 384	10 627	11 807	11 667	11 455	13 044	14 506	14 384	25 666
SMG Section 35: temporary discontinuation of penal action by the public prosecutors*	9 008	8 399	9 661	10 643	10 319	10 215	11 818	12 378	12 256	23 809
SMG Section 35, para. 4 (first report after at least 5 years, exclusively personal use of cannabis, mushrooms containing psilocin, psilocin or psilocybin, or psychotropic substances)*	1 841	2 249	2 780	3 166	4 059	5 515	6 766	-	-	-
SMG Section 37: temporary dismissal of proceedings by the court*	1 167	985	966	1 164	1 348	1 240	1 226	2 128	2 128	1 857
SMG Section 39 (suspension of sentence)	540	638	624	733	741	673	728	705	673	561

* Until 2013, data were communicated to the Ministry of Health by the public prosecutors and the courts.

** As of 2014, all data reported have been provided by the Federal Ministry of Justice (BMJ), which may result in a break in the time series; detailed figures on SMG Section 35, para. 4 cannot be made available as the entries in the BMJ database are not broken down by paragraph.

Until 2007:

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

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

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

As of 2008:

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

Section 35, para. 4 = temporary waiving of reports in the case of small quantities of cannabis for personal use.

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

Sources: BMG, BMJ; as of 2014: only BMJ; graphic representation: GÖG

Drugs

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3 Drugs

3.1 Summary

Drug use and the main illicit drugs

As to the prevalence of drug use, a distinction is made between lifetime prevalence (drug use at some point during a person's lifetime), last-year prevalence (drug use in the past year) and last-month prevalence (drug use in the past 30 days). Statements on current drug use can only be derived from last-year or last-month 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, around 2% to 4% of the population have experience of ecstasy, cocaine and amphetamine, and between roughly 1% and a maximum of 2% have experience of opioids.

Only few data are available regarding use in the general population of *new psychoactive substances* (NPS), formerly also referred to as *research chemicals* or *legal highs*. These data, however, indicate insignificant prevalence levels, in contrast to the great interest in this theme shown by the media.

A clear distinction must be made between experimental use of drugs or intermittent drug use that involves low risks, and problem/high-risk drug use. *The European Monitoring Centre for Drugs and Drug Addiction* defines high-risk drug use (HRDU) as 'recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high probability/risk of suffering such harms' (EMCDDA 2013). If exclusively legal problems have ensued, the term 'high-risk drug use' does not apply. Polydrug use involving opioids plays a key role in Austria. In the present day, Austria has between 29 000 and 33 000 high-risk drug users of opioids (mostly combined with use of other illicit drugs, alcohol or psychopharmaceuticals). Around half of these persons live in Vienna (drug addiction continues to be more frequently found in urban areas than in rural communities). One out of four high-risk drug users is female, and 11% are under 25 years old. Snorting continues to be a relevant form of opioid use.²⁴ Between 12 000 and 17 000 persons are estimated to lean towards injecting drug use as their preferred route of administration.

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This is characteristic of Austria, contrary to the European trend of inhaling.

New developments

In recent years, the range of substances taken in the context of experimental use has been found to be widening. Within certain scenes and groups of young people, high prevalence rates are apparent for a variety of substances, including biogenic drugs, solvents and inhalants. However, in most cases, use of illicit substances is limited to a short period in life.

Almost all available drug monitoring data indicate a decline in high-risk opioid use in the age group under 25 (fewer persons taking up this pattern of use). It is not yet certain whether this indicates a decrease in illicit drug use as such, or a shift towards other substances (cannabis, methamphetamine). At present, no definite indications of such a change are apparent for Austria. For some time, a methamphetamine scene became established in Upper Austria, and methamphetamine also entered the problem opioid use scene. Even though several sources of data indicate that methamphetamine use continues to be more frequent in Upper Austria than in other provinces (e.g. in terms of crime reports and use requiring treatment under SMG Section 12), the absolute figures of use have considerably declined as against past years.

With regard to high-risk drug use, several deaths connected with (high-potency) ecstasy pills have been recorded (see chapter 6). Even though the patterns of ecstasy use do not seem to have changed, it has apparently become more hazardous to use ecstasy, as the pills often contain (unexpectedly) high doses of the active ingredient (see chapter 7).

Relevant surveys and studies

The latest available figures on the use of illegal and legal substances are from 2015 and were collected from among the general population (representative survey on substance use) and from among school students (ESPAD European School Survey Project on Alcohol and Other Drugs). The results of the two surveys, which were conducted on behalf of the Ministry of Health, can be compared with the data of prior years (which thus enables analyses of time series).

3.2 Cannabis

3.2.1 Prevalence and trends

Cannabis use in the general population

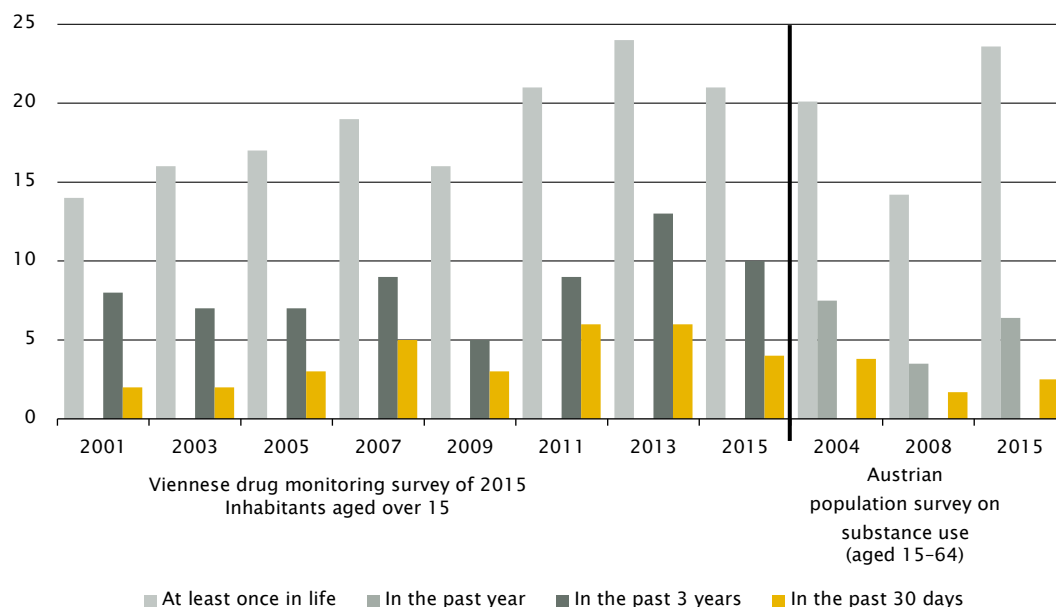
Regarding people aged 15 to 64 with experience of cannabis, the Austrian population surveys on drug use indicate a proportion of 20% for 2004, 14% for 2008 and 24% for 2015. The markedly lower figures for 2008 probably result from a surveying artefact (see GÖG/ÖBIG 2009). As far as long-term trends are concerned, a slight rise in the proportion of people aged 15 to 64, and fairly constant proportions for the entire adult population (aged 15 or older²⁵) are apparent (see Table A3.1). The Viennese drug monitoring survey, which is conducted every two years, indicates a steady rise in cannabis use over time. In the latest survey, however, a slight decline of lifetime prevalence rates has become apparent.

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The figures in Table A1 in the Annex refer to the entire adult population aged over 15, i.e. they include people over 64.

Figure 3.1:

Cannabis use (lifetime prevalence, 3-year prevalence, last-year prevalence, last-month prevalence), data obtained from the Viennese drug monitoring survey and three Austrian population surveys (time series)



Note: The Austrian population survey on substance use does not include figures for 3-year prevalence rates. The figures in Table A1 in the Annex refer to the entire adult population aged over 15, i.e. they include people over 64. Last-year prevalence is not covered by the Viennese drug monitoring survey.

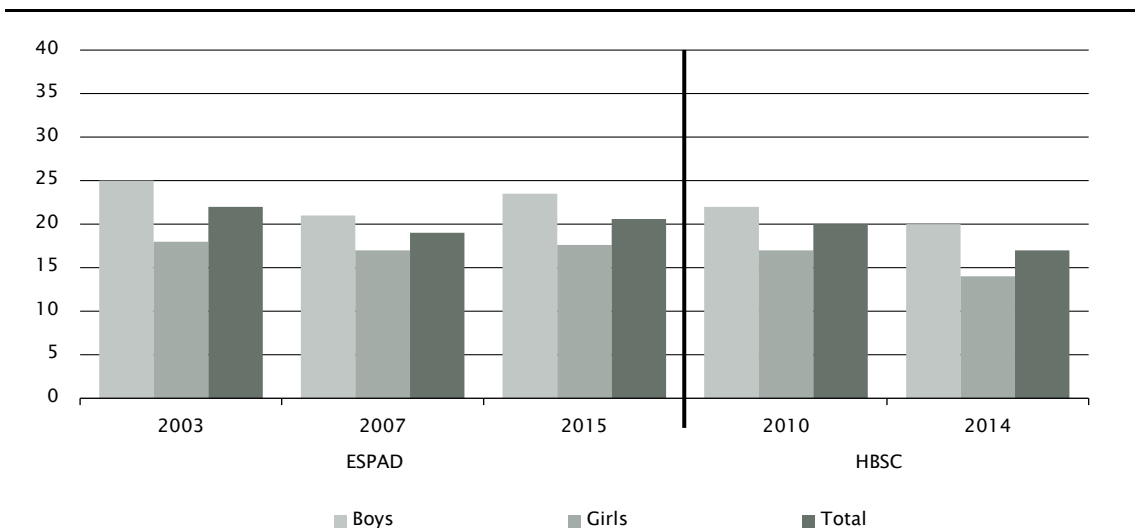
Sources: IFES 2001 to 2015, Uhl et al. 2005a; Uhl et al. 2009, Strizek and Uhl 2016; graphic representation: GÖG

However, experience of cannabis use is restricted to a short period in most cases, which is reflected in the considerable discrepancy between lifetime prevalence rates and cannabis use in the past month (see Figure 3.1).

Recent data from Upper Austria have also been made available (Seyer et al. 2016). In the *Upper Austrian drug monitoring survey*, the lifetime prevalence rate for cannabis in the age group between 15 and 59 is 26%, whereas the last-year prevalence rate is 6%, and the last-month prevalence rate, 3%.

Cannabis use among adolescents and young adults

Figure 3.2:
Cannabis use: Lifetime prevalence among young people, by gender, in ESPAD and HBSC (time series)



ESPAD = European School Survey Project on Alcohol and Other Drugs (see section 3.6.2).

HBSC = Health-Behaviour in School-Aged Children (see section 3.6.2).

Note: The ESPAD data relate to young people aged 15 and 16, and the HBSC data, to young people aged 15 and 17.

Sources: Uhl et al. 2005b, Strizek et al. 2009, Strizek et al. 2016, Ramelow et al. 2011, Currie et al. 2012, Ramelow et al. 2015; graphic representation: GÖG

Approximately one out of five school students (ESPAD, HBSC; see Table A3. 2) indicate that they have already used cannabis at least once. In all available data, the percentages are slightly higher for boys than for girls. In the time series, only small changes are apparent (see Figure 3.2).

Additional data on young people aged 15 to 24 are available for Upper Austria (Seyer et al. 2016). In the *Upper Austrian drug monitoring survey*, lifetime prevalence rates for cannabis of 35% are reported for the group of young adults, and the last-year prevalence is 13%.

According to the latest Austrian population survey on substance use (Strizek and Uhl 2016), the lifetime prevalence rate is 29% in the case of adolescents and young adults (aged 15 to 24), the last-year prevalence rate is 19%, and the last-month prevalence rate, 8%.

The available data do not indicate any significant change with regard to cannabis use either in the general population or among young people. Here, one should take into account that data obtained through surveys on illicit drugs can be extremely imprecise due to the fact that the questions relate to illicit behaviour. It must be assumed that the social climate regarding cannabis will considerably influence the respondents' readiness to admit or deny possible drug use.

3.2.2 Patterns, treatment and problem/high-risk cannabis use

No studies focusing on high-risk cannabis use have been conducted.

Reducing the demand for cannabis

Austria's treatment system as such is not oriented towards specific substances but based on an all-encompassing definition of addiction. However, wherever it is considered meaningful to do so, individual programmes focusing on specific target groups are implemented (see chapter 5).

High-risk cannabis use

The examinations by public health officers under SMG Section 12 provide information on cannabis use that is deemed to require treatment. In this regard, only data for Austria excluding Vienna are available (see chapter 2). In 2016, cannabis use requiring treatment was indicated in 1 092 cases (Busch et al. 2017). On the other hand, cannabis use is mentioned in 20 782 crime reports relating to violations of the Narcotic Substances Act (SMG). The latter figure again refers to Austria excluding Vienna (see chapter 7). This indicates that only a small proportion of cannabis users who have been reported by the police actually use cannabis in a way that requires treatment.

In 2016, approximately 2 200 persons took up support and treatment services solely for cannabis use (see chapter 5). However, a more detailed analysis dating back to 2012 reveals that only around one third of these persons were high-frequency cannabis users at the start of treatment (GÖG/ÖBIG 2013a). The rest had already reduced their cannabis use before entering treatment or had possibly never shown patterns of frequent drug use: in the case of these persons, service uptake seems rather to be regarded as an early intervention measure. However, cannabis use in the context of polydrug use is classified as requiring treatment relatively often (see chapter 5).

Since 2010 the proportion of first-time clients taking up outpatient treatment and support services who indicate cannabis as their primary drug has risen, whereas the percentage of clients with opioids as their primary drug has decreased. In 2013, the proportion of clients with the primary drug of cannabis was for the first time higher than the percentage of opioids as primary drugs. This situation was also apparent in 2015 and 2016. The reasons for this development are still being discussed: it is not sure whether it in fact represents a shift from problem opioid use to problem cannabis use, or whether a smaller need for treatment of opioid at the support centres is compensated for by the provision of services to cannabis users. In a focus group composed of representatives of addiction support centres, the participants reported new and different characteristics displayed by a changing group of clients: on the one hand, a rise in the number of patients who are undergoing treatment voluntarily has been registered, which can be explained by the destigmatisation of cannabis use. On the other, a rise in young clients with social problems has been recorded, which appears to be connected with the wider availability of high-potency cannabis.

In the hospital discharge data from 2015, harmful cannabis use (51 cases), psychotic disorder due to cannabinoids (107 cases) and dependence on cannabis (83 cases) are very rarely listed as the primary diagnoses. If secondary diagnoses are added, a total of 1 251 cases of harmful cannabis use, 154 cases of psychotic disorders and 645 cases of dependence on cannabis result (see Tables A3. 3 and A3. 4).

As the data sources mentioned above are likely to overlap to a considerable degree, the group of cannabis users for whom treatment is required does not seem to be large. The reported data do not cover persons with patterns of cannabis use that require treatment but who either do not receive treatment or are not treated within the system of addiction support and treatment services.

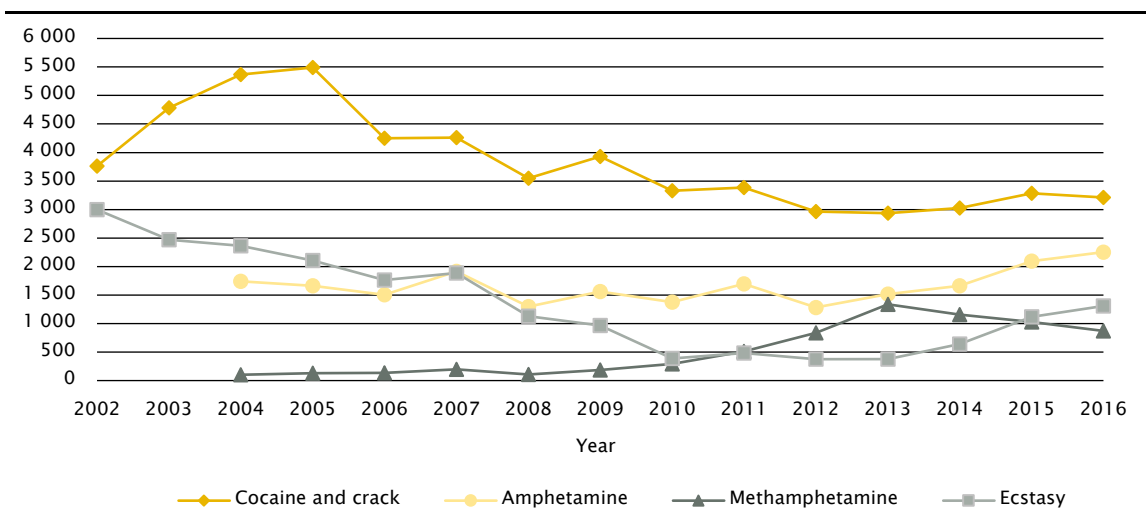
3.3 Stimulants

3.3.1 Prevalence and trends

Relative importance of different stimulant drugs

Cocaine is the stimulant that is most often mentioned in crime reports, followed by amphetamine, ecstasy and methamphetamine (see also chapter 7 and Figure 3.3). In 2016, 31% of crime reports relating to methamphetamine were accounted for by Upper Austria, which represents a considerable reduction compared to the previous year, i.e. 45%. With regard to nationwide data, both the number of crime reports concerning methamphetamine and the percentage of methamphetamine reports of the total number of SMG-related reports has seen a decline.

Figure 3.3:
Stimulants: Trends in crime reports relating to violation of the SMG in Austria, by type of substance; 2002-16



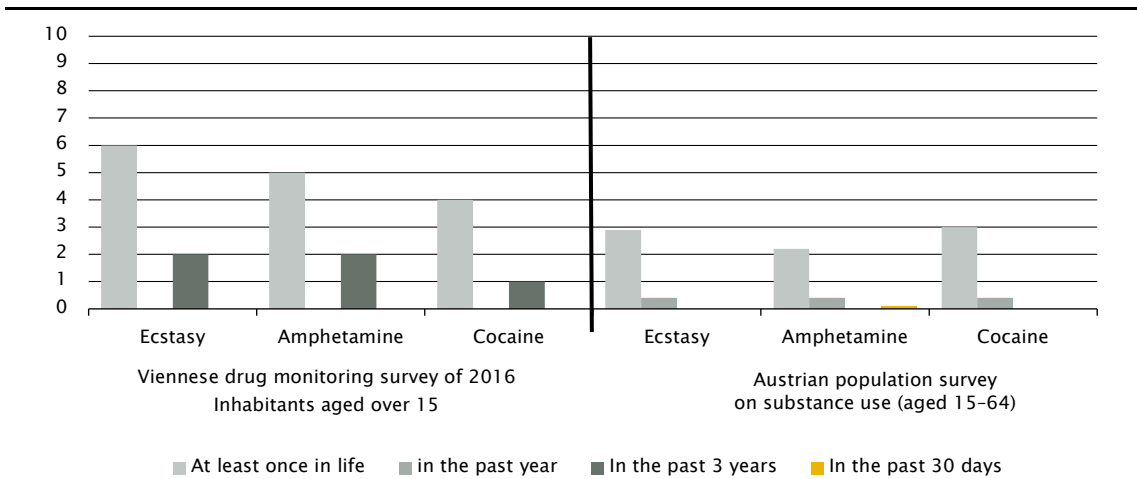
As the figures are broken down by type of drug, multiple counts of individual reports cannot be ruled out. Regarding the group 'cocaine and crack', please note that in Austria very few reports actually relate to crack.

Source: BMI/.BK; graphic representation: GÖG

Stimulant use in the general population

Only a very small proportion of the general population have experience of ecstasy, amphetamine and cocaine use (see Figure 3.4), and the figures relating to recent stimulant use are again significantly smaller. Due to the small percentages, it does not make sense to study trends over time.

Figure 3.4:
Use of stimulants (lifetime prevalence, 3-year prevalence, last-year prevalence and last-month prevalence)



Note to the 2015 Austrian population survey on substance use: the figures in Table A1 in the Annex refer to the entire adult population aged over 15, i.e. they include people over 64.

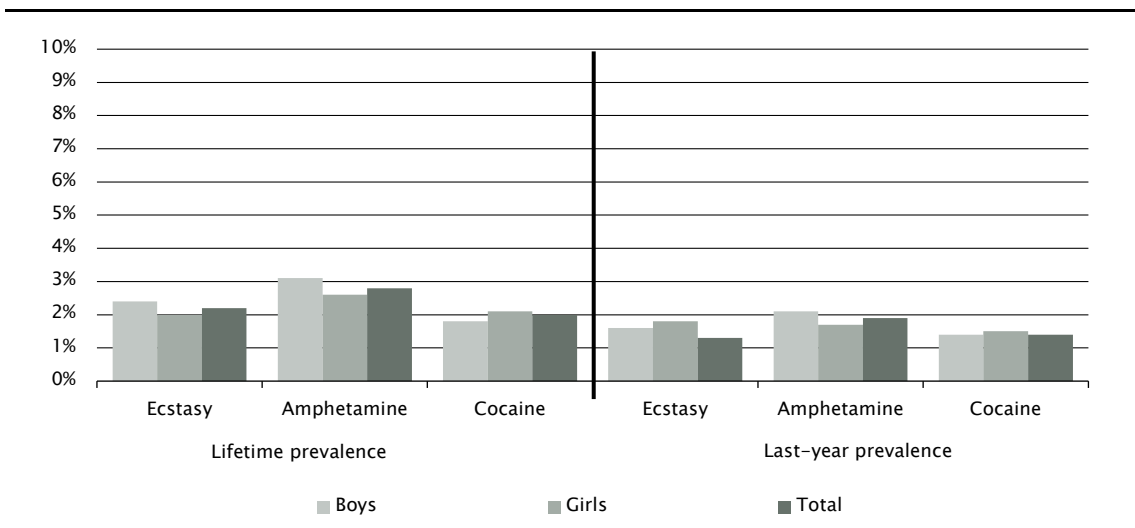
Source: IFES 2015, Strizek and Uhl 2016; graphic representation: GÖG

Additional data on stimulant use are available for Upper Austria (Seyer et al. 2016). The *Upper Austrian drug monitoring survey* of 2015 gives lifetime prevalence rates of 0.8% for amphetamines, 1.5% for ecstasy, 1.1% for cocaine and 0.3% for methamphetamine, among persons aged between 15 and 59. The very low prevalence rates for methamphetamine indicate that even though its massive media coverage does correspond with a rise in methamphetamine use in certain sub-groups, this is not reflected in a rise in its use in the general population.

Use of stimulants among young people and other populations

Figure 3.5:

Use of stimulants: Lifetime prevalence among young people, by gender (ESPAD 2015)



Source: Strizek et al. 2016; graphic representation: GÖG

The surveys among school students also generally reveal low percentages of experience of stimulant use. However – not surprisingly, due to the young age of respondents – in contrast to experience of use among adults, only small differences between lifetime prevalence and last-year prevalence have become apparent.

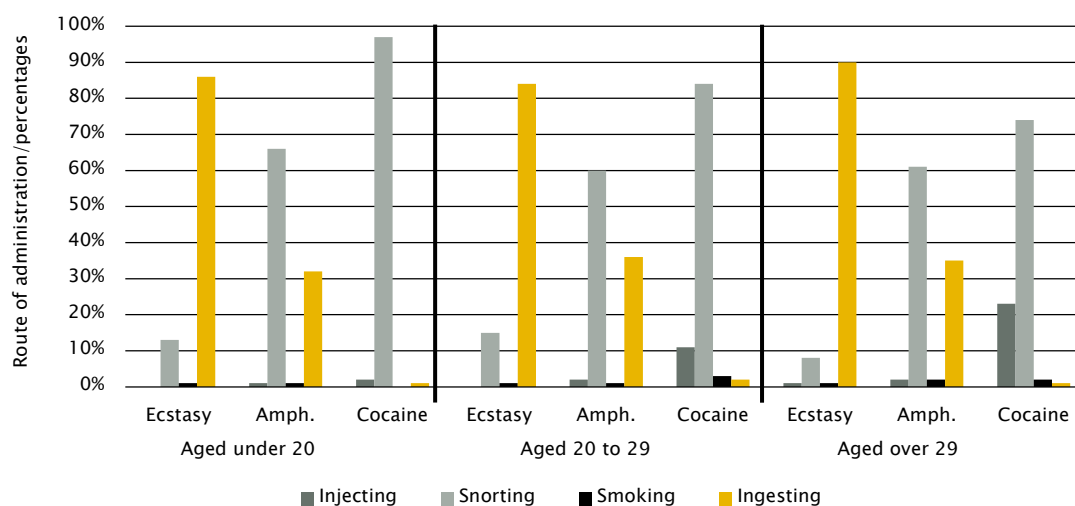
In view of the available data, a stable, low-level prevalence of stimulant use can be assumed. Use of methamphetamine has so far been restricted to local scenes and has been found primarily in Upper Austria. In the party scene, after a very short phase of intensified use of NPS, amphetamine and ecstasy have again prevailed (see section 3.5.1).

3.3.2 Patterns of high-risk stimulant use and treatment

Patterns of stimulant use

The only available information on routes of administration comes from the treatment sector (DOKLI nationwide documentation system of clients of Austrian drug services). Ecstasy is primarily ingested, amphetamines are mostly snorted and ingested, whereas cocaine is snorted, and, to a smaller degree, injected. It has become apparent that injecting cocaine more often constitutes the predominant route of administration among older cocaine users (see Figure 3.6).

Figure 3.6:
Use of stimulants: Preferred route of administration among persons starting long-term outpatient treatment in 2016 (by age group)



Amph.=Amphetamine

Source: DOKLI client year 2016

Stimulants only play a minor role with regard to drug-related deaths; they are primarily detected in the context of polydrug use involving opioids. Overdoses solely involving stimulants are rather rare (see section 6.2).

Treatment for stimulants

Austria's treatment system as such is not oriented towards specific substances but based on an all-encompassing definition of addiction. However, wherever it is considered meaningful to do so, individual programmes focusing on specific target groups are implemented (see chapter 5). With regard to methamphetamine, several experts have criticised the lack of adequate treatment options (e.g. low-threshold services, regional services in rural areas, specific treatment approaches for this target group, specific services for young people; Seyer et al. 2016).

Problem/high-risk use of stimulants

The examinations by public health officers under SMG Section 12 provide information on stimulant use deemed to require treatment (see Table 1.1). Only data for Austria excluding Vienna are available in this regard. Cocaine is the stimulant whose use is most often deemed to require treatment, followed by amphetamine use. Until 2014, methamphetamine was also included in the group of amphetamines in the examination reports by public health officers; since 2015, a separate group of methamphetamine has been added. Here, Upper Austria (5 out of a total of 11 cases) ranks first, before all other provinces. However, the figures for Upper Austria have also seen a declining

trend: in 2014, 35 cases of (meth)amphetamine use requiring treatment were recorded, and in 2015, 53 cases, with 17 of those involving methamphetamine.

Table 3.1:
Stimulant use requiring treatment according to the examinations by public health officers under SMG Section 12, by province; in 2016

Stimulant	B	C	LA	UA	S	St	T	Vb	A*
Ecstasy	1	16	5	16	2	10	4	4	58
Amphetamine	2	6	22	29	5	12	10	7	93
Methamphetamine	0	0	2	5	0	3	1	0	11
Cocaine	6	31	17	12	7	7	5	14	99
Total	9	53	46	62	14	32	20	25	261

B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, St = Styria, T = Tyrol, Vb = Vorarlberg, A = Austria.

A* = Austria not counting Vienna. In the examinations carried out in Vienna, rather than providing substance-related statements on the need for further interventions, a comprehensive addiction-related case history is compiled, which focuses on the status of addiction disease and not on individual substances. No data from Vienna are therefore available.

Source: eSuchtmittel; calculation and graphic representation: GÖG

In the expert panel on crystal meth, which was held in addition to the general population survey in the context of the *Upper Austrian drug monitoring of 2015*, it became apparent that there are individual subgroups or subcultures where methamphetamine is used excessively. This underpins the hypothesis that high-risk/problem methamphetamine use in Austria is restricted to certain local scenes and does not constitute a mass phenomenon. With regard to trends, based on qualitative data, two pictures become apparent, which are contradictory in some respects: the majority of respondents working in addiction support services, streetwork and low-threshold services report a decline in crystal meth problems and less harmful patterns of use, due to an increase in safer use. However, other respondents working in areas with direct contact with high-risk consumers (police officers, doctors specialising in addiction medicine) indicate an increase of the problem. An important result of the survey is that, in Upper Austria, the use of methamphetamine seems to have become firmly established in the scene of problem opioid users (Seyer et al. 2016).

In 2016, approximately 540 persons took up support and treatment services due to cocaine use (without additional opioid use), and 392 persons, due to use of other stimulants (without additional use of opioid and cocaine). Particularly cocaine use in the context of polydrug use (combined with opioids) is quite frequently deemed to require treatment (see chapter 5).

In the hospital discharge data from 2015 (inpatient treatment), harmful cocaine use or dependence on cocaine are very rarely listed as the primary diagnosis (3 cases and 14 cases respectively). If both primary and secondary diagnoses are considered, a total of 226 cases of harmful cocaine use, and 122 cases of dependence on cocaine result. Harmful use of, or dependence on, stimulants other than cocaine (19 and 21 cases respectively) is found slightly more often as the primary diagnosis given in hospital discharge data. If secondary diagnoses are added, a total of 222 cases of harmful use of other stimulants, and 74 cases of dependence result (see Tables A3. 3 and A3. 4).

As the data sources mentioned above are likely to overlap to a considerable degree, the group of stimulant users for whom treatment is required does not seem to be large. The data reported do not cover persons with patterns of stimulant use that require treatment but who either do not receive treatment or are not treated within the system of addiction support and treatment services.

The *checkIt!* data indicate that the trend towards high-potency ecstasy pills continues to exist. Whereas in 2013, 26% of all ecstasy pills analysed were classified as high-dose pills, in 2016, their proportion rose to 66%. In the case of 19% of tablets, their potency was so high that they were regarded as posing a health risk (SHW 2017). These observations correspond to the results of analyses carried out by MDA-Basecamp in Tyrol (Z6/Drogenarbeit 2017). In 2016, high-potency ecstasy has even been the cause of death in a few cases in Austria (see chapter 6). Use of ecstasy has apparently become more risk-laden, as the pills often contain (unexpectedly) high doses of the active ingredient (see chapter 7).

3.4 Heroin and other opioids

3.4.1 Prevalence and trends

Relative importance of different opioid drugs

The majority of opioids seized in Austria are heroin and medicines containing narcotic drugs – mostly substitution medicines (BMI 2017). In 2016, 2 077 crime reports under the SMG concerned heroin and other opioids and 1 186 reports concerned medicines containing narcotic drugs (see chapter 7). Heroin and substitution medicines sold on the black market are thus the most frequent illicitly used opioids found in Austria.

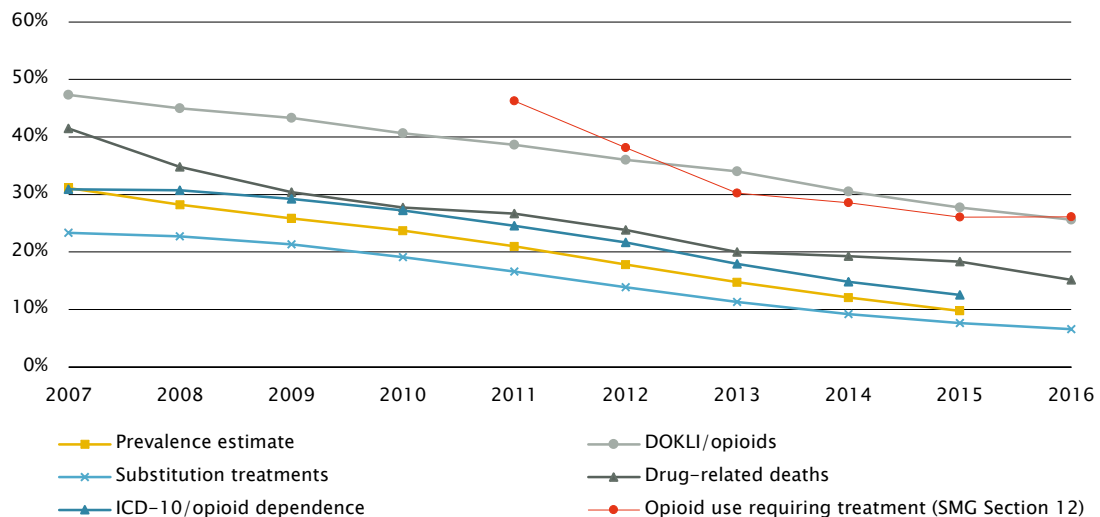
Estimates of Opioid Use in the General Population

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

According to recent estimates covering the years 2014 and 2015 respectively, a nationwide prevalence of 29 000 to 33 000 high-risk opioid users, most of them polydrug users, seems plausible for Austria (see ST7 and ST8). This means that approximately five out of 1 000 Austrians aged between 15 and 64 are in this group. Three out of four high-risk opioid users are male, and 11%

are under 25 (46% are aged between 25 and 34). For a detailed analysis of current estimates please consult the 2016 report (Weigl et al. 2016)

Figure 3.7:
Proportion of high-risk drug users aged under 25 (prevalence rates according to DOKLI, in the group receiving OST, among hospital discharges and among drug-related deaths), time series (moving mean); 2000-16



DOKLI/opioids: All persons indicating opioids as their primary drug who took up inpatient or outpatient long-term services at a DOKLI centre.

ICD-10 (opioids): Persons with F11.2 (opioid dependence) as the primary or secondary diagnosis after discharge from inpatient treatment (most recent available data).

Opioid use requiring treatment under SMG Section 12 = examination by a public health officer in accordance with SMG Section 12 reveals opioid use requiring treatment; these data are incomplete as data from Vienna are not included: in the examinations carried out in Vienna, rather than substance-related statements on the need for further interventions, a more comprehensive addiction-related case history is provided, which focuses on the status of addiction disease and not on individual substances; the data from 2011 and 2012 do not include Carinthia.

In all data sources, from 2000 up to the last-but-one year included, the mean from three years has been given in order to compensate for random fluctuations (moving mean). For the latest year covered, raw figures have been used (this also applies to the 2011 figures for opioid use requiring treatment under SMG Section 12).

Sources: 2016 prevalence estimates, Busch et al. 2014, DOKLI, eSuchtmittel, statistics on drug-related deaths, diagnosis and performance documentation of Austrian hospitals; calculation and graphic representation: GÖG

The continuing decline in the number of young high-risk opioid users is reflected in all drug monitoring data sources (see Figure 3.7) and has been confirmed by reports from practitioners. For further information on opioid use requiring treatment based on examinations under SMG Section 12 carried out by public health officers please also consult chapter 2.

Opioid use – mostly in the context of polydrug patterns of use – accounts for by far the largest proportion of high-risk drug use in Austria (see chapter 5).

3.4.2 Patterns, treatment and problem/high risk use

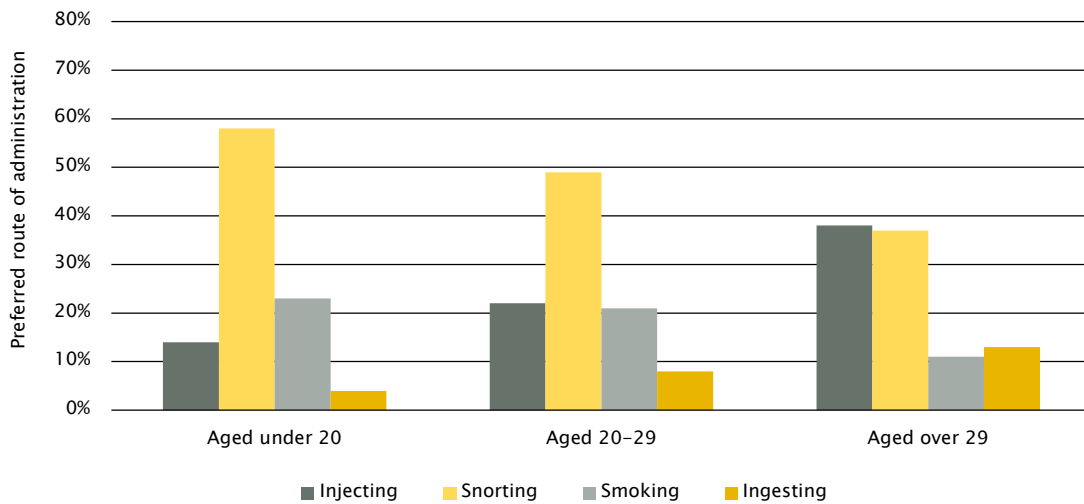
Patterns of Heroin/Opioid Use

In addition to substance-related prevalence rates (e.g. opioid prevalence), it is also interesting to study the predominance of patterns of use (e.g. injecting drug use). In Austria, no specific estimates for injecting drug use are available. If the number of persons registered in the DOKLI system who indicate opioids as their primary drug and injecting use as their preferred route of administration (40% to 50%) is extrapolated to all high-risk drug users who take opioids, the estimated number of (primarily) injecting drug users lies between 12 000 and 17 000 people in Austria. However, these figures probably represent an upper limit, as it seems safe to assume that injecting drug users are considerably more likely than others to turn to drug support and treatment services, as they suffer from severe drug problems.

The DOKLI data also permit an observation of the respective connections between the age of drug users or the duration of opioid use, and the route of heroin administration (see Figure 3.8). A more detailed analysis dating back to 2010 reveals that several persons who initially snorted heroin turned to injecting use in the course of their drug-using career (Busch and Eggerth 2010).

Figure 3.8:

Route of administration* of heroin among persons starting long-term outpatient treatment in 2016; by age group (n = 1 370)



* Only the route of administration that has been indicated as the preferred route has been taken into account.

Source: GÖG - DOKLI client year 2016

3.5 New psychoactive substances (NPS) and other drugs not covered above

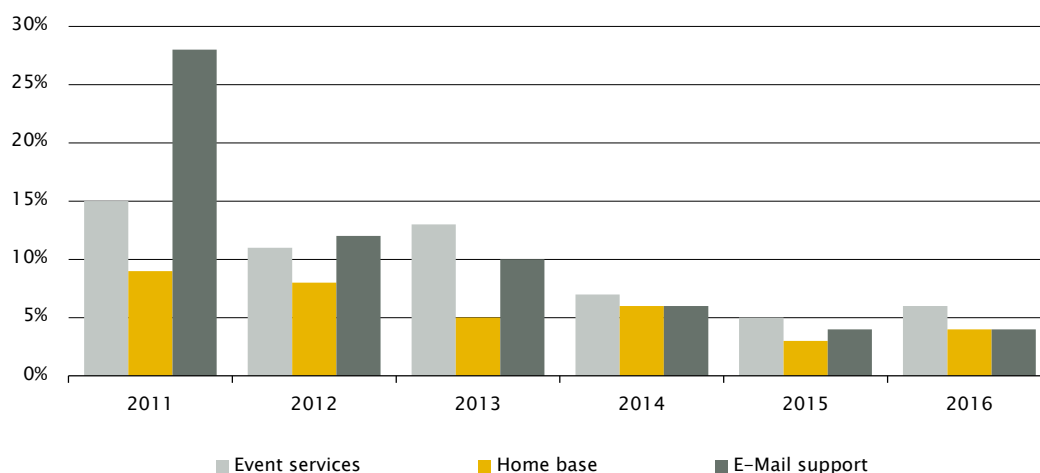
3.5.1 New psychoactive substances (NPS) and other new or novel drugs, and less common drugs

Prevalence and trends in NPS use

Only a small number of crime reports concern violations of the New Psychoactive Substances Act (NPSG): in 2016, 78 crime reports related to the NPSG (2015: 48, 2014: 113, 2013: 128, 2012: 93 – see chapter 7). The few available data from general population surveys indicate a very low prevalence of NPS use in the general population (Weigl et al. 2014). According to the most recent available data, the lifetime prevalence rate is less than one per cent in the general population (aged 15 or older; Strizek and Uhl 2016). In the case of school students aged between 14 and 17, the lifetime prevalence is three per cent, and the last-year prevalence is two per cent (Strizek et al. 2016).

The substances mentioned in the context of advisory talks offered by *checkit!* provide indirect information on the use of NPS in party settings.

Figure 3.9:
checkit! – NPS use discussed, by setting; from 2011 to 2016



Source: SHW 2017

Depending on the support setting, cannabis or ecstasy is the substance that is most frequently discussed with regard to party settings. Since 2011, NPS have played a less important role (see Figure 3.9). For instance, in 2016, the proportion of e-mail advice contacts in which NPS were

mentioned decreased to 4% (compared to 28% in 2011). Based on an analysis of the drug-checking results over time, the *checkit!* team concludes that deliberate use of NPS in party settings is rather seldom, and that young people prefer the 'traditional' party drugs (MDMA and amphetamine) as these substances are more easily available (SHW 2017). *MDA basecamp* also reports a decline in the use of NPS among their clients. These substances were hardly discussed in the advisory talks offered at the *MDA basecamp* info stall at various party events in 2016 (Z6/Drogenarbeit 2017).

In contrast to Austria's neighbouring countries (e.g. Hungary), NPS play a rather subordinate role nationwide. However, isolated occurrences of higher NPS use at certain times and places have been recorded. (GÖG/ÖBIG 2012; Busch et al. 2015).

3.6 Sources and methodology

3.6.1 Sources

Examinations by public health officers

Persons who are suspected of drug use based on information provided by the police, a head of school, a military authority or a driving licence authority are given a medical examination by the health authorities to check whether there is a possible need to undergo a health-related measure. The results of the said examination must be reported to the BMGF²⁶ (reporting requirement). For 2016, a total of 5 465 results of examinations of 5 222 persons are available (several persons were examined more than once). In the examinations carried out in Vienna, rather than providing substance-related statements on the need for further interventions, a comprehensive addiction-related case history is compiled, which focuses on the status of addiction disease and not on individual substances. The data obtained are registered in the *eSuchtmittel* database and forwarded to GÖG's Drug Competence Centre as pseudonymised data, for the purpose of analysis.

Advisory talks by *checkit!*

checkit! is a cooperation project run jointly by *Suchthilfe Wien* and the Clinical Institute of Medical and Chemical Laboratory Diagnoses of the Medical University of Vienna. Its services include lab analyses of psychoactive substances at (music) events (parties, raves, festivals, etc.). In 2016, *checkit!* offered its services at 18 event days, and registered approximately 5 200 information and advisory contacts; at least 2 100 persons were reached through workshops, and 1 200 samples were analysed (SHW 2017).

Advisory talks by *MDA basecamp*

Approximately two or three times each month, *MDA basecamp* is present at music events in Innsbruck and smaller Tyrolean municipalities, where it runs an info stall and offers information on secondary prevention and harm reduction with regard to legal and illicit drugs. In 2016, their staff were available at 26 events, during which 5 216 contacts with clients were recorded, as well as 644 information talks and 119 advisory talks (Z6/Drogenarbeit 2017).

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Federal Ministry of Health and Women's Affairs; prior to 1 July 2016: Federal Ministry of Health.

Data on crime reports due to violation of the Narcotic Substances Act

The data on crime reports relating to the Narcotic Substances Act (SMG) are collected by the Ministry of the Interior and published annually (see chapter 7). These reports also reflect the activities and focuses of police interventions. In 2016, a total of 36 235 crime reports were filed, with 80% of reports relating to cannabis (see chapter 7).

Diagnoses from the performance documentation of Austrian hospitals (ICD-10 hospital discharge diagnoses)

The data on inpatient treatment were obtained with the QGIS system (Quantum geoinformation system). The data for this system come from the DLD diagnosis and performance documentation of Austrian hospitals and are made available to GÖG by the Federal Ministry of Health and Women's Affairs. 2015 is the most recent year for which data were available at the time of drawing up this report. In the DLD, every single inpatient stay in hospital is documented. For each stay, information on the patient and the corresponding diagnosis is entered. One must bear in mind, however, that hospital stays are documented after the patients' discharge, so that any information provided relates to what is known at the time of discharge. Transferrals of patients between different departments of one hospital are not regarded as different hospital stays. It is not possible to identify patients on the basis of the DLD statistics on discharges: here, only discharges as such are documented. The estimates of the number of patients are based on the assumption that hospital stays for which both the postal code of the patient's place of residence as well as their gender and date of birth (day-month-year) are identical relate to a single person (patient) who has been admitted to hospital several times during the period of observation.

This estimate must be qualified in the following way: on the one hand, there may be persons of the same gender and with the same date of birth who live in the same part of town (same postal code), which would lead to an underestimation of patients, and on the other hand, patients may have moved to an area or town with another postal code or continue to live in the same town but under a new postal code, e.g. due to merging of municipalities, which would result in an overestimation of the number of patients. Since 2015, information on the date of birth has no longer been provided. It has therefore been no longer possible to estimate the number of patients. Instead, for each person, a patient ID is communicated, which permits a definitive identification. However, in some cases, this ID is lacking. The change in the system has resulted in a break in the time series as of 2015.

Drug-related deaths

The data on drug-related deaths are collected annually by the Federal Ministry of Health and Women's Affairs (see chapter 6).

Client data from the DOKLI nationwide documentation system of clients of Austrian drug services

See chapter 5.

Austrian information and early warning system on specific health hazards in the context of illicit substance use

Since 2006, GÖG has been in charge of coordinating the information and early warning system, and in this context, has collected information on NPS. The corresponding data are provided primarily by the Federal Ministry of the Interior/Federal Criminal Agency (BMI/.BK) and the BASG Federal Office for Safety in Health Care/AGES Medicines and Medical Devices Agency (BASG/AGES²⁷), which occasionally analyse substances seized by the BMI or the customs authorities. Further information is provided by the *drug checking* projects, i.e. *checkit!*, and since 2014, also *MDA basecamp* (see Weigl et al. 2014).

3.6.2 Methodology

Austrian population survey on substance use of 2004

The representative population survey of 2004 was conducted from 2 July to 19 October 2004 by the *market* polling institute, in the form of face-to-face interviews. The persons interviewed in this context were selected by random sampling. The 512 interviewers who worked in this project were provided with the respondents' addresses, and then contacted and interviewed them. In the household, the person to be surveyed was selected using the last-birthday method. One reason for the rather small response rate of 21% (only one out of five persons selected was actually interviewed) is the surveying period itself (the main surveying time was during the summer: from July to September). With regard to the main demographic characteristics (e.g. gender or age), the composition of the respondent sample was representative of the Austrian population over 14. After a first check of the data gathered and subsequent elimination of faulty interviews, the remaining sample comprised 4 546 data sets (gross sample: approx. 22 000 persons; Uhl et al. 2005a).

Austrian population survey on substance use of 2008

The questionnaire was jointly prepared by the Ludwig Boltzmann Institute for Addiction and GÖG. The face-to-face interviews were conducted by the *market* polling institute. After a briefing for the interviewers, the respondents were selected by means of random sampling. The 593

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The BASG Federal Office is part of the AGES Austrian Agency for Health and Food Safety.

interviewers were provided with the respondents' addresses, and then contacted and interviewed them. In contrast to the previous survey, this research project distinguishes between two subsamples of the same size: persons aged between 15 and 24, and persons over 24. In the set for the sample aged over 24, the person in the household who was 25 or older and who last had a birthday (last-birthday method) was interviewed. In the set for the sample aged 15 to 24, it was first ascertained whether a person in this age group was living in the household, and if several persons of the defined age group were available, an appointment with the person who last had a birthday was scheduled. Each address was contacted at least three times (exceptions: no respondent in the required age group in the household, interview already completed or refused). Respondent participation was 34.4%, and thus much higher than in the 2004 survey. The fieldwork took place from 27 October to 1 December 2008. Telephone checks were made for 46% of the interviews. 73 questionnaires had to be eliminated, and 4 196 remained for analysis (gross sample: approx. 12 000 persons; Uhl et al. 2009).

Austrian population survey on substance use of 2015

The Austrian population survey on substance use of 2015 was largely conducted in the same way as the two previous surveys in order to enable a high degree of comparability at national level. The alcohol items of the questionnaire were drawn up in cooperation with the RARHA (Reducing Alcohol Related Harm Alliance) research project of the EU so as to maximise international comparability. The survey was carried out by the *market* polling institute. Unlike in previous surveys, in 2015 more than half of interviews were conducted with an online sample for the first time (and the other half as face-to-face interviews, as in prior years). The participants in the online survey were randomly chosen from an existing sample that had been recruited offline, and were invited to participate in the survey by e-mail up to three times. A comparison of the online sample and the face-to-face sample (with control of age, gender and education) revealed only minimal differences with regard to prevalence rates. The random sampling and contacting of participants for the personal interviews, as well as the control of interviewers took place in the same way as in the previous surveys. In the case of the personal interviews, the response rate was 32%, and in the case of the online interviews, it was 51%. The data were collected from 27 October to 11 December 2015. A total of 4 014 interviews were conducted (Strizek and Uhl 2016).

Upper Austrian drug monitoring survey of 2015

In the context of drug monitoring on behalf of the Province of Upper Austria, the Linz-based *Institute of Addiction Prevention* has regularly conducted representative general population surveys on drug and substance use, covering the entire province. From December 2014 to January 2015, 1 184 persons from Upper Austria aged 15 or older were interviewed face to face. The respondents were selected by the Linz-based *market* institute, in accordance with the quotas defined for the individual interviewers. The sample was a representative quota sample based on the characteristics of age, gender and regional distribution. In addition to the population survey, an expert panel on methamphetamine was included to link quantitative and qualitative data. Apart from focus groups with representatives of the police, the treatment sector, streetworkers, addiction counsellors, low-threshold service providers and other relevant stakeholders, 163 experts

from the areas of youth work, addiction support, treatment, as well as police and probation officers were interviewed by means of an online questionnaire. In addition, routine data sources in this field (crime reports relating to the SMG, diagnoses from public hospitals, case history data from addiction support centres and documentation of substitution treatment) were analysed (Seyer et al. 2016).

ESPAD 2003

The target group for the 2003 survey was young people born in 1987 who were still attending school in spring 2003. A random sample was selected from all schools with 9th or 10th grade classes. The number of randomly selected classes for each type of school was indirectly proportional to the average size of class per type of school in order to draw a sample as representative as possible of the birth year 1987. For the analysis, 5 281 school students aged 14 to 17 from all over Austria were included. The participation rate was very high: 74% of schools selected, 77% and 92% respectively, of classes selected (9th and 10th grades), and 90% and 92% respectively, of students (9th and 10th grades; Uhl et al. 2005b).

ESPAD 2007

Analogous to the 2003 survey, a total of 5 959 9th and 10th grade students (aged mostly 14 to 17) were interviewed on their drug use based on a questionnaire. Parallel to the survey, a validation study was carried out to obtain information on the validity of data. For the validation study, 100 school students who had taken part in the ESPAD survey and had completed the questionnaire were subsequently interviewed to assess whether the questionnaire was comprehensible and whether the respondents had taken it seriously. The students were randomly selected from different schools (and different types of school) in Vienna and Lower Austria. Each interview took about 50 minutes (Strizek et al. 2008, Schmutterer et al. 2008).

ESPAD 2015

The 2015 ESPAD survey also addressed 9th and 10th grade students. In contrast to previous surveys, all interviews were conducted on the basis of online questionnaires. Access codes which were partly personalised and partly random were used in order to ensure the anonymity of respondents while being able to relate them to a specific school and class. In three 'waves', all schools with 9th and 10th grade students were contacted, two classes were randomly selected and all students of these classes were invited to take part in the survey. With regard to the schools contacted, a return rate of 21% was recorded. However, in the case of students in the randomly selected classes, the participation rate was 99% (Strizek et al. 2016).

HBSC 2010

The HBSC (Health Behaviour in School-Aged Children) study is the largest European health-related survey among children and young people. It systematically and repeatedly surveys self-reported

health as well as health and risk behaviour among school students aged 11, 13 and 15, and since 2010, also students aged 17. The repetition of the survey enables the study of trends over time. The HBSC study was developed in 1982 and was carried out for the first time during the school year 1983/84. Austria has been part of this research project from the start. Since 1986, the surveys have taken place every four years. In 2010, the total sample comprised 6 493 girls and boys, and was representative – with regard to age, gender, province and type of school – of the entire population of school students of the same age. The return rate was 72% (Ramelow et al. 2011, Currie et al. 2012)

HBSC 2014

The survey was conducted in the same way as in 2010. In 2014, the overall sample for Austria comprised 5 983 girls and boys. The return rate was 65% (Ramelow et al. 2015).

Austrian prevalence estimates on high-risk drug use

As of 1993, the capture–recapture (CRC) method has been used for making prevalence estimates of high-risk drug use in Austria. The capture–recapture method is a statistical procedure of dark figure estimation, based on the comparison of two (2–sample CRC estimate) or several sources of data (e.g. 3–sample CRC estimate; see Uhl and Seidler 2001). The data basis comprises pseudonymised data on crime reports connected to opioids, the substitution registry and drug-related deaths. In addition, information provided by the nationwide documentation system for clients of Austrian drug services is very helpful for interpreting the results obtained. The 2016 drug epidemiology report (Busch et al. 2016) includes a more detailed discussion of prevalence estimates and comparisons with other data sources, as well as a validation of the 2–sample CRC estimates by means of 3–sample CRC estimates, taking into account the data on drug-related deaths. However, it is also important to mention that, due to methodological limitations, results obtained through the CRC method only permit approximations. The methodological restrictions are described in greater detail, for instance, by Uhl and Seidler 2001, ÖBIG 2003, GÖG/ÖBIG 2006 and GÖG/ÖBIG 2010.

Viennese drug monitoring survey

Vienna's drug monitoring survey is conducted every other year in spring among a representative sample of approximately 600 persons (stratified multi-stage clustered random sampling based on recent address data available at the IFES institute) in the form of oral interviews at the respondents' homes. The surveys on experience of drug use have been conducted on behalf of the *Vienna Addiction and Drug Coordination* every other year since 1993, using a similar methodology (IFES 2001 to 2015). The data of the 2017 survey have not yet been made available.

3.7 Bibliography and Annex

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3.7.2 Annex

Table A3. 1:

Overview of selected surveys on drug experience in the Austrian general population; 2004–15

Study/English description (year of publication)	Area covered, year of data collection (period covered)	Target group (sample)	Drug types surveyed	Respondents with drug experience, % (by age)	
				Age	%
Bevölkerungsbefragung zu Substanzgebrauch Österreich/general population survey, Austria (Uhl et al. 2005a)	Austria 2004 (lifetime)	General population aged 14 and over (n = 4 547)	Cannabis	14+	20.1
			Ecstasy	14+	3.0
			Amphetamine	14+	2.4
			Cocaine	14+	2.3
			Opioids	14+	0.7
			Biogenic drugs	14+	2.7
			LSD	14+	1.7
			Solvents and in-halants	14+	2.4
Gesundheitsbefragung Österreich (ATHIS)/Austrian Health Interview Survey (ATHIS) (Klimont et al. 2007)	Austria 2006/07 (lifetime)	General population aged 15 to 64 (n = 11 822)	Cannabis	15–24	9.7
			Cannabis	15–24	13.0
			Cannabis	25–34	15.0
			Cannabis	35–44	10.1
			Cannabis	45–54	6.7
			Cannabis	55–64	2.8
Bevölkerungsbefragung zu Substanzgebrauch Österreich/general population survey, Austria (Uhl et al. 2009b)	Austria 2008 (lifetime)	General population aged 14 and over (n = 4 196)	Cannabis	14+	12
			Ecstasy	14+	2
			Amphetamine	14+	2
			Cocaine	14+	2
			Opioids	14+	1
			Biogenic drugs	14+	2
			LSD	14+	2
			Solvents and in-halants	14+	2
Wiener Suchtmittel-Monitoring/Viennese drug monitoring survey (IFES 2009)	Vienna 2009 (lifetime)	General population aged 15 and over (n = 600)	Cannabis	15+	16
			Ecstasy	15+	3
			Amphetamine, Speed	15+	3
			Cocaine	15+	4
			Opioids	15+	3
			Biogenic drugs	15+	4
			Other illicit drugs	15+	3
Drogenmonitoring Oberösterreich/Upper Austrian drug monitoring (Seyer et al. 2016)	Upper Austria 2014/15 (lifetime)	General population 15–59 (n = 984)	Cannabis	15–59	25.7
			Ecstasy	15–59	4.4
			Heroin	15–59	2.0
			Methamphetamine	15–59	0.5
			Amphetamine	15–59	2.5
			Cocaine	15–59	3.5
			LSD	15–59	2.6
			Herbal blends	15–59	2.1
			Bathing salt	15–59	1.2
			Biogenic drugs	15–59	2.5
Wiener Suchtmittel-Monitoring/Viennese drug monitoring survey (IFES 2011)	Vienna 2011 (lifetime)	General population aged 15 and over (n = 600)	Cannabis	15+	21
			Ecstasy	15+	3
			Amphetamine	15+	3
			Cocaine	15+	5
			Opioids	15+	2
			Biogenic Drugs	15+	6
			Liquid ecstasy	15+	1
			Mephedrone	15+	<1
			Incense blends	15+	3
			Other illicit drugs	15+	2

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Table A3. 1 continued

Study/English description (year of publication)	Area covered year of data collection (period covered)	Target group (sample)	Drug types surveyed	Respondents with drug experience, % (by age)	
				15+	24
Wiener Suchtmittel- Monitoring/Viennese drug monitoring survey (IFES 2013)	Vienna 2013 (lifetime)	General population aged 15 and over (n = 600)	Cannabis	15+	24
			Ecstasy	15+	4
			Amphetamine	15+	4
			Cocaine	15+	5
			Opioids	15+	2
			Biogenic drugs	15+	7
			Liquid ecstasy	15+	<1
			Mephedrone	15+	1
			Incense blends	15+	2
			Other illicit drugs	15+	4
Wiener Suchtmittel- Monitoring/Viennese drug monitoring survey (IFES 2015)	Vienna 2015 (lifetime)	General population aged 15 and over (n = 617)	Cannabis	15+	21
			Ecstasy	15+	6
			Amphetamine	15+	5
			Cocaine	15+	4
			Opioids	15+	3
			Biogenic drugs	15+	5
			Liquid ecstasy	15+	1
			Mephedrone	15+	2
			Incense blends	15+	3
			Crystal meth	15+	<1
Other illicit drugs	15+	3			
Bevölkerungsbefragung zu Substanzgebrauch Österreich/general population survey, Austria (Strizek and Uhl 2016)	Austria 2015 (lifetime)	General population aged 14 and over (n = 4 014)	Cannabis	15+	19.5
			Ecstasy	15+	2.3
			Methamphetamine	15+	0.3
			Amphetamine	15+	1.7
			Cocaine	15+	2.5
			Heroin	15+	0.4
			LSD	15+	1.5
			Biogenic drugs	15+	2.7
			Solvents and inhal- ants	15+	2.4
			NPS	15+	0.5

Summary and graphic representation: GÖG

Table A3. 2:

Overview of selected surveys on drug experience among young people in Austria; 2001–15

Study/English description (year of publication)	Area covered year of data collection (period covered)	Target group (sample)	Drug types surveyed	Respondents with drug experience, % (by age)	
				Age	%
ESPAD Austria (Uhl et al. 2005b)	Austria 2003 (lifetime)	Students aged 14 to 17 (n = 5 281)	Cannabis	14-17	22
			Ecstasy	14-17	3
			Cocaine	14-17	2
			Crack	14-17	2
			Heroin	14-17	1
			Amphetamine	14-17	5
			GHB	14-17	1
			LSD	14-17	2
			Solvents and inhalants	14-17	15
			Magic mushrooms	14-17	4
Berufsschulstudie Steiermark/vocational school survey, Styria (Hutsteiner et al. 2005)	Styria 2005 (lifetime)	Vocational school students aged approx. 15 to approx. 19 (n = 3 919)	Cannabis	15-20	27.1
			Party drugs	15-20	4.8
			Cocaine	15-20	2.0
			Crack	15-20	1.1
			Opioids	15-20	1.4
			Amphetamine	15-20	3.1
			Hallucinogenic drugs	15-20	1.8
			Solvents and inhalants	15-20	11.4
			Magic mushrooms	15-20	8.9
			HBSC survey (Dür and Griebler 2007)	Austria 2005/06 (lifetime)	Students aged 15 (n = 1 239)
Bevölkerungsbefragung OÖ/general population survey, Upper Austria (Seyer et al. 2007)	Upper Austria 2006 (lifetime)	Young people and young adults aged 15 to 24 (n = 669)	Cannabis	15-24	36.9
			Ecstasy	15-24	12.3
			Heroin	15-24	7.7
			Morphine	15-24	8.5
			Amphetamine	15-24	12.3
			Cocaine	15-24	10.0
			LSD	15-24	9.0
			Solvents and inhalants	15-24	16.5
			Biogenic drugs	15-24	13.0
			Schulstudie Burgenland/school survey, Burgenland (Falbesoner and Lehner 2008)	Burgenland 2007 (lifetime)	Students in 7th to 13th grades (n = 1 213)
Ecstasy	12-19	2			
Cocaine	12-19	2			
Heroin	12-19	2			
Speed	12-19	3			
Solvents and inhalants	12-19	15			
Biogenic drugs	12-19	4			
ESPAD Austria (Strizek et al. 2008)	Austria 2007 (lifetime)	Students aged 15 to 16 (n = 4 574)			
			Ecstasy	15-16	3.4
			Cocaine	15-16	3.2
			Crack	15-16	2.3
			Heroin	15-16	1.8
			Amphetamine	15-16	7.7
			GHB	15-16	2.3
			LSD	15-16	2.8
			Solvents and inhalants	15-16	14.1
			Magic mushrooms	15-16	4.1

Continued next page

Table A3. 2 continued

Study/English description (year of publication)	Area covered year of data collection (period covered)	Target group (sample)	Drug types surveyed	Respondents with drug experience, % (by age)	
				Age	%
Bevölkerungsbefragung OÖ/general population survey, Upper Austria (Seyer et al. 2010)	Upper Austria 2009 (lifetime)	Young people and young adults aged 15 to 24 (n = 590)	Cannabis	15-24	26.2
			Ecstasy	15-24	4.7
			Heroin	15-24	2.1
			Morphine	15-24	1.7
			Amphetamine	15-24	5.1
			Cocaine	15-24	2.6
			LSD	15-24	2.1
			Solvents and inhalants	15-24	8.9
			Biogenic drugs	15-24	1.3
			Erhebung zum Suchtverhalten von Jugendlichen in NÖ/youth survey, Lower Austria (Bittner et al. 2010)	Lower Austria 2009 (lifetime)	Young people aged 13 and 18 (n = 722)
Ecstasy	14-17	1			
Cocaine	14-17	1			
Heroin	14-17	0			
Speed	14-17	1			
Solvents and inhalants	14-17	1			
Biogenic drugs	14-17	1			
HBSC survey (Ramelow et al. 2011, Currie et al. 2012)	Austria 2010 (lifetime)	Students aged 15 and 17 (n = 1 820 and 1 490)			
				17	27
Flash Eurobarometer Youth Attitudes on Drugs (European Commission 2011a and b)	Austria 2011 (lifetime)	Young people aged 15 to 24 (n = 501)	Cannabis	15-24	18.1
Flash Eurobarometer Young People and Drugs (European Commission 2014a and b)	Austria 2014 (lifetime)	Young people aged 15 to 24 (n = 501)	Cannabis	15-24	38
			NPS	15-24	7
HBSC survey (Ramelow et al. 2015)	Austria 2014 (lifetime)	Students aged 15 and 17 (n = 1 712 and 1 184)		15	10
				17	25
Drogenmonitoring Oberösterreich/Upper Austrian drug monitoring (Seyer et al. 2016)	Upper Austria 2014/15 (lifetime)	Young people and young adults aged 15 to 24 (n = 463)	Cannabis	15-24	34.8
			Ecstasy	15-24	4.7
			Heroin	15-24	1.9
			Methamphetamine	15-24	1.4
			Amphetamine	15-24	4.3
			Cocaine	15-24	4.7
			LSD	15-24	2.8
			Herbal blends	15-24	4.8
			Bathing salt	15-24	1.4
			Biogenic drugs	15-24	3.8
ESPAD Austria 2015 (Strizek et al. 2016)	Austria 2015 (lifetime)	Students aged 15 to 16 (n = 6 560)	Cannabis	15-16	19.9
			Ecstasy	15-16	2.0
			Cocaine	15-16	1.8
			Crack	15-16	0.6
			Heroin	15-16	0.6
			Amphetamine	15-16	2.7
			GHB	15-16	1.4
			LSD	15-16	1.6
			Solvents and inhalants	15-16	9.7
			Magic mushrooms	15-16	2.0
			Methamphetamine	15-16	0.8

Summary and graphic representation: GÖG

Table A3. 3:

Selected drug-related hospital discharge diagnoses (primary diagnoses) according to ICD-10 in Austria, absolute figures and per 100 000 inhabitants) (aged 15 to 64)

Diagnosis	F11.1	F11.2	F12.1	F12.2	F14.1	F14.2	F15.1	F15.2	F19.1	F19.2
	Absolute no. of patients									
2006	26	570	36	38	4	10	5	5	146	1 685
2007	26	710	26	48	4	16	4	7	115	1 554
2008	37	828	28	46	8	16	7	5	125	1 538
2009	32	773	24	33	4	15	4	11	122	1 567
2010	25	704	41	45	7	11	23	15	119	1 523
2011	32	853	40	52	5	10	17	14	396	1 507
2012	21	938	32	56	7	16	18	16	529	1 374
2013	15	877	33	75	6	17	15	34	388	1 305
2014	17	1 195	67	96	4	8	16	18	388	925
2015	12	881	51	83	3	14	19	21	118	640
Diagnosis	F11.1	F11.2	F12.1	F12.2	F14.1	F14.2	F15.1	F15.2	F19.1	F19.2
	Per 100 000 inhabitants aged 15-64									
2006	0.5	10.2	0.6	0.7	0.1	0.2	0.1	0.1	2.6	30.2
2007	0.5	12.7	0.5	0.9	0.1	0.3	0.1	0.1	2.1	27.8
2008	0.7	14.8	0.5	0.8	0.1	0.3	0.1	0.1	2.2	27.4
2009	0.6	13.7	0.4	0.6	0.1	0.3	0.1	0.2	2.2	27.9
2010	0.4	12.5	0.7	0.8	0.1	0.2	0.4	0.3	2.1	27.0
2011	0.6	15.1	0.7	0.9	0.1	0.2	0.3	0.2	7.0	26.6
2012	0.4	16.5	0.6	1.0	0.1	0.3	0.3	0.3	9.3	24.2
2013	0.3	15.4	0.6	1.3	0.1	0.3	0.3	0.6	6.8	22.9
2014	0.3	20.8	1.2	1.7	0.1	0.1	0.3	0.3	6.8	16.1
2015	0.2	15.3	0.9	1.4	0.1	0.2	0.3	0.4	2.0	11.1

F11.1 Mental and behavioural disorders due to use of opioids – harmful use

F11.2 Mental and behavioural disorders due to use of opioids – dependence syndrome

F12.1 Mental and behavioural disorders due to use of cannabinoids – harmful use

F12.2 Mental and behavioural disorders due to use of cannabinoids – dependence syndrome

F14.1 Mental and behavioural disorders due to use of cocaine – harmful use

F14.2 Mental and behavioural disorders due to use of cocaine – dependence syndrome

F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine – harmful use

F15.2 Mental and behavioural disorders due to use of other stimulants, including caffeine – dependence syndrome

F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances – harmful use

F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances – dependence syndrome

Harmful use = psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

Dependence syndrome = a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use, and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, and giving higher priority to drug use than to other activities and obligations. Increased tolerance, and sometimes a physical withdrawal state, can develop. The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances.

Survey result filter: Excluding zero-day hospital stays and persons resident abroad; until 2014, the number of patients was estimated (post codes, year of birth, gender), whereas since 2015 (most recent data) estimates of the number of patients have no longer been possible or necessary due to a change in the system, as anonymised patient IDs have been introduced for each patient; however, as some patient IDs are lacking, their number could be underestimated; due to the changes in 2015, the time series has been subsequently recalculated. The change has resulted in a break in the time series as of 2015.

Source: BMG diagnosis and performance documentation of Austrian hospitals; ST.AT – population statistics; calculation and graphic representation: GÖG

Table A3. 4:

Selected drug-related hospital discharge diagnoses (primary and secondary diagnoses) according to ICD-10 in Austria, absolute figures and per 100 000 inhabitants) (aged 15 to 64)

Diag-nosis	F11.1	F11.2	F12.1	F12.2	F14.1	F14.2	F15.1	F15.2	F19.1	F19.2
	Absolute no. of patients									
2006	129	1 079	670	250	140	68	45	28	617	2 856
2007	131	1 259	677	316	131	111	51	23	592	2 688
2008	159	1 450	648	258	160	83	57	15	592	2 730
2009	189	1 522	806	260	149	65	45	28	597	2 734
2010	186	1 626	842	370	151	69	89	31	572	2 779
2011	181	1 612	929	403	154	97	93	44	899	2 866
2012	140	1 624	994	432	165	99	115	41	1 018	2 690
2013	165	1 686	1 188	607	211	121	173	106	822	2 512
2014	154	1 946	1 447	714	299	125	203	89	868	2 129
2015	119	1 514	1 251	645	226	122	222	74	534	1 570
Diag-nosis	F11.1	F11.2	F12.1	F12.2	F14.1	F14.2	F15.1	F15.2	F19.1	F19.2
	Per 100 000 inhabitants aged 15-64									
2006	2.3	19.3	12.0	4.5	2.5	1.2	0.8	0.5	11.0	51.1
2007	2.3	22.5	12.1	5.7	2.3	2.0	0.9	0.4	10.6	48.1
2008	2.8	25.9	11.6	4.6	2.9	1.5	1.0	0.3	10.6	48.7
2009	3.4	27.1	14.3	4.6	2.6	1.2	0.8	0.5	10.6	48.6
2010	3.3	28.9	14.9	6.6	2.7	1.2	1.6	0.6	10.2	49.3
2011	3.2	28.5	16.4	7.1	2.7	1.7	1.6	0.8	15.9	50.6
2012	2.5	28.6	17.5	7.6	2.9	1.7	2.0	0.7	17.9	47.3
2013	2.9	29.6	20.8	10.6	3.7	2.1	3.0	1.9	14.4	44.0
2014	2.7	33.9	25.2	12.5	5.2	2.2	3.5	1.6	15.1	37.1
2015	2.1	26.2	21.7	11.2	3.9	2.1	3.8	1.3	9.2	27.2

Legend:

F11.1 Mental and behavioural disorders due to use of opioids – harmful use

F11.2 Mental and behavioural disorders due to use of opioids – dependence syndrome

F12.1 Mental and behavioural disorders due to use of cannabinoids – harmful use

F12.2 Mental and behavioural disorders due to use of cannabinoids – dependence syndrome

F14.1 Mental and behavioural disorders due to use of cocaine – harmful use

F14.2 Mental and behavioural disorders due to use of cocaine – dependence syndrome

F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine – harmful use

F15.2 Mental and behavioural disorders due to use of other stimulants, including caffeine – dependence syndrome

F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances – harmful use

F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances – dependence syndrome

Harmful use = psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

Dependence syndrome = a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use, and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, and giving higher priority to drug use than to other activities and obligations. Increased tolerance, and sometimes a physical withdrawal state, can develop. The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances.

Survey result filter: Excluding zero-day hospital stays and persons resident abroad; until 2014, the number of patients was estimated (post codes, year of birth, gender), whereas since 2015 (most recent data) estimates of the number of patients have no longer been possible or necessary due to a change in the system, as anonymised patient IDs have been introduced for each patient; however, as some patient IDs are lacking, their number could be underestimated; due to the changes in 2015, the time series has been subsequently recalculated. The change has resulted in a break in the time series as of 2015.

Source: BMG diagnosis and performance documentation of Austrian hospitals; ST.AT – population statistics; calculation and graphic representation: GÖG

Prevention

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4 Prevention²⁸

4.1 Summary

National Profile

Goals and principles of prevention have been defined in all addiction/drug policy strategies, and underline the importance of a holistic, all-encompassing approach, as well as orientation towards specific target groups. Prevention is regarded as a long-term educational process and a task that concerns our entire society. Its aim is to enhance the personal development and life skills of children and young people, and explicitly includes measures taken in the context of environmental prevention strategies. This helps prevent, or delay, the use of legal and illegal substances, and, particularly with regard to young people – also encourages reflection on risk behaviour. The prevention of addiction has thus been defined as an integral part of the educational principle of health promotion, and of general measures to this end.

In Austria, prevention measures are primarily planned, organised and implemented at the local or regional levels, with the provincial addiction prevention units playing an important role in this regard. Further stakeholders involved in the implementation of addiction prevention are addiction support and treatment services, and police officers specialising in prevention. However, they often cooperate closely with the addiction prevention units. As a rule, prevention measures are oriented towards long-term effectiveness and sustainability, which is to be achieved primarily by means of training and by actively integrating multipliers.

In line with a comprehensive approach to addiction, many prevention measures taken in Austria are not aimed at specific substances but also encompass non-substance-related forms of addiction behaviour. In addition, general prevention measures in the context of universal prevention are an important basis for subsequent substance-related interventions. Specific activities and interventions also exist for legal substances. Examples of well-established nationwide programmes are *Eigenständig werden* [Become independent] and *plus*, as well as *Move* and *Step by Step* (which are also implemented under different names).

Quality assurance is mostly based on nationwide coordination (by *ARGE Suchtvorbeugung*, coordinating body of the addiction prevention units), as well as regional cooperation, specific standards (e.g. for prevention in school settings), and a variety of (further) training programmes.

28

In this chapter, the term 'prevention' exclusively relates to the prevention of addiction and does not include, for instance, tertiary prevention measures. As has already been mentioned in the introduction, the focus is on illicit drugs. This chapter therefore primarily covers interventions encompassing different types of addiction or specific measure targeting illicit drugs – and gives only a few examples of such interventions.

Trends

In addition to numerous unspecific measures that can relate to various types of addiction, legal substances have for a long time been a focus of prevention activities in Austria. This trend has further intensified in the past 10 years, so that specific measures aimed at preventing the development of dependence on illicit substances have meanwhile played a subordinate role. In particular, measures of selective prevention, including prevention in party settings, as well as in other specific settings such as labour market policy programmes, are being expanded. People with an immigration background have become a further relevant target group.

New developments

The current focus is on expanding the training programmes for multipliers, i.e. on supporting persons who have contact with children and young people and who can influence their beliefs and patterns of behaviour. This includes the advancement of existing programmes, as well as the development of new ones, such as Vorarlberg's life skills project *Gesundes Aufwachsen in Vorarlberg* [Growing up healthy in Vorarlberg], or projects targeting children in families with addiction problems (e.g. *startklar* [Ready to go] and *Kleiner Leuchtturm* [Small lighthouse]). A new study (Institut für Gesundheitsplanung 2016) investigated endeavours undertaken in Upper Austria to intensify addiction prevention in line with the provincial health goals, by conducting an online survey among multipliers. The results showed that it has become harder to motivate towns and young people to take an active part in prevention activities.

4.2 National profile

4.2.1 Policy and organisation

All provincial addiction/drug strategies (see chapter 1), as well as the new national Addiction Prevention Strategy include goals and principles of prevention. The majority of these underline the fact that a comprehensive strategy is needed that pursues a holistic, all-encompassing (environmental, interdisciplinary) approach that integrates the underlying causes of addiction, addresses specific target groups and encompasses both legal and illicit substances, as well as non-substance-related forms of addiction. Cooperation with schools and other educational institutions, youth policy actors (youth social workers) and the health care sector is regarded as relevant in this respect. Several strategies also focus on secondary prevention and problem drug use as a prevention issue. Prevention is regarded as a long-term educational process and a task that concerns our entire society. Its aim is to enhance the personal development and life skills of children and young people. A few strategies also include the goal of helping people develop a critical approach, e.g. to new psychoactive substances. For instance, the *Viennese addiction and drug strategy of 2013* underlines the importance, as a prevention principle, of taking a respectful, participative and emancipatory view of human beings as actors who take responsibility for their actions. According

to Salzburg's new framework plan 2016–20 (see also chapter 1), a critical approach to psychoactive substances and patterns of behaviour means the prevention of use, the longest possible postponement of initial substance use by children and young people, encouragement of short-term abstinence and the development of risk competence (Land Salzburg 2016). The Austrian Addiction Prevention Strategy underlines the necessity of taking appropriate measures targeting adults as well (BMG 2015).

The provincial addiction/drug strategies define certain priorities. This includes use of the internet for prevention, as well as measures in, or for, youth work in recreational settings (e.g. establishing outreach youth social work). The majority of plans for prevention activities addressing specific target groups are oriented towards homeless young people, young people at risk of becoming addicted, or young people with an immigration background, as well as users of stimulants or *new psychoactive substances (NPS)*, and pregnant women. The priority areas very often also include education and (further) training programmes for experts or multipliers from various fields (e.g. clubs or enterprises), as well as the advancement of existing, and the development of new, services based on risk profiles. Some strategies list a number of specific programmes as measures that should be implemented. For instance, Lower Austria mentions the implementation of the existing life skills programme in all compulsory schools of the province (Fachstelle für Suchtprävention NÖ 2016). Awareness-raising among the general public and public decision-makers to enable them to identify mechanisms and structures that increase addiction risks has been added as a task of prevention in Salzburg's framework plan (Land Salzburg 2016).

In addition to the provincial addiction/drug strategies and the new national Addiction Prevention Strategy, Section 13 of the Narcotic Substances Act (SMG; see chapter 2), various strategic documents (e.g. from the Ministry of Education, and the health-in-all-policies approach of Health Targets Austria; see also chapter 1), are also important for the prevention of addiction in Austria. Here, two publications deserve special mention: the *Principal General Circular on Health Education*, which integrates the prevention of addiction into the educational principle of health promotion (BMUK 1997); as well as the Ministry of Education publication on psychological health promotion in school environments (BMUKK 2008)²⁹. Finally, the principles of school-based prevention³⁰ are also relevant in this regard.

Strategic documents that refer to the prevention of addiction also exist at the provincial level, e.g. the tobacco prevention strategies of Carinthia³¹ and Styria³², which continue to be implemented

29

See <http://www.schulpsychologie.at/psychologische-gesundheitsfoerderung/?L=0> (accessed 4 August 2016).

30

See <http://www.schulpsychologie.at/psychologische-gesundheitsfoerderung/suchtpraevention/> accessed 4 August 2016).

31

For further information please visit <http://kaernten-rauchfrei.at/> (accessed 26 July 2016).

32

See http://www.vivid.at/uploads/Jahresberichte/Tabakpr%C3%A4ventionsstrategie2007_2010.pdf (accessed 26 July 2016).

(Drobesh-Binter, personal communication), as well as the Styrian APA *action plan*³³ on alcohol. In addition to specific activities, measures encompassing different substances are also taken (e.g. feel-ok.at³⁴) to implementing these strategies. The measures defined in the APA plan address the general population of Styria, as well as the groups of primarily moderate and problem users (Land Steiermark 2013).

Finally, the 2014 *position paper on tobacco* drawn up by *ARGE Suchtvorbeugung* (the coordinating body of the addiction prevention units) is relevant: it demands an Austrian long-term tobacco strategy of nationwide coverage, integrated into an overall health promotion and addiction prevention strategy. Its vision is *non-smoking as the normal state* – which has meanwhile been laid down in a federal act – and its goals are to prevent people from starting to smoke, to support people wanting to quit, and to protect non-smokers. The position paper lists numerous measures which, in the view of *ARGE Suchtvorbeugung*, can contribute to reducing tobacco consumption.

In Austria, prevention measures are primarily planned, organised and implemented at the local or regional levels, with the provincial addiction prevention units (see chapter 1) playing an important role in this regard. The units are heterogeneous with regard to their owners and available funds, which is reflected in their structures, number of staff, and thus the scope of projects implemented. For instance, the Addiction Prevention Unit of Burgenland is affiliated with *Burgenland Psychosocial Services*, whereas the Lower Austrian Unit is organised as a separate association, and the Carinthian Addiction Prevention Unit is part of the Provincial Government (Department 5/Health and Care; Subdepartment of Prevention and Addiction Coordination).

As a rule, prevention measures are oriented towards long-term effectiveness and sustainability, to be achieved primarily by means of training and actively integrating multipliers. They mainly comprise school teachers, but also after-school care staff, kindergarten teachers, recreational education staff, decision-makers in towns and enterprises, etc. The activities of the addiction prevention units cover both unspecific and specific measures, as well as different settings and approaches, mostly aimed at universal³⁵ and selective³⁶ prevention. The addiction prevention units

33

See <http://www.gesundheitsfoerderung-steiermark.at/themen/gesundheitsfoerderungsfonds/alkoholpraevention> (accessed 25 July 2017).

34

See http://www.feel-ok.at/de_AT/jugendliche/jugendliche.cfm accessed 4 August 2016).

35

Universal prevention focuses on different settings (e.g. school, towns, kindergartens) to address larger groups of the population who, irrespective of their individual situation, are equally likely to develop certain characteristics.

36

Selective prevention focuses on smaller groups whose members, due to biological, psychological, social or environmental risk factors – irrespective of their individual situation – are more likely to develop addiction than the general population (e.g. children of addicted parents).

also plan measures of indicated prevention³⁷, which are, however, primarily implemented by the staff of other services (e.g. drug advice and support centres) or employment projects. Other relevant activities of the addiction prevention units include network-building and public relations work, the (financial) support of prevention initiatives and the organisation of further training events for experts.

Furthermore, depending on the individual province, additional stakeholders are involved in planning, organising and implementing prevention measures: for instance, providers of advice, support and treatment services. In all provinces, police officers specialising in prevention, as well as the school medical officers and school psychologists, play an active role in the prevention of addiction. They often closely cooperate with the addiction prevention units. A general circular issued by the Federal Ministry of the Interior ensures the availability of specialised police officers, who are often trained by the addiction prevention units. In addition, several provinces employ coordinators for addiction prevention at school, who are also trained by the addiction prevention units and contribute to the structural consolidation, as well as quality assurance, of prevention in school settings.

Long-term experience with such forms of cooperation has been gathered, for instance, in Tyrol (*Addiction information in schools supported by experts*)³⁸ and Upper Austria (in the *clever & cool project*)³⁹. Regional health promotion stakeholders are also worthy of mention (see section 4.2.2.), e.g. *Styria Vitalis* runs the internet-based prevention programme *feel-ok.at*. Apart from these examples of cooperation, a number of individual persons (e.g. doctors, former drug users) also play an active role: they contact schools and organise one-off workshops.

In order to coordinate nationwide prevention programmes, to ensure the transfer of knowledge, and to establish links with one another, the addiction prevention units formed *ARGE Suchtvorbeugung*. ARGE organises an annual expert meeting for its staff (see section 4.2.3), and represents addiction prevention services in federal bodies such as the Federal Drug Forum and the Alcohol Forum.

37

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

38

For further information please visit http://www.kontaktco.at/fachbereiche/schule/allgemein/schulische_suchtinfor/ (accessed 4 August 2016).

39

For further information please visit <http://www.praevention.at/schule/schul-und-klassenprojekte/clever-cool.html> (accessed 24 August 2016).

In the provinces, the addiction prevention units have established links with other relevant actors and are, for example, represented in addiction advisory boards. In addition, the Styrian *SAG* working group deserves mention: it is composed of representatives of the Addiction Coordination Office (Province of Styria and Graz), the Addiction Prevention Unit, various specialised departments, the police (Security Directorate, Federal Police Directorate, Provincial Criminal Agency), the Children's and Youth Ombuds Office, the Provincial School Board, the Provincial Youth Office, the Provincial Parents' Association, the Provincial Drug Advice Service and the Board of Drug Experts. Furthermore, regional networks have been built with the most important actors and institutions in the area of prevention, e.g. through the '*prevention breakfast*'⁴⁰ which is organised regularly in Salzburg and Vorarlberg, or regional working groups.

At the federal level, the Ministry of Education is also involved as far as school settings are concerned, but its activities are mainly oriented towards planning and supporting health promotion at school (see also GÖG/ÖBIG 2012, Haas et al. 2012).

Prevention measures can be financed through various sources, but the main funds come from provincial budget items earmarked for health (e.g. from the provincial health promotion funds), as well as from the social care and education budgets. According to Salzburg's new framework plan, Salzburg's provincial Disabled Persons Act (and specifically Section 10) provides the basis for the lump-sum subsidisation of the Addiction Prevention Unit of Salzburg (Land Salzburg 2016). At the federal level, funding can be granted by FGÖ (Healthy Austria Fund), which, however, is mainly focused on innovative projects and events involving the transfer of knowledge, and co-financing is required. Funds from the Ministry of Education primarily go to school psychologist services, which are also involved in prevention interventions. In addition, information materials on preventing addiction at school are drawn up and updated (BMUKK 2012 and BMUKK 2007)⁴¹, and also projects on a variety of health and environmental themes are funded through the Federal Environment and Health Education Fund. Interventions such as school social work and youth coaching (see section 4.2.2), which are not specifically aimed at preventing addiction but rather come under environmental prevention strategies, are funded by the Ministry of Social Affairs. Other sources such as the BMGF, the *Eigenständig werden* private foundation or Rotary Austria, also play a certain, if less relevant, role. It is not possible to provide an overview of budgets for prevention activities at the federal or provincial levels. However, in the context of a study, an endeavour has been made to investigate public expenditure for health promotion and prevention, and thus also for the prevention of addiction in Austria (see chapter 1).

School programmes such as *plus* or *Eigenständig werden* [Become independent] are funded by the provinces, through the addiction prevention units. The implementation of other prevention

40

For further information please visit <http://www.akzente.net/fachbereiche/suchtpraevention/salzbuerger-praeventionsfruehstueck/> (accessed 4 August 2016).

41

To download the materials go to <http://www.schulpsychologie.at/psychologische-gesundheitsfoerderung/suchtpraevention/> (accessed 4 August 2016).

measures can involve costs which the ‘buyers’ (i.e. schools, kindergartens, etc. that want to take part in the programme) have to pay from their own budgets, or which must be borne by the parents. In Tyrol’s programme *Schulische Suchtinformation* [Addiction information in schools], police officers specialising in prevention, as well as staff of the *kontakt+co* Addiction Prevention Unit, visit schools during their working hours, and in accordance with an agreement with the Province School Board, the schools must only bear the cost incurred if they fail to provide a documentation report⁴².

When funds are granted, this is usually linked to quality requirements that are defined by the province: e.g. funding by the Vienna Addiction and Drug Coordination Office (SDW) is subject to compliance with the Fund’s support guidelines⁴³.

As a rule, prevention is not financed through revenues from taxes on alcohol or tobacco products in Austria. However, certain proportions of the revenues from the VAT and the tobacco tax have been earmarked for general health promotion, health-related information and awareness raising. One per mille of the income from gambling establishments is earmarked for gamblers’ protection activities by the Ministry of Finance Staff Unit for Addiction Prevention and Counselling (Gambling Act Section 1; BGBl. 1989/620). However, only a very small proportion of the funds from these sources are likely to be spent on specific prevention measures or addiction-related research. The issue of earmarking tax revenues for prevention has been a long-standing demand put forward by experts – for instance, in the position paper on tobacco issued by *ARGE Suchtvorbeugung*. Austria’s Addiction Prevention Strategy finally states that the funding needed is to be provided by the federal and provincial governments and the social insurance funds, and also through revenue from taxes on alcohol, tobacco and gambling.

4.2.2 Prevention interventions⁴⁴

4.2.2.1 Environmental prevention

The immediate environment is a determining factor for the likelihood that young people will experiment with psychoactive substances, and possibly go on using them. An attempt is therefore

42

For further information please visit http://www.kontaktco.at/fachbereiche/schule/allgemein/schulische_suchtinfo/ (accessed 4 August 2016).

43

For details on the support guidelines please visit <https://sdw.wien/de/ueber-uns/foerderungen/> (accessed 24 August 2016).

44

Due to the great number of activities at the regional level, only certain selected examples can be described in the present report.

being made, by means of a variety of measures, to create environments for young people that are protective and reduce the probability of psychoactive substance use. These interventions in the context of environmental prevention range from measures to reduce the availability of substances and specific youth protection interventions, as well as health promotion⁴⁵, to actions in other policy areas that influence the situation in life and the choices that young people have, and thus constitute important health determinants. Further details on health determinants and their connection with children' and young people's health are provided in Haas et al. (2012).

The Health Targets Austria (BMG 2016), the federal health promotion strategy (BMG 2014) as well as the child and adolescent health strategy (BMG 2011) incorporate endeavours to ensure healthy environments and conditions in which children can grow up healthy (see also chapter 1).

Initiatives to this effect include, for instance, the *healthy schools*⁴⁶ and *healthy communities* programmes, as well as the *healthy enterprises network*. The Federal Ministry of Education initiative to enhance school quality in general education (SQA)⁴⁷ can also play a relevant role in this context as 'classroom and school as a social environment' has been defined as a quality area. With regard to the quality area of learning experience and learning results, emphasis is laid on the fact that its quality is expressed in the students' skills and the physical and mental health of all people involved. The specific topics to be focused on in order to enhance quality are defined by the schools themselves, and can include, for instance, health promotion or the prevention of addiction.

In this context, *early interventions* are particularly relevant. *Regional early intervention*⁴⁸ networks have been built to provide appropriate structures that permit targeted early support for pregnant women and families with newborn babies and infants, in terms of indicated prevention. The early interventions integrate diverse outcomes and aspects of action: they serve as health promotion strategies in family settings and also include elements of indicated prevention. Their focus is not primarily on addiction or the prevention of addiction, but families with addiction problems are among the target groups of *early interventions*. The regional early intervention networks cooperate with the addiction prevention units to enable, whenever necessary, the referral of families to specific addiction prevention and support services. For instance, Lower Austria organises lectures on addiction during pregnancy and breastfeeding, and pregnant women or mothers with problem patterns of legal or illicit substance use thus can be referred to the DESK project that focuses on drugs and addiction with regard to parents and children.

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Health promotion, in accordance with the Ottawa Charter of the WHO, is defined 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. (<http://www.euro.who.int/en/publications/policy-documents/ottawa-charter-for-health-promotion,-1986>).

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See <http://www.gesundeschule.at/> (accessed 4 August 2016).

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See <http://www.sqa.at/> (accessed 13 July 2016).

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For further information please visit <http://fruehehilfen.at/> (accessed 4 August 2016).

In the context of health promotion at the workplace, a variety of strategies are being pursued: in addition to structural changes, works agreements are often concluded that define specific steps to be taken in the case of addiction-related behaviour. The provisions of these agreements are often unspecific, but concrete measures usually target drinking among adult staff (see also section 4.2.2.2).

Other interventions that directly address children and young people and produce positive effects on their environments include, for instance, general youth work in recreational settings (aimed at establishing appropriate spaces for young people on the one hand, and lobbying on the other), school social work (aimed at influencing the specific situation of school students), and youth coaching (aimed at preventing school drop-out). In this respect, the *young peoples' health conferences*⁴⁹ are gaining importance as forums for presenting preparatory projects implemented by young people, as well as the health proposals derived from them.

With regard to environmental prevention measures concerning the protection of young people, as well as alcohol and tobacco, the applicable provincial acts are worthy of mention. The corresponding interventions focus on changing social norms, as well as the advancement of the current trend towards non-smoking, and awareness-raising among adults with regard to their function as role models. In order to assist multipliers, for instance, VIVID⁵⁰ runs further training programmes on smoking for various health care professionals.

4.2.2.2 Universal prevention

In line with a comprehensive approach to addiction, many prevention measures taken in Austria are not aimed at specific substances and also encompass forms of addiction that are not substance-related. Moreover, general prevention measures, as well as measures encompassing a range of different substances taken in the context of universal prevention are an important basis for subsequent substance-related interventions. Specific activities and interventions also exist for legal substances. The majority of prevention measures implemented in Austria aim at the promotion of life skills in children and young people, social learning and experience-based approaches, and, particularly with regard to young people, they also aim to discuss high-risk patterns of behaviour. Peer education is used especially in programmes focusing on drinking (e.g. in *Party Fit!*

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These are funded by the Federal Health Agency, as a focal aspect of the preventive care strategy 2015/16, with the aim of fostering health skills among young people. For further information please visit http://www.bmg.gv.at/home/Schwerpunkte/Gesundheitsfoerderung_Praevention/Vorsorgemittel/Projekte_im_Zeitraum_2015_bis_2016 (accessed 4 August 2016).

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For further information please visit <http://www.vivid.at/angebot/gesundheitsberufe/> (accessed 4 August 2016).

in Vienna⁵¹ or *Peer drive clean* in Upper Austrian driving education programmes), but also in interventions that encompass different substances (e.g. the *peer education*⁵² project of Upper Austria).

Gender-related approaches are, for instance, taken into account with regard to eating disorders, but separate workshops for female and male participants are also organised for other addiction-related issues. Prevention activities targeting drinking and smoking among young people are often oriented towards providing and discussing facts and figures, and thus influencing behavioural norms. The interventions focusing on eating disorders aim at raising the teachers' awareness of this issue, and at developing strategies for action to find appropriate responses to those affected. In Lower Austria, *Männer Leben Anders* [Men live differently], a programme encompassing a range of different substances, specifically addresses male school students, and interactive workshops (4 lessons) are used to encourage a reflection on male role models (Weissensteiner, personal communication). It also includes lectures for parents (2 lessons), and workshops for teachers, school medical officers and other school staff (4 lessons).

Regarding new media, it is of key importance to enhance the corresponding media skills, which is increasingly often combined with reflections on lifeworlds or addictive patterns of behaviour, and with providing additional information on addiction (e.g. in Vorarlberg's *REFLECT AND ACT! 2.0 project*⁵³; see also section 4.3).

In addition to a number of standard programmes carried out at the nationwide level (*Eigenständig werden*⁵⁴ [Become independent] and *plus*⁵⁵; see Tabelle A4. 1 and Tabelle A4. 2, as well as Weigl et al. 2014), numerous regional activities have also been routinely initiated and advanced, and adopted by other provinces in recent years. The *feel-ok.at* programme is run in the majority of Austrian provinces. It is an internet-based programme which addresses young people aged between 12 and 18, and aims at encouraging a healthy approach to stress, as well as building appropriate self-esteem and self-confidence. It uses self-tests, quizzes, videos, etc., and teaching materials for teaching staff are also available. Furthermore, new strategies and approaches have been developed in order to optimise the quality of prevention activities and to improve their orientation towards the specific needs of individual target groups and towards different settings. Due

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For further information please visit <http://www.partyfit.at/> (accessed 4 August 2016).

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For further information please visit <http://www.praevention.at/schule/schul-und-klassenprojekte/peer-education.html> (accessed 24 August 2016).

53

For further information please visit <http://www.supro.at/projekte/reflect-and-act/> (accessed 4 August 2016).

54

For further information please visit <http://www.eigenstaendig.net/> (accessed 4 August 2016).

55

For further information please visit <http://www.suchtvorbeugung.net/plus/> (accessed 4 August 2016).

to the great number of activities at the regional level, only a few selected examples can be described in the present report.

Schools are an important implementation setting for addiction prevention. It is recommended that measures at schools should generally involve all stakeholders of the school community, as well as regional addiction experts. On this basis, training courses on prevention and further training events are organised, teaching materials and projects are prepared, and assistance in planning and implementing prevention activities is offered. These activities are generally aimed at awareness-raising and health promotion throughout the system and at increasing the students' life skills. Prevention activities addressing students in older age groups usually focus on discussing, and reflecting on, patterns of use. The programmes often include parents' evenings or parents' workshops.

In addition to the nationwide programmes mentioned (*Eigenständig werden* [Become independent] and *plus*), Lower Austria has, for instance, implemented the modular *Station Model*⁵⁶ programme (addressing students from the 5th grade upwards) for many years. After a further training programme in two parts that addresses teachers and communicates basic information and methods of prevention activities (including structural measures), a parents' evening is organised, followed by an action day at school. On the action day, the teachers who have participated in the training programme are present at different information points that the school students visit in small groups. This can be complemented by prevention activities offered by the police, such as workshops for school students or the provision of information for parents. *Clever & Cool*, a proven programme from Upper Austria, consists of 11 modules comprising a total of 34 lessons for 7th and 8th grade students. It is implemented in cooperation with the Upper Austrian Provincial Criminal Police Office, the Youth Service of the Province of Upper Austria, as well as the *Bily* sexual education association. The involvement of peers is a key element of the Upper Austrian *Peer Education* programme. Its target group is school students from the 9th to 11th grades, and assists peers in implementing prevention activities during these two years.

Theatre education and experience-based approaches are also popular, particularly in programmes that encompass a range of different substances (e.g. *Achterbahn 12-14*⁵⁷ [Roller Coaster 12-14] in Vienna, in the form of an outdoor day or a three-day event for 6th to 8th grade students, as well as *GrenzGang*⁵⁸ [Borderline walk], an outdoor day or outdoor week for 8th to 13th grade

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For further information please visit <http://www.suchtpraevention-noe.at/de/index.php?nav=41&id=1002> (accessed 4 August 2016).

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For further information please visit <https://sdw.wien/de/praevention/schule/#achterbahn> (accessed 31 August 2017).

58

For further information please visit <https://sdw.wien/de/praevention/schule/#grenzgang> (accessed 31 August 2017).

students; and the Lower Austrian *Treffpunkt ICH* [Meeting point: me] join-in theatre play for primary schools), or programmes that focus on alcohol (e.g. the *Fetter Auftritt*⁵⁹ [Drunk with drama] forum theatre focused on the prevention of alcohol addiction, organised for school students and apprentices in Vienna and the Carinthian *Immer und überall* [Always and everywhere] classroom theatre play for students as of the 8th grade); or on tobacco/nicotine (e.g. *Hast du Feuer*⁶⁰ [Got a light?] in Vienna, for school students aged 12 or older). The above methods rely on the formative effect of, and reflection on, first-hand experience. Experience-based approaches also aim at helping the students become aware of, and assess, high-risk situations. In addition, they enhance the team spirit.

In **crèche, kindergarten** and **family** settings, further training schemes for multipliers are the most frequent form of activity, in addition to the provision of information material and the organisation of parents' evenings. The key elements of the further training programmes include the communication of information and opportunities for the practical promotion of life skills, as well as reflection on one's personal attitudes and role models (e.g. VIVID's further training series *Suchtprävention im Kindesalter* [Addiction prevention in childhood]). The toy-free kindergarten or toy-free crèche approach has also been repeatedly encouraged in this context. Many projects aim at intensifying the cooperation between crèche, kindergarten and day-care centre staff on the one hand and parents on the other (e.g. the Carinthian project *Acht Sachen, die Erziehung stark machen* [Eight strong parenting points]). In Lower Austria, theatre education is also used in kindergarten settings (*Schmetterling & Pandabär* [Butterfly & panda bear]).

Many activities directly focus on parenting skills. For instance, all provinces organise lectures for parents and parent workshops which both provide theoretical input and offer plenty of time to discuss specific everyday situations that parents are experiencing. In Upper Austria, the *Starke Partnerschaft von Anfang an* [Strong partners from the start] workshops are aimed at assisting parents of new-born babies in organising their everyday lives and maintaining their relationships as couples. VIVID's *Elterncafé* [Parents' café] consists of a series of three 2-hour courses conducted in a relaxed atmosphere, where parents of children aged 10 or younger can choose from key topics and reflect on their experiences in a closed group.

The majority of prevention programmes at the **workplace** that are relevant for this report aim to prevent apprentices from developing patterns of addiction behaviour, particularly by means of awareness-raising, reflection and guidance for trainers and other key persons at work and in halls of residence for apprentices. They focus on enhancing the apprentices' personal protection factors, as well as on the risks of substance use, and provide support with regard to what steps should best be taken at the workplace at an early stage (e.g. the *pib* [Prevention in Enterprises] programme in Tyrol). There are also interventions aimed at preventing the development of addiction among at-risk adults, and to develop adequate responses to addiction issues among adults

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For further information please visit <https://sdw.wien/de/praevention/schule/#fetterauftritt> (accessed 31 August 2017).

60

For further information please visit <https://sdw.wien/de/praevention/schule/#hastdufeuer> (accessed 31 August 2017).

in workplace settings. Here, the question of drinking usually predominates. In the context of the *ZOOM* project, Vorarlberg organises one-day (eight-lesson) *klartext* [Plain language] training programmes for teachers and apprentices' instructors, which enable the participants to implement the corresponding teaching aids, and are combined with workshops for young people (Stiftung Maria Ebene 2015).

With regard to workplace-based responses to adults at risk of addiction, for instance, Upper Austria provides expert assistance in planning customised prevention programmes (Institut Suchtprävention 2016). Already in 2013, a practical guideline for small and very small enterprises was made available, which also includes labour law aspects.

Prevention in **youth social work settings** also focuses on further training programmes for multipliers. In the programmes that the addiction prevention units run for young people, new media have played an increasingly important role in recent years (e.g. *digital story-telling*). They address young people both at school and outside school. Carinthia's training course focusing on *young people and addiction* embraces different occupations and addresses representatives from halls of residence for young people and youth centres, streetworkers and school social workers. In addition to basic knowledge on addiction, specific interventions are communicated. The addiction prevention units' workshops that directly address young people provide opportunities for discussions and reflections in a familiar setting; participation is voluntary; and they pursue a low-threshold approach with an open, accepting position towards the target group.

Universal prevention measures in **recreational settings** primarily focus on drinking and are implemented, for instance, in cooperation with (football) clubs. They are mostly aimed at communicating a responsible approach to alcohol, by awareness-raising on the part of trainers and other key persons or by means of *peer education* (e.g. *VOLLFAN statt voll fett* [Great fan rather than great drunk] in Viennese football stadiums).

Prevention at the community level, apart from awareness-raising among the general public, is also aimed at developing and implementing activities oriented towards the specific situation of the region in question. It is important in this context that the community itself starts activities, that participation within the community is promoted, and that the programmes chosen address the concrete needs of the community. Prevention at the community level plays a significant role in Upper Austria, where the community project *Wir setzen Zeichen*⁶¹ [We're making a point] has already been used for many years to help the communities plan and implement prevention measures.

Pre-enlistment medical examinations are a further specific setting worthy of mention, as practically all young men aged between 17 and 18 have to undergo such examinations. In Lower Austria,

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For further information please visit <http://www.praevention.at/gemeinde/praeventionsprojekt-wir-setzen-zeichen.html> (accessed 24 August 2016).

short lectures have been held in this context for many years, covering the issues of problem patterns of substance use, addiction behaviour and support services, as well as the substances alcohol, nicotine and cannabis.

By agreement with experts in the field, no **media campaigns** on illicit substances are launched in Austria. The only exception are media campaigns in the context of public relations work for individual, usually community-oriented, projects, or awareness-raising campaigns concerning legal substances. The tobacco prevention initiative run by the Federal Ministry of Health and Women, which will be continued until 2018 and includes an intensified implementation of the *plus* programme, is a case in point here (see Weigl et al. 2016).

4.2.2.3 Selective Prevention

The selective prevention measures include, for instance, programmes for **children in families with addiction problems**. They are based on programmes for multipliers, either in the context of their regular training (at universities of education) or in specific courses and workshops, e.g. for kindergarten teachers. In Vienna, both basic training and advanced training courses are organised in this field: they provide basic theoretical information, and the competence acquired can then be consolidated by means of practical exercises and specific examples⁶². The focus is on awareness-raising among experts in child education and childcare, as they are able to build rapport and can thus support the children at risk in the best possible way.

In Styria, the further training programme *Darüber spricht man nicht!?* [One doesn't talk about that!?!], which focuses on children in families with addiction problems, is also offered to providers of social education family services. The project *Trampolin*⁶³ [Trampoline] run by the *Clean* advisory centre in Vorarlberg directly addresses children at risk (aged 6 to 12). It is a free programme comprising 10 sessions in an animal-assisted children's group, where the children learn basic facts about the effects of alcohol and drugs, but the main element is an exchange with other children in a similar situation, as well as helping them build self-esteem and cope with difficult situations.

A number of well-established interventions, such as **social education services, labour market policy programmes/measures** and **employment projects**, address **young people** in specific settings. For the majority of these settings, the focus is on further training programmes for trainers in order to communicate knowledge, raise their awareness of their own function as role models and enhance their practical competence. For instance, VIVID offers both a basic training course and an

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For further information please visit <https://sdw.wien/de/praevention/kindergarten/> (accessed 31 August 2017).

63

For further information please visit <http://clean.mariaebene.at/programm-trampolin/> (accessed 20 July 2016).

advanced course in addiction prevention, as well as individual advisory sessions⁶⁴ for the development of alternative courses of action at support centres or institutions and the implementation of measures with long-term effects. Activities that directly address young people aim at enhancing their risk competence. For instance, VIVID offers *CHOICE* for young people, combined with measures for trainers (see section 4.2.2.4). In contrast to Vorarlberg, the young people are selected according to the goals and subjects of the programme rather than on individual risk potentials (Kahr, personal communication). For organisational reasons and due to restricted resources, not all young people from a support centre can take part simultaneously.

The above settings frequently include young people who have already experimented with drugs, or even followed high-risk patterns of use. One goal can therefore also be to reduce the use of legal substances (e.g. in the context of prevention measures in vocational orientation courses in Burgenland or in the *pib* [Prevention in Enterprises] programme in Tyrol). However, the main focus is on identifying personal resources, raising self-esteem and finding alternative strategies for problem resolution. The programmes often include elements of outdoor education and exercises aimed at relaxation and body awareness.

In **recreational settings**, the focus is on communicating a critical approach to psychoactive substances (risk competence), as well as offering alternatives to substance use. The club and party scene is a typical setting for such programmes. In and around Vienna, the *checkit!* project plays a significant role in this context: it is a scientific project on the one hand, and it offers drug checking⁶⁵ services on the other, thus being able to warn users in the case of unexpectedly potent preparations and potential health hazards of certain substances (see chapter 3, 6 and 7), which in turn is an opportunity to reach young people. Similar projects are run in Tyrol (*Z6 mobile drug services*⁶⁶) and Vorarlberg (*taktisch klug*⁶⁷ event services, but without drug testing in the latter case).

Walk About (Tyrol) is a good example of a programme targeting young people who are already experimenting with drugs, to show them alternatives to drug use. It uses experience-based approaches to highlight patterns of behaviour and group dynamics as a starting point for further reflection on substance use (Z6/Drogenarbeit 2015).

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For further information please visit <http://www.vivid.at/angebot/jugendqualifizierung-und--beschaeftigung/> (accessed 4 August 2016).

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Drug checking is an integrated approach that combines drug testing with advisory services (TEDI 2011). For further information on the drug checking approach please visit <http://www.checkyourdrugs.at/drug-checking-2/> (accessed 4 August 2016).

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For further information please visit <http://www.drogenarbeitz6.at/mda.html> (accessed 4 August 2016).

67

For further information please visit <http://www.taktischklug.at/index.php/begleiten> (accessed 4 August 2016).

The specific situation of **people with an immigration background** may be connected to an elevated risk of developing an addiction, because immigration, particularly forced immigration, can in itself be an event in life that is traumatising and subsequently triggers addiction. Here, selective prevention primarily focuses on those immigrants who, because of their current situation in life and because of specific social factors, are particularly vulnerable and cannot be adequately addressed in the context of universal prevention. *Mamma Mia* (Upper Austria)⁶⁸ and *eltern.chat* (Vorarlberg)⁶⁹ are examples of such prevention projects. Their goal, i.e. to encourage social network-building and to enhance parenting skills, is pursued by means of informal facilitated discussion events in the relevant communities, with trained facilitators from immigration backgrounds. The Addiction Prevention Unit of Lower Austria runs an intercultural addiction prevention course for multilingual persons with an immigration background, who subsequently work in intercultural projects in the context of open youth services, at schools and in parent training projects (Fachstelle für Suchtprävention NÖ 2016). This approach is similar in some respects to *Mamma Mia* and *eltern.chat*: for instance, *Treffpunkt Familie* [Meeting point: family] has also facilitated parent groups that meet in the flat of a host family.

4.2.2.4 Indicated prevention interventions

In Austria, indicated prevention primarily focuses on early identification and early intervention in the case of substance use while signs of dependence have not yet become apparent. The corresponding measures are exclusively based on observations of high-risk patterns of behaviour and related behavioural disorders and in most cases refer to alcohol use or encompass a variety of substances. Under the name *Movin' or MOVE*, regular further training programmes on motivational interviewing for talks with (at-risk) young substance users have been organised in all provinces for many years already. They address participants from a variety of fields (e.g. youth work in recreational settings (see also Table A3). The focus is on communication on an equal footing, based on the transtheoretical behaviour change model developed by Prochaska and DiClemente⁷⁰.

Step by Step, a programme promoting uniform responses to incidents at school, as well as early detection and intervention under SMG Section 13 (see chapter 2), is implemented all over Austria (mainly in the form of training courses). In recent years, the programme has seen adaptations to regional requirements in the individual provinces, and has occasionally been run under a different name (see Table A4.4). It provides training for participants working with young people (e.g. in the

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For further information please visit <http://www.praevention.at/familie/mammamia-muetter-im-gespraech.html> (accessed 24 August 2016).

69

For further information please visit <http://www.supro.at/home/eltern/eltern-chat/> (accessed 4 August 2016).

70

For further information, including the theoretical background, please visit <http://www.motivationalinterviewing.org/> (accessed 12 September 2017).

context of internal training programmes for teachers, for 15–25 participants), and awareness of the need for, and the expedience of, standardised procedures is raised at other levels as well. Specific tools are being developed to provide guidelines for action to key staff members (e.g. the Upper Austrian website *STEPCHECK*⁷¹). In Carinthia, young people at risk in accordance with SMG Section 13 can be referred to the *Way out* project: during a period of six months, they can take part in individual and group sessions to get familiar with alternative courses of action and to enhance their psychosocial skills. *Way Out* has been defined as a health-related measure in accordance with SMG Section 11, and participation is only possible on the basis of SMG Sections 12 and 13 (Drobesch–Binter, personal communication). In Tyrol, unlike other provinces, no training programmes for teachers are run. Teachers only report incidents to the head of school, who then informs the school medical officer or school psychologist, who in turn address the problem in accordance with their own guidelines for action. This theme is therefore discussed with varying degrees of intensity in the regular further training events for school medical officers and school psychologists (Gollner, personal communication).

In Vorarlberg, the *ZOOM* project offers advice and coaching services in cases of crisis in order to de-escalate the situation and organise further support (Stiftung Maria Ebene 2015). The *CHOICE* programme, which is run in Styria and in Vorarlberg (in the latter as part of *ZOOM*) in the context of prevention work addressing young people in labour market policy programmes and occupation projects, is based on health psychology principles: eight three-hour sessions are held in group settings (of 6 to 10 young people), where the participants acquire easily manageable self-perception and emotion regulation techniques to enable them to enhance their self-regulation skills and build self-confidence. In Vorarlberg, the participants are individually selected with regard to elevated risk of harm (see GÖG/ÖBIG 2013).

Carinthia's *Grenzwert*⁷² [Limit value] project addresses young people who have been admitted to hospital due to high-risk alcohol use (see GÖG/ÖBIG 2013). The young patients and their parents are contacted there and referred to the *Neustart* service. In individual and group settings, the young people are motivated to reflect on, and reduce, their substance use and to find alternative ways of coping with peer group pressure. Since 2016, the project has also targeted young people who have been admitted to hospital due to poisoning by other substances. The Carinthian hospitals of Klagenfurt and Villach are participants in the project.

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The website was jointly developed by the *Institute of Addiction Prevention* and the Austrian Workers' Compensation Board (AUVA) of Linz. For further information please visit www.stepcheck.at (accessed 13 July 2016).

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For further information please visit <http://www.suchtvorbeugung.ktn.gv.at/Default.aspx?Slid=106> (accessed 4 August 2016).

4.2.3 Quality assurance

The quality of prevention interventions is subject to a variety of influences and is assured in various ways. The provisions of the addiction/drug strategies or plans, as well as the numerous coordination and cooperation structures (see section 4.2.1 and chapter 1) play an important role in quality assurance. Furthermore, the education and (further) training programmes, which are often obligatory for the staff of addiction prevention units, make a significant contribution to this end. They include

- » the master's programme and continuing training course in preventing addiction and violence in educational contexts run by the University of Education Upper Austria in cooperation with the University of Applied Sciences Upper Austria, the Upper Austrian pro mente Institute of Addiction Prevention and the Johannes Kepler University Linz;
- » the Lower Austrian training course in project organisation and implementation in the field of addiction prevention;
- » the training course in intercultural prevention of addiction of the Lower Austrian Addiction Prevention Unit (see Weigl et al. 2014);
- » training courses for multipliers, such as the course in addiction prevention at school run by the Lower Austrian University of Education, or the training course in coordination of prevention at schools in Upper Austria;
- » the annual 2-day *Prägend* further training courses for police officers in Upper Austria organised by the Upper Austrian pro mente Institute of *Addiction Prevention* (Institut Suchtprävention 2015);
- » the training course in addiction and young people organised by the Carinthian Agency for Addiction Prevention, which addresses different professional groups, for instance, staff in shared housing communities for young people and youth centres (successive modules comprising a total of 98 lessons);
- » the training course in addiction prevention in the context of youth education and employment that takes place in Styria (7 modules, with a total of 76 hours).

The further training programmes for multipliers such as those listed above and in section 4.2.2 cover a variety of professions and settings.

The annual expert meeting held by *ARGE Suchtvorbeugung* is a further noteworthy event. The 2016 meeting focused on the issue of drinking and provided an opportunity for a general discussion of topical issues. In addition, ARGE maintains close links with other German-speaking institutions in this field in order to enable regular exchange at the expert level.

The quality standards that must be met in order to receive funding (see also section 4.2.1) are also relevant in this context, as are other standards, such as the quality standards for addiction prevention at school issued by the Styrian SAG working group, or *ARGE Suchtvorbeugung's* standards for peer education in primary addiction prevention. The basic principles of professional addiction prevention in Austria, which the addiction prevention units drew up in 2002 in collaboration with external experts, also support quality assurance.

From 2013 to 2015, the Institute of Addiction Prevention (Upper Austria) took part in the review of the European Drug Prevention Quality Standards (EDPQS⁷³) as well as in the development of materials to enhance implementation. At present, ARGE Suchtvorbeugung is discussing how the standards can be transferred to Austria and adapted to the national situation (Schmidbauer, personal communication).

Most evaluations of prevention measures take place during the pilot stages of new projects, but evaluations are not carried out systematically. This is partly due to financial problems, while another reason given is that carefully evaluated, proven methods are being applied in most cases, so that good monitoring and occasional process evaluation are deemed to be sufficient. A number of evaluation reports on Austrian projects have been published on the websites of the addiction prevention units or FGÖ, and have also been included in the EDDRA database⁷⁴ of the EMCDDA and can be accessed there. New evaluation results have also been detailed in the individual reports on the drug situation.

4.3 Trends

Legal substances have been a focus of Austrian prevention interventions for a long time, and this trend has intensified further during the past 10 years. Specific prevention measures with regard to illicit substances meanwhile play a subordinate role. This results from a prevention approach that concentrates on the actual significance, expressed in terms of prevalence rates, that individual forms of addiction have for society and young people (see chapter 3). Increasingly tight budgets are another relevant factor. Parallel to this, the range of prevention activities has continually been expanded, in line with a broader concept of addiction, and consequently, the prevention of violence (e.g. in Upper and Lower Austria) and prevention of suicide (e.g. in Vorarlberg) have gained importance as issues covered by the addiction prevention units. This is also reflected in the development and integration of additional modules in the *Eigenständig werden* [Become independent] and *plus* programmes. In accordance with the all-encompassing approach of addiction prevention (strategies), since 2015, workshops on gambling that address young people have also been tested (e.g. in Upper Austria and in Salzburg).

Generally speaking, the implementation and advancement of well-established programmes is being intensified, particularly training programmes for multipliers. For instance, additional professions are being addressed (e.g. in the context of *movin' or MOVE*), and additional settings integrated. As in previous years, several provinces plan to intensify the development or expansion of selective prevention measures. Activities encompassing a range of different substances, as well as activities concerning legal substances, play an important role in this regard (e.g. Salzburg and

73
See <http://prevention-standards.eu/> (accessed 26 July 2016).

74
See <http://www.emcdda.europa.eu/themes/best-practice/examples> (accessed 26 July 2016).

Tyrol). Services in party settings that are aimed at encouraging a critical view of psychoactive substances are also being started and expanded.

As well as community-oriented prevention and digital storytelling approaches (e.g. also aimed at promoting media skills), programmes for people with an immigration background, as well as for children in families with addiction problems have played an increasingly important role.

4.4 New developments

With regard to **new strategies or position papers**, the *new framework plan on addiction support in the province of Salzburg* is worthy of mention (see also chapter 1). It describes the goals and tasks of addiction prevention in general, as well as the specific tasks of the provincial Addiction Prevention Unit, but does not include concrete measures (Land Salzburg 2016).

A new position paper of *ARGE Suchtvorbeugung*, the coordinating body of the addiction prevention units, comprises 20 recommendations for action aimed at promoting responsible approaches to alcohol in Austria (ARGE Suchtvorbeugung 2016). They include alcohol-related recommendations to, for example, draw up a nationwide action plan or modify the legal framework, as well as recommendations encompassing a range of different types of addiction, particularly the following:

- » to promote the development of prevention-oriented overall policies;
- » to expand life-skill programmes for children and young people;
- » to create empowering general conditions in different settings;
- » to enhance programmes for children in families with addiction problems and further training programmes for the professions involved.

Promoting prevention-oriented general policies means that political decisions in all areas of life need to be examined with regard to their contribution to health promotion and addiction prevention in social environments. The recommendation to create appropriate general conditions refers to the consistent implementation of environmental prevention strategies, i.e. to ensure that a person's everyday settings enhance their well-being and help prevent the development of addiction.

In this context, the *1st Austrian alcohol dialogue week* is worthy of mention: it is a nationwide prevention campaign addressing the adult population, and was launched by *ARGE Suchtvorbeugung* in May 2017. All addiction prevention units, the Ministry of Health, the Main Association of Austrian Social Security Institutions and the Healthy Austria Fund (FGÖ) cooperated to provide a varied programme⁷⁵. The dialogue week took place simultaneously to other action weeks held throughout the German-speaking world.

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See <http://www.dialogwoche-alkohol.at/> (accessed 4 July 2017).

The reporting period saw the development of several **new programmes**: the pilot stage of the *Look@your.Life* addiction and violence prevention programme run by the Federal Ministry of the Interior, which is listed on its website as one of several crime prevention programmes⁷⁶, will be continued until summer 2017 (BMI 2017)⁷⁷. The aim is to collaborate with the addiction prevention units, with actors at the provincial level in charge of implementation. The programme addresses 7th grade school students (aged 13 to 15), as well as their parents and teachers. In 6 modules with a total of 19 lessons, a variety of subjects are discussed, e.g. classroom atmosphere and leisure activities. The programme is aimed at enhancing the students' life skills and pointing out positive ways of coping with difficult everyday situations. So far, 120 prevention officers have completed the training, but no field reports on implementation have yet been made available.

In Vorarlberg, the pilot project *Gesundes Aufwachsen in Vorarlberg* [Growing up healthy in Vorarlberg] is currently being developed and implemented; it draws on the experience of the two existing life-skill programmes *Eigenständig werden* [Become independent] and *Gemeinsam stark und gesund* [Strong and healthy by joining forces] (Stiftung Maria Ebene 2017). Its modules cover the subjects of diet, exercise and psychosocial health; they can be presented as a comprehensive overall programme and can easily be integrated into the everyday routines of kindergartens and family life. In this way, a health-promoting environment can be furthered. In order to ensure equal opportunities in health, it will particularly focus on families in difficult situations, families facing socioeconomic disadvantages, and families with an immigration background. All relevant institutions and stakeholders will be involved in the development of the project.

The Dialog association is developing the semi-structured group programme *Kleiner Leuchtturm* [Small lighthouse] for children aged 8 to 10 who come from families with addiction problems and have lived with foster parents for at least six months, and have contact with their biological parents (Springer, personal communication). At first, the focus is on the children's emotional lifeworlds, then on cognitive input. After providing information on addiction, in an appropriate way that takes into account the children's age, everyday situations and the feelings related to them are addressed, and exchange with other children with similar experiences is encouraged.

The free programme *Familien stärken*⁷⁸ [Empowering families], which has been offered since 2017 by the Vienna Addiction Prevention Institute and Kolping Austria, addresses families with children aged 10 to 14 and aims to strengthen family life. Both parents/guardians as well as the child(ren) in the above age group are invited to take part. In a total of 11 sessions, interactive exercises are used to foster positive communication and a constructive approach to conflicts, and thus a good relationship between parents and child(ren). After the seventh session, there is a break of several

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See http://www.bmi.gv.at/cms/BK/praevention_neu/jugend/start.aspx (accessed 5 September 2017).

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See http://www.polizei.gv.at/lpd_docs/953.pdf (accessed 12 July 2017).

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For further information please visit <https://sdw.wien/de/praevention/familie/#familienst%C3%A4rken> (accessed 31 August 2017).

weeks so that the families have enough time to try out what they learned the programme in everyday life. This intermission is followed by four weekly sessions for consolidation. Childcare for younger children is also offered.

Since 2015, particular attention has been paid to **unaccompanied refugee minors (URM)**, who have often suffered trauma before or during their flight, which, combined with their current situation in life as well as their insecure future outlook, poses an elevated risk of developing addiction. The question is what type of prevention measure is appropriate for this specific target group. 2016 saw intensified efforts at the regional and federal levels to gather and exchange experience gained hitherto, and to adapt or develop measures accordingly. For instance, in December 2016 the Austrian REITOX Focal Point organised a national REITOX Academy on this theme, in which experts in the areas of both addiction prevention and refugee services participated. The expert input provided and the exchange of experience concerning interventions tested so far confirmed the vulnerability of the target group on the one hand, and the frequently difficult working situation of the staff on the other. The addiction prevention units as well as other experts primarily organise training for the staff concerned, and in 2017 GÖG has contributed by conducting a qualitative study to collect information on drug experience on the part of URM, as well as on the causes and solutions they have indicated.

Experience from other fields is also of interest in this context. For instance, GÖG, on behalf of the Vienna Chamber of Labour, collected information on experience of health promotion programmes for and with immigrants and used it for preparing various action modules (Weigl and Gaiswinkler 2016). The Lower Austrian Addiction Prevention Unit, in turn, collected information on experience of sexual education workshops held in URM accommodation (Fachstelle NÖ 2017).

Further new measures at the provincial level:

- » Lower Austria started a new programme for primary schools: the *Alles was Flügel hat* [All that has wings] join-in theatre play, which is implemented in the well-proven way of combining it with further training for teachers and a parents' evening.
- » In Salzburg, the new *startklar* [Ready to go] workshop addressing children in families with addiction problems was developed and implemented (Akzente Fachstelle Suchtprävention 2017). It informs kindergarten teachers about possible stress that children are experiencing due to drug use by their parents, and helps them respond to this situation.
- » The production schools that support children and young adults during the transition from compulsory school to other education options, which have been increasingly implemented in recent years, have now also become a setting for addiction prevention activities. For instance, a series of six workshops is offered in Salzburg, which provides both general information on addiction and prevention as well as risk competence, in addition to specific information on drinking, smoking and gambling (Akzente Fachstelle Suchtprävention 2017).
- » *In 2016 Walk About* (Tyrol) ran a cross-border Interreg-V-A project in which young drug users from Austria and Bavaria jointly participated in three experience-based events that lasted several days (Z6/Drogenarbeit 2017). The groups were heterogeneous, and the young participants came from drug advice, inpatient treatment and youth centre settings.

In addition, the existing **nationwide programmes** (see also Tables in the Annex) have been **developed further**:

- » In Tyrol, *pluspunkt light* [Strong point light] was developed as a follow-up programme to *Ei-genständig werden* and *plus*, and addresses 9th grade school students in their pre-vocational year. The teachers are trained in the methods by e-learning, and the programme is implemented in the schools in three double lessons. Themes such as current challenges the young people are facing, as well as the *feel.ok* programme, are used as starting points to get to grips with the subject. A pilot stage has been planned for 2017.
- » Vorarlberg, on behalf of the Ministry of Education, is currently updating the guideline for action with regard to the implementation of SMG Section 13 (Stiftung Maria Ebene 2017).

The reporting period also saw the publication of a **new study**. An online survey among multipliers in the area of addiction prevention was conducted to study the endeavours made to meet Upper Austria's health goal 7 (i.e. to intensify addiction prevention; Institut für Gesundheitsplanung 2016). The results have revealed that for the majority of respondents, addiction prevention is their profession (80%), but several of them work in this field as volunteers (27%) or as a secondary occupation (20%). In the past year the persons interviewed reached an average of 30 persons directly or indirectly (median) with their prevention work, and a small percentage reached a very high number of people (8% or 10% respectively reached over 200 persons directly or indirectly). Depending on the job and function of the multipliers, they respectively reach numbers ranging from 23 persons (youth workers in recreational settings) or 15 persons (decision-makers in enterprises) to 190 persons (decision-makers in community settings) or 100 persons (kindergarten teachers). Approximately one out of four said they had made decisions relevant to addiction prevention in the past year: 94% in the context of their job, 28% during volunteer work or in their spare-time, and only 2% in a peer setting. Compared to the first survey in 2012 (see also GÖG/ÖBIG 2013), only few differences have become apparent. The most relevant change is the age of target groups that have been reached directly: a smaller number of younger people but a larger number of people aged over 18. Based on the survey, the experts have identified a certain need for action, as it has apparently become more difficult to access municipalities and they have become less willing to start prevention activities. However, appropriate measures are needed in order to motivate young people to train as multipliers and to maintain their commitment in the long run.

4.5 Sources and methodology

Sources

Prevention measures currently being taken are described on the individual websites and in the annual reports and newsletters of the addiction prevention units, ARGE Suchtvorbeugung⁷⁹, the

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For a list of all services of the nine units please visit www.suchtvorbeugung.net/suchtpraeventionsinfo/Hauptseite.

Ministry of Education (BMBF), FGÖ [Health Austria Fund] and other relevant actors, as well as in previous reports on the drug situation and in the EMCDDA *best practice portal*⁸⁰. To illustrate this point, a few examples have been selected from the wide variety of prevention measures being taken in Austria. The majority of projects chosen are implemented at the provincial level or as pilot projects. In order to provide an overview of the diversity of practical approaches, a number of individual measures that specifically focus on legal drugs or non-substance-related addiction behaviour have also been included.

Studies and surveys

Survey of multipliers in Upper Austria (Institut für Gesundheitsplanung 2016): In this context, the term 'multiplier' refers to persons who have acquired and use prevention skills either in clearly defined projects/programmes (e.g. teachers) or in the context of their everyday routines (e.g. peers). For the online survey, 3 121 persons were contacted late in 2015 (from mid-November to the end of December); 667 persons completed the questionnaire (return rate: 21%). Two out of three respondents were women, mostly aged over 40 (74%), and their average age was 48 (median). 38% lived in or around the provincial capital of Linz and 45% indicated that they were teachers.

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4.8 Personal communications (alphabetical order)

Name	Institution or function
Barbara Drobesch-Binter,	Agency for Addiction Prevention, Carinthia
Gerhard Gollner	Kontakt + co Jugendrotkreuz
Claudia Kahr	VIVID
Rainer Schmidbauer	Institute of Addiction Prevention, pro mente Upper Austria
Nadja Springer	Dialog association
Markus Weissensteiner	Lower Austrian Addiction Prevention Unit

4.9 Annex

Standardised interventions organised by the regional addiction prevention units and implemented at a nationwide level

The following programmes were devised by, or in cooperation with, the addiction prevention units and aim at promoting life skills. To guarantee sustainability, the teachers involved are trained and certified by experts (providing theoretical background and methods), who also assist them at the implementation stage. Obligatory reflection meetings are held to ensure quality and to advance the programmes. Standardised materials are available, and the parents are involved and informed via parents' evenings and mailings, and through the school community boards (in which heads of school, teachers, parents and students are represented).

The programme *Eigenständig werden* [Become independent] is implemented in primary schools (children aged 6 to 10) over at least 10 lessons per year. It is oriented towards a holistic view of individuals, personal resources, interactive learning and the integration of group processes. In the participating provinces, the programme has been running since 2002 (B, C, S, St, T, Vb), 2004 (LA) and 2006 (V) respectively, and includes a 24-lesson training course for primary school teachers.

Table A4. 1:

Become Independent, school year 2016/2017

Province	Number of completed trainings SY 2016/17	Number of training sessions for teachers ¹ SY 2016/17	Number of certified teachers SY 2016/17	Percentage of primary school teachers reached	Number of primary schools reached SY 2016/17	Percentage of primary schools reached	Number of parents' evenings SY 2016/17	Number of workshops SY 2016/17	Number of primary school teachers reached by SY 2016/17	Percentage of primary school teachers reached by SY 2016/17	Number of primary schools reached by SY 2016/17	Percentage of primary schools reached by SY 2016/17
B	2	48	20	2	11	6.3	0	0	218	21	97	55.0
C	0	0	0	0	0	0	0	0	422	35.2	138	56.3
LA	3	84	46	0.62	8	1.14	0	18	905	12.2	189	27.0
UA	11	308	206	4.2	41	7.0	15	11	2 149	44.5	490	84.0
S	3	84	49	2.1	10	5.6	1	2	655	27.9	138	77.5
St	5	125	65	1.5	25	5.4	0	4	589	13.9	222	48.1
T	4	96	93	2.7	17	5.0	1	3	566	23.5	184	50.1
Vb	2	56	33	2.2	2	2.2	17	12	846	60.4	111	66.9
V	4	96	54	0.8	12	4.4	0	8	1 650	25	203	74.9

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

n.a. = not available, SY = school year.

¹including reflection meeting.

Sources: Akzente Addiction Prevention Unit Salzburg, Addiction Prevention Unit Burgenland, Addiction Prevention Unit Lower Austria, VIVID Addiction Prevention Unit Styria, Addiction Prevention Institute Upper Austria, kontakt+co, SUPRO Addiction Prevention Unit; Addiction Prevention Institute Vienna, Addiction Prevention Unit Carinthia:

graphic representation: GÖG

The programme *plus* is implemented in years 5 to 8 (secondary school students aged 10 to 14). It consists of four annual focuses, each of which includes five themes covered in 10 lessons. The principles of the programme take into account the age and growing competence of the students, as well as interactions between different problem areas (violence, sexuality, consumption and addiction), challenges in everyday life and gender-related needs and demands. In the individual provinces, the programme has been running since 2008 (S, St, T) and 2009 (B, C, LA, UA, Vb, V) respectively, and includes a four-year training course for teachers with 10 individual events and a total of 20 to 44 training sessions per course.

Table A4. 2:

Programme *plus*; school year 2016/2017

Province	Number of completed further training courses for teachers	Number of teachers reached SY 2016/17	Percentage of teachers reached	Number of schools reached SY 2016/17	Number of teachers per school SY 2016/17 (min-max)	Number of students per school SY 2016/17 (min-max)	Percentage of schools reached SY 2016/17	Number of teachers reached by SY 2016/17	Percentage of teachers reached by SY 2016/17	Number of schools reached by SY 2016/17	Percentage of schools reached by SY 2016/17
B	15	88	5.2	10	1-16	20-160	19.0	201	11.8	38	71.7
C	12	198	6.6	46	2-27	20-120	56.8	364	12.1	54	66.7
LA	5	57	0.7	9	1-16	n.a.	3	221	2.6	43	14.4
UA	15	410	4.3	105	1-10	25-400	37.5	720	7.7	125	44
S	5	59	2.9	15	1-20	0-200	20.8	84	4.2	28	38.9
St	11	199	4.9	56	2-8	15-26	33.9	397	9.8	58	35.2
T	9	133	2.9	48	n.a.	40.2	169	4.0	61	53.3	n.a.
Vb	6	33	1.3	8	1-3	20-60	12.1	199	7.55	55	83.4
V	9	249	2.3	27	n.a.	n.a.	6.4	377	3.5	98	23.1

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

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

Under the name *movin'* and *MOVE* (V), the addiction prevention units organise standardised courses in *motivational interviewing*, a technique used in both prevention settings and addiction support and treatment centres. Motivational interviewing permits a supportive atmosphere and rapport, which enhances the motivation to change behaviour. On average, the courses comprise 20 hours, in which the basic approaches and strategies of this method are communicated by means of practical exercises, role play and reflection on the role-play exercises. In the individual provinces, the programme has been run since 2004 (V), 2005 (C, LA, St, T), 2007 (S) or 2009 (Vb) respectively.

Table A4. 3:
movin' and *MOVE* courses; in 2016

Province ¹	Direct/final target group (age group)	Indirect target group (advisers, multipliers)	Number of courses/course series in 2016	Number of lessons for multipliers in 2016	Number of certified participants in 2016
C	Young people aged 12 to 21 in youth centres, clients of inpatient treatment centres	Key persons in school/youth coaching; staff of Klagenfurt hospital; staff of open youth services; staff of youth welfare services	4	40	77
LA	Young people, people with addiction problems, people with basic education needs	Health promotion staff, youth workers in recreational settings, staff of (ad-diction) advisory services, probation officers, social workers; multipliers from support and treatment networks, youth coaches and addiction prevention staff; two reflection workshops for persons having completed <i>movin'</i> courses	6 2	120 9	91 20
UA	Young people aged 12 to 21 in youth centres, labour market policy programmes, advisory services and social-care centres, or in contact with street workers	Staff of open youth services, social care and advisory services; basic course in youth social work in recreational settings for provincial youth officers, trainers in labour market policy projects	8	108	156
S	Young people in youth centres; young people taking up social education services (workplace, apprenticeship, assisted shared housing); adolescents/young adults aged 12 to 21	Staff of youth centres, shared housing for young people and labour market policy programmes such as youth coaching; guidance counsellors, job in-structors, street workers, police officers specialising in prevention, apprentice instructors	5	80 lessons (50 min. each)	ca. 70
St	Young people aged 12 to 25, young adults	Staff of open youth services, school social workers/advisers, staff instructing or working with young people, social education workers	2	36	35
T	Young people, clients of drug support services and social psychiatric care institutions	Staff of youth centres, drug advisory services, social psychiatry institutions	2	44	25
Vb	Young people aged 12 to 21; persons with addiction problems	Staff of child and youth support services, open youth services, employment projects for young people	3	48	43

Continued next page

Table A4. 3 continued

Province ¹	Direct/final target group (age group)	Indirect target group (advisers, multipliers)	Number of courses/course series in 2016	Number of lessons for multipliers in 2016	Number of certified participants in 2016
V	School students, apprentices, young people, parents, staff in enterprises	Staff and peers in open youth services; key persons in schools, apprentice instruction settings and enterprises (e.g. occupational health physicians, works council members, (health) managers and teachers), experts from child education and childcare institutions	6	136	78

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

¹ *movin'* is not implemented in Burgenland.

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

Step by Step is a computer-aided programme aimed at early detection and early intervention in the case of behavioural disorders that can indicate addiction problems. The programme was developed in 1992 and consists of several modules: a website with an info section (glossary, advisory centres, laws) and a section on early detection which includes information on the training programme; a CD-ROM and the STEP BY STEP manual on secondary prevention at school (help instead of punishment) complement the materials provided. The training programme for teachers forms the basis for an effective use of the section on early detection. In addition, the training is offered as an internal programme for all teachers in a school.

Table A4. 4:

Step by Step or *Stepcheck* or *help instead of punishment* training programmes in 2016/17

Province ¹	Direct/final target group (age group)	Indirect target group (advisers, multipliers)	Number of trainings (projects) in SY 2016/17	Number of lessons for multipliers in SY 2016/17	Number of participants in SY 2016/17
B			n.a.	n.a.	n.a.
C	Adolescents and young adults aged 13 to 18	Key persons in schools and other social education institutions	5	22	86
LA	School students	Heads of school, teachers, school medical officers, school social workers, other educational staff, parents, etc. All persons concerned in the case of an incident at school	11	51	178
UA	School students	Teachers, heads of school, school medical officers and teachers with special functions (e.g. addiction prevention coordinators, educational counsellors); or, in the event of specific incidents, all staff	7	18	98
S			n.a.	n.a.	n.a.
St	School students aged 10 or older	Multipliers in school settings such as teachers, school medical officers, school social workers and school psychologists	2	7	19
T	Young people aged 13 to 18	School medical officers, school psychologists, heads of school	n.a.	n.a.	n.a.
Vb	School students aged 12 to 21	Teachers, heads of school, school medical officers, social network staff. school psychologists	3	18	54
V	School students aged 13 or older	Teachers	2	24	33

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

n.a. = not available.

¹ *Step by Step* is not implemented in Burgenland, and in Salzburg it is not implemented (by the Addiction Prevention Unit). In Tyrol, only an abridged version is implemented, in which this subject is addressed with varying degrees of intensity in the context of the regular further training events for school medical officers and school psychologists.

Sources: Akzente Addiction Prevention Unit Salzburg, Addiction Prevention Unit Burgenland, Addiction Prevention Unit Lower Austria, VIVID Addiction Prevention Unit Styria, Addiction Prevention Institute Upper Austria, kontakt+co; SUPRO Addiction Prevention Unit, Addiction Prevention Institute Vienna, Addiction Prevention Unit Carinthia

Drug treatment

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5 Drug treatment

5.1 Summary

National profile

In Austria, the provincial addiction or drug strategies, as well as the Austrian Addiction Prevention Strategy, are the basis for addiction advice and support services including treatment. The above documents underline the need for diversified treatment options as well as multiprofessional structures in order to respond to the individual situation of addicted patients. With regard to implementation, various strategies are pursued, e.g. decentralised v. centralised supply structures for opioid substitution treatment, or establishment or expansion of specialised departments v. agreements with neighbouring provinces (particularly for inpatient treatment). Implementation is coordinated primarily by the provincial addiction/drug coordination offices. In addition, the district administration authorities, in their function as health authorities, play an important role.

On principle, the entire general health care system is open to addicted patients in need of treatment, and there are also inpatient and outpatient centres specialising in addiction. This permits a wide range of support and treatment options, from advice on diverse aspects of addiction, psychosocial counselling and treatment, to pharmacologically assisted outpatient and inpatient treatment, detoxification in outpatient or inpatient settings, as well as various forms of abstinence-oriented inpatient/residential treatment. Whereas the majority of these types of treatment are not oriented towards specific substances or target groups, individual specialised services have also been established, for instance, for cocaine users or addicted women.

Quality assurance is based on legal requirements and standards at the federal or provincial levels. A variety of (further) training programmes and other opportunities for an exchange of experience (e.g. expert meetings and quality circles) play a key role here. Evaluations are not carried out regularly, with the exception of the regular surveys among (former) clients of the *Carina* and *Lukasfeld* treatment units. These surveys indicate rather good results with regard to successful completion of treatment, or completion of treatment as scheduled, but also list possibilities for improvement.

In 2016, a total of approximately 24 120 persons took up drug-related services including treatment, with opioid users (mostly in the context of polydrug patterns of use) accounting for by far the largest proportion (approximately 20 250 persons). With regard to the number of patients, the group of persons who are treated solely due to use of cannabis (approximately 2 400 persons) is also relevant. The age of the clients receiving advice and treatment in addiction support services depends on the service setting: the clients taking up short-term services tend to be younger, whereas the clients undergoing long-term inpatient treatment are older. The proportion of women is between 20% and 24% in all settings surveyed. Approximately half of all clients indicate completion of compulsory school as their highest educational level. The majority of clients starting long-term treatment are Austrian nationals.

Trends

In outpatient treatment settings, a decrease in opioids as the primary drug was registered until 2013, whereas cannabis as the primary drug was increasing. This particularly applies to people taking up outpatient treatment for the first time. Drugs such as cocaine or stimulants have also become more relevant in quantitative terms. It cannot yet be ascertained whether this indicates a long-term change in high-risk drug use or whether cases of less harmful drug use, irrespective of the type of drug used, now also tend to receive drug-related treatment. From 2013 to 2016, the above trend has, in fact, not continued or has not been as obvious. A positive development is that the in-treatment rate among problem users of opioids has significantly risen over time, to more than 60%.

New developments

The areas of advice, support and treatment have increasingly been oriented towards integrated services, and regional networking has been a key feature of recent developments. The existing services have been further developed in all areas, e.g. in order to ensure the availability of opioid substitution treatment in the long run, to improve contact with people with an immigration background or to enable appropriate social reintegration measures. In Upper Austria, a survey was conducted among clients with opioid addiction to investigate their satisfaction with opioid substitution treatment, and has confirmed that, as a rule, OST does work well. Recommendations for improvement have been made primarily with regard to the option of injecting administration of the substance prescribed, or easier take-home regulations, as well as with regard to complicated procedures for the clients.

5.2 National profile

5.2.1 Policies and coordination

Treatment strategies are defined in the addiction/drug strategies of the nine provinces, in the Austrian Addiction Prevention Strategy and in the relevant laws and regulations (see also chapter 1 and 2). The Narcotic Drugs Regulation (BGBl. II 1997/374) defines the framework for opioid substitution treatment, and the Further Training Regulation (BGBl. II 2006/449) provides the requirements that doctors delivering OST have to meet (see section 5.2.4 and 5.2.5). With regard to structures of service provision, the regional structural plans on health and the psychiatry plans of the provinces are relevant.

The majority of addiction/drug strategies underline the importance of having a wide range of support and treatment options (and recourse to diverse methods). Interdisciplinary teams are needed to respond to different causes for and developments of addiction, as well as to the individual problems of clients. The corresponding wide range of treatment options includes abstinence-oriented approaches and substitution treatment, as well as harm reduction, aftercare and

the social integration of addicted patients. This requires networks that link different services, as well as the cooperation of multiprofessional teams. Both *Lower Austria's addiction strategy* and the *Viennese addiction and drug strategy of 2013* give top priority to the enhancement of the patients' life quality, irrespective of their current status of drug use or addiction. The *Lower Austrian addiction strategy* describes abstinence as a possible goal after stabilisation, but emphasises that this is a decision on the part of the patient. The Austrian Addiction Prevention Strategy emphasises the liaising function of the social psychiatry institutions. An increasing number of strategies pursue integrated approaches (see also section 5.4) across different types of addiction, or focus on the integration of addiction services into the general health-care services, and particularly psychiatric care.

Regarding concrete interventions, the individual plans and strategies differ considerably from each other. In several provinces, the addiction/drug strategies stress the need for separate services for young people and adults. A number of strategies plan different services for users of different substances (e.g. a programme for older cocaine users in Vorarlberg), while others focus on interdisciplinary cooperation and links between specialised service providers and the general health and social care system (e.g. Vienna and Salzburg). Assessment of the patient's condition and long-term support or treatment as well as reintegration play a key role in outpatient settings. Lower Austria therefore plans to expand its outpatient services, which includes 'competence centres' in the form of outpatient clinics with multiprofessional teams. The province of Burgenland only provides outpatient services; the small number of patients requiring inpatient/residential treatment (apart from detoxification) are referred to neighbouring provinces, with Burgenland cofinancing their treatment. Other provinces also underline the need for service provision across provincial borders. Many provinces are now discussing issues such as insufficient provision, as well as the improvement or optimisation of certain forms of treatment and intervention (e.g. support in situations of crisis or with regard to housing and jobs). In Vorarlberg, the focus is on *immediate treatment or rehabilitation*. Services for relatives of addiction patients are also explicitly mentioned in several provinces, whereas multilingual services have only recently become a focal issue (e.g. in Lower Austria).

The implementation of treatment services is coordinated primarily at the provincial level, i.e. by the addiction/drug coordination offices, in line with the provincial drug/addiction strategies/plans (see chapter 1). At the federal level, the following activities are relevant in this context:

- » official publication and cofinancing by the Ministry of Health and Women's Affairs (in accordance with SMG Sections 15 and 16) of addiction support and treatment centres that plan to carry out health-related measures (in accordance with SMG Section 11; see chapter 2);
- » Ministry of Justice financing of the *treatment instead of punishment* programme (see chapter 1);
- » maintenance by the Ministry of Health and Women's Affairs of the substitution registry to prevent multiple treatment (SMG Sections 24 and 25; see chapter 2 and 5.2.5);
- » provision of narcotic drug stickers for the prescription of narcotic drugs (Narcotic Substances Regulation Section 22; see chapter 2), maintenance of a database for registering doctors entitled to deliver substitution treatment to patients addicted to opioids in accordance with the Regulation on Further Training in *Oral Substitution* (see chapter 2 and 5.2.5).

SMG Section 15 provides for the legal requirement to publish a sufficient number of support and treatment centres in the Federal Collection of Statutes, taking into account regional demands. It also defines the criteria that those services must meet, the official publication procedure and the documentation of their activities. With regard to federal funding for addiction support and treatment services, SMG Section 16 includes a discretionary provision on federal grants. However, this does not extend to treatment measures whose costs must be borne by a social insurance institution, a hospital or a provider of welfare services. Any federal grants depend on grants from the budgets of other regional authorities.

The Committee on Quality and Safety in Substitution Treatment is a federal actor that provides consultancy to the Federal Minister for Health with regard to OST (SV Section 23k). According to SV Section 23i, an expert commission in charge of the regional coordination of opioid substitution treatment must be established at the provincial level.

The district administration authorities, in their function as health authorities, as well as the public health officers play a key role for opioid substitution treatment: they check the long-term prescriptions that are issued with regard to legal conformity of indication and treatment, and whenever there is reason for doubt, must consult the doctor involved, and possibly refuse authorisation⁸¹ (see 5.2.5). The doctor delivering OST must communicate to the health authority any necessary information, and whenever required, also present the treatment contract. In the case of single prescriptions, the pharmacy must, immediately after dispensing the medicine, send the said prescription to the public health officer in charge for inspection. The public health officers also verify the qualification of the attending doctors, provide narcotic drug stickers for the prescriptions forms, check the non-patient-related documentation of narcotic drug prescriptions and issue the certificates that permit patients to take medicines containing narcotic drugs or psychotropic substances with them when they undertake a journey (SV Section 24).

Apart from opioid substitution treatment, public health officers also play an important role with regard to health-related measures under SMG Section 11 (see also chapter 2). They decide who has to appear for examination, they must carry out the said examination and assess the person examined with regard to their drug use. They also decide whether a health-related measure is deemed necessary and which type of measure is to be taken. Their task also includes motivating the persons examined to actually undergo the health-related measure. Whenever necessary, they can also require the patient to submit a confirmation of uptake.

The Austrian Medical Association is, in turn, in charge of providing an adequate further training programme with regard to opioid substitution treatment for persons addicted to opioids (see 5.2.5), and of entering doctors into, or striking them from, the list of doctors entitled to deliver OST.

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Authorisation: Confirmation of the medical necessity of the prescription including check whether all legal requirements have been met.

Apart from the funding by the Federal Ministry of Health and Women mentioned above, and funding by the Ministry of Justice of measures in the context of *treatment instead of punishment*, the cost of addiction treatment is primarily covered by the provinces (see chapter 1) and to an increasing degree through ‘object-oriented’ and ‘subject-oriented’ funding, i.e. financial support for specific services on the one hand, and client-related financial support on the other. These funds come from the health or social care budgets, depending on the province in question, and in the case of Vienna, authorisation by the Institute for Addiction Diagnostics (ISD) is required. The social insurance funds also play an important role, particularly with regard to detoxification, substitution treatment for patients with opioid addictions, and, to a certain degree, inpatient treatment. For the clients themselves, treatment is usually free, and many of them are also exempt from prescription fees. However, Austria lacks uniform, coherent regulations for cost coverage by the relevant institutions and sectors. In recent years, in an increasing number of provinces, agreements have been concluded with the social insurance funds, and separate remuneration items for opioid substitution treatment delivered to patients with opioid addictions have been established (see Weigl et al. 2015). This permits the remuneration of OST by the regional health insurance funds. For many doctors, this is a key prerequisite for delivering OST, and essentially contributes to the availability of this type of treatment.

5.2.2 Organisation and provision of drug treatment

Outpatient drug treatment system – main providers

The entire general health-care system is in fact open to, and used by, persons suffering from addiction. However, there are additional services specialising in addiction (see Table 5.1). In the outpatient sector, specific addiction treatment is provided either by centres that have specialised in addiction (e.g. the Dialog association), or which are affiliated with an organisation that offers a wider range of psychosocial services (e.g. the Psychosocial Service of Burgenland). However, doctors’ offices (general practitioners, psychiatrists, psychotherapists) or outpatient departments of (psychiatric) hospitals are also important providers of outpatient treatment.

Apart from opioid substitution treatment, they primarily deliver general medical services, and – to a significantly smaller degree – they also provide psychiatric treatment or psychotherapy, whereas specialised centres such as drug/addiction support centres usually offer a wider range of services (see 5.2.4). Outpatient treatment in hospitals is primarily delivered by specialised outpatient departments (addiction or drug outpatient clinics). Their services often comprise a wide range of care and treatment measures (e.g. outpatient withdrawal and substitution treatment), whereas advisory services play a less important role. Low-threshold services are primarily provided by specialised centres; and emergencies are treated in the emergency outpatient departments of hospitals (see chapter 6).

The specialised service providers are often organised as non-profit limited companies or as private associations. In addition, there are private centres that are run as limited companies or foundations. The majority of hospitals are public institutions, but may nevertheless be organised as limited companies.

Outpatient drug treatment system – client utilisation

In 2016, a total of 10 331 persons were registered as long-term outpatients of a centre included in the DOKLI documentation system (see 5.5). According to the *eSuchtmittel* database, 18 222 patients received opioid substitution treatment. 700⁸² of these patients were undergoing treatment in prison and have thus been registered as inpatients. Another 892 clients were admitted as inpatients and have thus also been registered accordingly. Assuming a proportion of 22% of multiple counts among DOKLI-registered clients outside Vienna (in Vienna, double counts can be excluded by means of a specific identifier) and a coverage of 93% outside Vienna (in Vienna, the coverage is 100%), and taking into account an average 70%⁸³ overlap between the substitution registry and DOKLI data on opioid-addicted clients, the following figures result:

- » 9 295 clients were undergoing long-term outpatient drug-related support or treatment in an institution officially published in accordance with SMG Section 15, or opioid substitution treatment in hospital in 2016.
- » 12 827 persons received opioid substitution treatment at a doctor's office or a group practice in 2016.

Overlaps of the two categories cannot be excluded. It is now evident that opioid substitution treatment has become the most important form of treatment for high-risk/problem drug users in Austria (see Table 5.2 and 5.2.4).

Inpatient drug treatment system – main providers

Again, in the case of inpatient treatment, the entire health-care system is open to, and also used by, persons suffering from addiction. However, there are additional centres specialising in addiction diseases. Inpatient/residential addiction treatment is delivered by centres that either exclusively specialise in addiction (e.g. *Grüner Kreis*) or are affiliated with an institution that offers a wider range of medical or psychosocial services (e.g. addiction departments or psychiatric departments of hospitals). Institutions that primarily provide addiction-related services can also cover a wide range of treatment options, sometimes ranging from prevention and advice to inpatient and

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This figure differs from the figure presented in chapter 8. This results from differences in the source of data used (substitution registry v. reports by the Federal Ministry of the Interior).

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70% of patients covered by the DOKLI system who give opioids as their primary drug have also been entered into the substitution registry as patients currently undergoing OST.

outpatient detoxification and treatment, as well as crisis intervention and reintegration – for various types of addiction (e.g. Maria Ebene Foundation).

Hospital-based inpatient treatment primarily comprises emergency treatment and detoxification, but there are also special hospitals that provide inpatient drug-free treatment following detoxification. The latter type of treatment is also available in specialised treatment centres.

Many inpatient service providers are organised as non-profit limited companies or as private associations. In addition, there are (special) hospitals organised as limited companies or foundations, which can also be run on a non-profit basis. Whether an institution or centre is recognised as a (special) hospital depends on various factors, which cannot be discussed in greater detail here.

For further details on organisation (and funding) of inpatient/residential addiction treatment please consult GÖG/ÖBIG 2012. It is also worthy of mention that – under the principle of equivalence of care and equal treatment of diseases – treatment services in prison must be equivalent to the services available outside prison; this also applies to addiction treatment (see also chapter 8).

Inpatient drug treatment system – client utilisation

In 2016, a total of 1 256 persons received inpatient treatment in centres integrated into the DOKLI documentation system. According to the *eSuchtmittel* database, 18 222 patients received opioid substitution treatment. 700 of this total number of patients were undergoing treatment in prison and have thus been registered as inpatients. Another 435 were admitted as inpatients; their number is thus already included in the above 1 256 persons. Assuming a proportion of 22% of multiple counts among DOKLI-registered clients outside Vienna (in Vienna, double counts can be excluded by means of a specific identifier) and a coverage of 93% outside Vienna (in Vienna, the coverage is 100%), the following figures result (see Table 5.1):

- » 1 298 clients received inpatient abstinence-oriented treatment or inpatient substitution treatment in 2016.
- » 700 persons were given substitution treatment in prison.

Overlaps of the above categories cannot be excluded.

5.2.3 Key data

Patterns of use of clients with drug addiction starting treatment in 2016

Whereas the figures in the previous chapters relate to all persons undergoing treatment due to drug addiction (irrespective of when they started treatment), this section provides an overview of patients entering treatment in 2016. For the data presented below, the same corrections with

regard to multiple counts and coverage by DOKLI, as well as overlaps between DOKLI and the substitution registry, have been carried out as described in 5.2.2.

In all, approximately 3 800 persons entered long-term outpatient or inpatient drug-related treatment in Austria in 2016 (see Table 5.1).

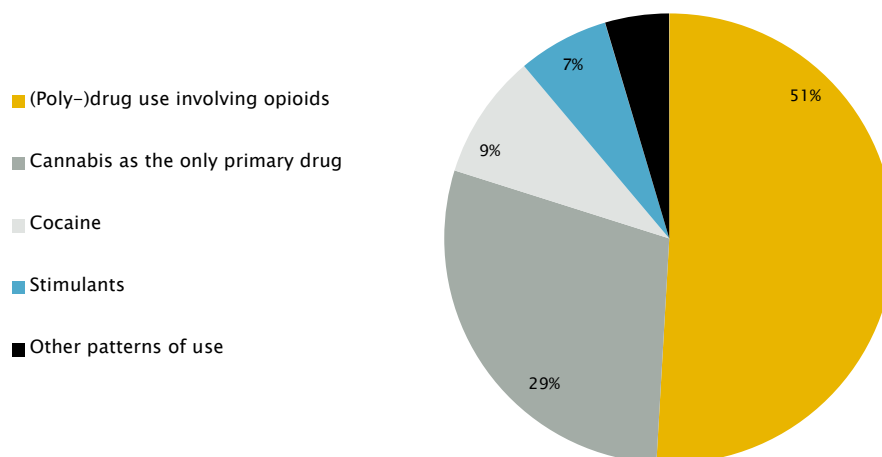
Table 5.1:
Clients entering drug-related treatment in 2016

Type and location of treatment	Number of clients
Outpatient addiction treatment (including opioid substitution treatment in specialised outpatient centres)	2 398
Opioid substitution treatment delivered by office-based doctors	472
Inpatient addiction treatment without detoxification	824
Opioid substitution treatment during imprisonment	99
Total addiction treatments	3 793

Source: DOKLI; eSuchtmittel

Figure 5.1 shows that approximately half of the estimated total number of 3 800 persons starting treatment due to drug addiction in 2016 were opioid users, mostly in the context of polydrug use. Almost one in three entered treatment due to cannabis use. Only a small proportion of clients gave cocaine, stimulants and other drugs as their primary drug.

Figure 5.1 :
Patterns of use among persons entering drug-related treatment in 2016



Sources: DOKLI analysis: client year 2016, eSuchtmittel; calculation and graphic representation: GÖG

Patterns of drug use in the total treatment sector

Approximately 3 800 persons started treatment due to drug addiction in 2016, compared to approximately 20 300 patients who had already entered treatment in the previous year(s) and have continued to undergo treatment up to 2016 (or longer). In all, approximately 24 120 persons are therefore assumed to be undergoing long-term outpatient or inpatient drug-related treatment in Austria (see Table 5.2).

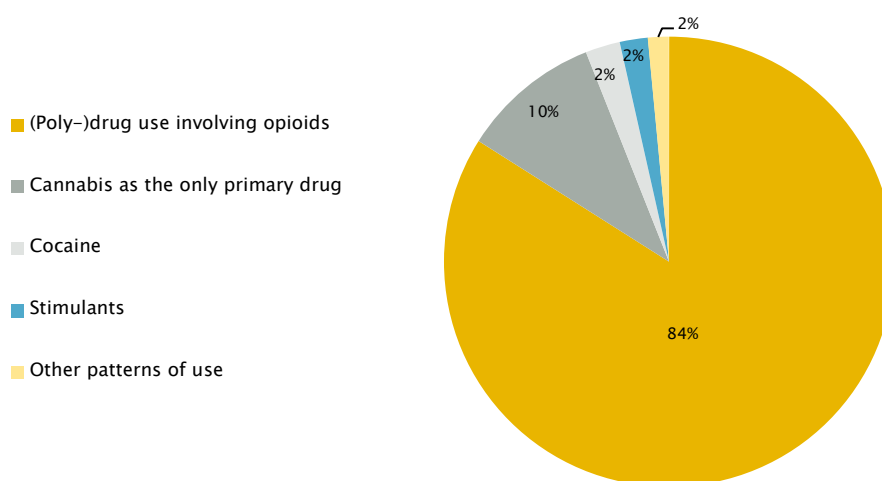
Table 5.2:
All clients in addiction treatment; in 2016

Type and location of treatment	Number of clients
Outpatient addiction treatment (including opioid substitution treatment in specialised outpatient centres)	9 295
Opioid substitution treatment delivered by office-based doctors	12 827
Inpatient addiction treatment without detoxification	1 298
Opioid substitution treatment during imprisonment	700
Total addiction treatments	24 120

Source: DOKLI; eSuchtmittel

Figure 5.2 reveals that by far the largest proportion of patients – approximately 20 250 persons – are in treatment due to opioid use, mostly in the context of polydrug use. The fact that the proportion of persons with opioid addiction out of the total number of persons in treatment is larger than among those starting treatment is primarily due to the comparatively longer duration of treatment in the case of opioid problems (see Busch et al. 2014).

Figure 5.2:
Patterns of use among persons undergoing drug-related treatment (estimate); in 2016



Sources: DOKLI analysis: client year 2016, eSuchtmittel; calculation and graphic representation: GÖG

A second large group of patients in treatment is persons who have used solely cannabis as their primary drug; they account for a proportion of approximately 2 400 persons. Only a small part of the patients in treatment give cocaine, stimulants and other drugs as their primary drug.

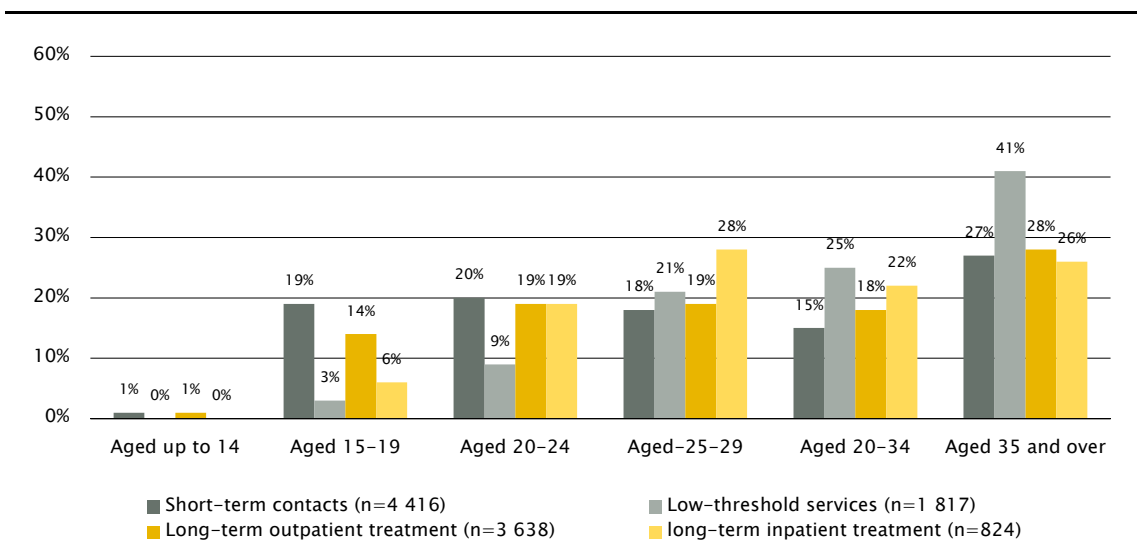
Characteristics of clients in treatment

The information on the characteristics of clients in treatment is based on the data which have been gathered in the context of the DOKLI nationwide documentation system of clients of Austrian drug services. The few available data on the characteristics of clients in substitution treatment are discussed in section 5.2.4.

The drug support and treatment centres in Austria that are covered by the DOKLI system communicated data on a total of 3 638 people who had started **long-term outpatient treatment** in 2016. For 1 512 of them, this was the first drug treatment they had ever had in their lives. 824 clients started long-term **inpatient/residential treatment**, and for 402 of them this was their **first** long-term drug-related treatment. Apart from these persons undergoing conventional drug-related medical treatment, DOKLI also registered 1 808 people turning to **low-threshold services**, and 4 425 people requiring drug-related services in the form of **short-term contacts** in 2016.

Age and gender: Depending on the setting, between 6% (long-term inpatient treatment) and 19% (short-term contacts) of clients are aged under 20. Between 30% (low-threshold services) and 47% (long-term inpatient treatment) of clients are aged between 20 and 29 (see Figure 5.3).

Figure 5.3:
Proportion of persons entering drug-related treatment in 2016, by age and type of service

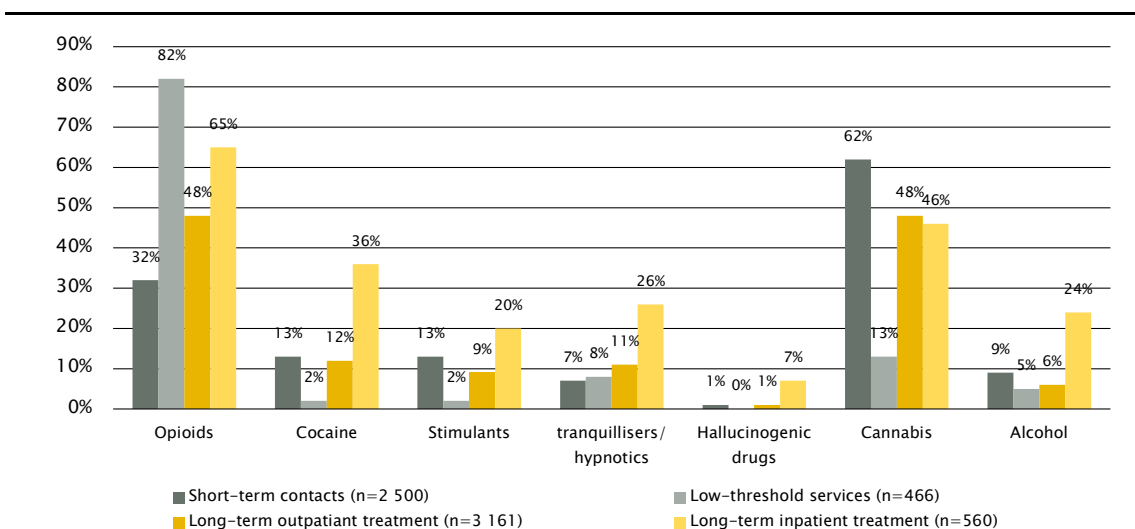


Source: DOKLI analysis: client year 2016; calculation and graphic representation: GÖG

In all settings studied, the proportion of women in the total number of clients was between 20% and 24% (see also Table A1).

Patterns of drug use: In DOKLI, drug use that requires treatment is registered in terms of primary drug and secondary drug⁸⁴. Multiple answers are admissible for both categories. Based on these data, patterns of drug use can be depicted in various ways, depending on the question studied. Figure 5.4 shows the primary drugs, including multiple responses, for 2016. Persons who indicated more than one primary drug are represented more than once. Therefore the sum of all primary drug percentages is higher than 100% (see also Table A5.2).

Figure 5.4:
Primary drug(s) used by persons starting drug-related treatment or service uptake in 2016;
by type of service



Multiple responses admissible.

Source: DOKLI analysis: client year 2016; calculation and graphic representation: GÖG

Patterns of use can also be represented according to the primary drug hierarchy⁸⁵. The Austrian

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The **primary drug** is the drug which causes the greatest problems from the client's personal viewpoint. Here, "problems" – on the basis of ICD 10 – are understood to be psychosocial and health-related problems and not exclusively legal problems. As a rule, the primary drug is the drug that has caused the client to start their current treatment. If a client cannot decide which drug is the primary drug, several drugs may be indicated.

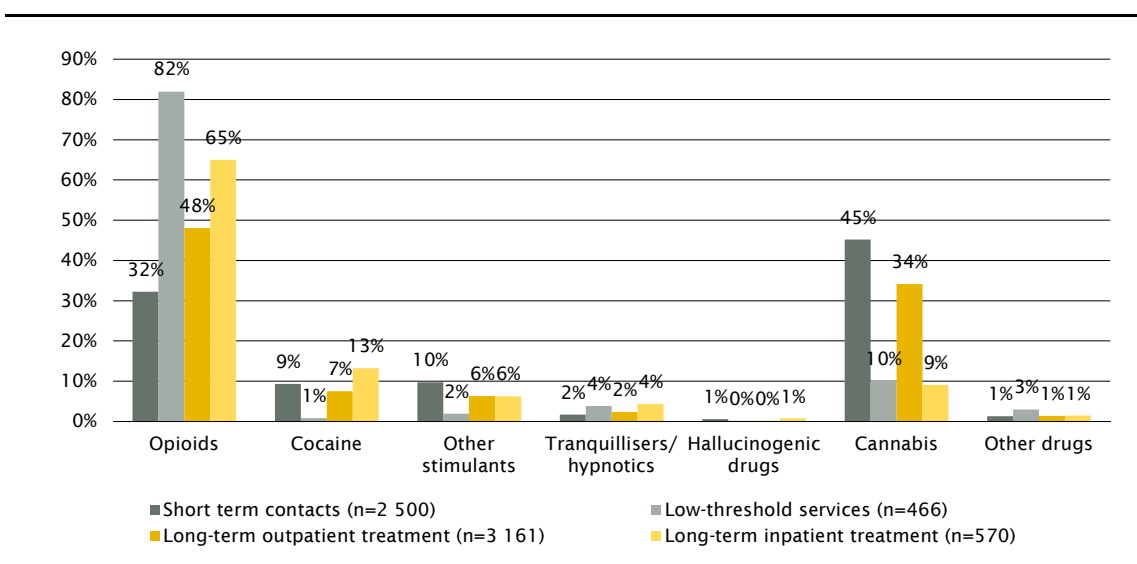
Secondary drugs are drugs which the client has used in addition to the primary drug in the past six months and which also constitute a problem for them. 'Drug use not requiring treatment' has to be ticked in cases of intermittent use of the corresponding drug in the past six months, without harmful use or manifesting addiction problems. 'Only legal problems' has to be ticked if no drug use requiring treatment is found but clients have been referred to treatment for legal reasons (GÖG/ÖBIG 2013a).

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In its Treatment Demand Indicator, the EMCDDA breaks down client data by primary drug. Each client is assumed to use only one primary drug. Any other drugs that cause problems for the client are regarded as secondary drugs. This deviates from the DOKLI system, where several drugs can be documented as primary drugs consumed in the context of polydrug use. For this reason, a 'primary drug hierarchy' has been established for the communication to the EMCDDA of data on polydrug users who name several primary drugs. For instance, if a client indicates use of both opioids and cannabis as their primary

data are communicated to the EMCDDA in this way. If the data are broken down in accordance with this definition, every person is represented in the diagram only once (see Figure 5.5).

Figure 5.5:
Primary drug in accordance with the primary drug hierarchy (start of treatment or service uptake in 2016), by type of treatment



Source: DOKLI analysis: client year 2016; calculation and graphic representation: GÖG

In both diagrams, two different groups are predominant: persons with opioids as their primary drug, and persons with cannabis as their primary drug. According to the hierarchic primary drug definition, the group of primary cannabis users is considerably smaller than in the representation based on multiple counts, i.e. there are many persons who, in addition to the primary drug of opioids, indicate cannabis as a further primary drug. Furthermore, when interpreting the figures on cannabis one has to bear in mind that the proportion of clients referred to compulsory treatment (health-related measures in accordance with SMG Section 11) solely due to cannabis use is very high (see also GÖG/ÖBIG 2013b).

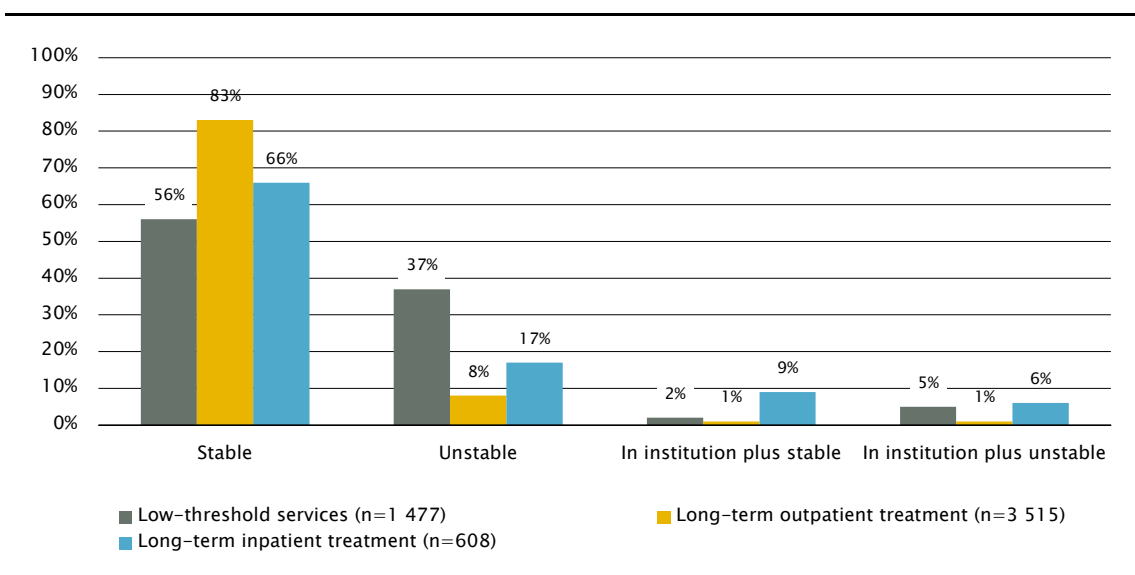
In contrast to other EU member states, in the traditional treatment settings (long-term outpatient and inpatient/residential treatment), opioids thus predominate as the primary drug. Cocaine and other stimulants plays a very insignificant role as primary drugs (see Figure 5.4 and Figure 5.5).

drugs, opioids are defined as the primary drug. The following hierarchy is used:
opioids > cocaine > stimulants > tranquillisers > hallucinogenic drugs > cannabis. This definition is the closest possible approximation to the (logical) requirement that one primary drug must be specified (for instance, if a client indicates problems due to use of both opioids and of cannabis but only one primary drug can be entered, usually opioids are chosen).

34% of persons in long-term outpatient treatment, and 53% of clients in long-term inpatient/residential treatment indicate having injected drugs at least once (short-term contacts: 25%, low-threshold services: 71%; see Table A5. 3).

Social situation: While homelessness does not seem to be a pressing problem for the majority of persons in long-term treatment, the clients of low-threshold centres are facing significant problems with regard to housing (see Figure 5.6 and Table A5.4). However, when interpreting the statements about housing situations, it should be noted that ‘stable’ does not necessarily mean that the housing situation involves no problems whatsoever (e.g. clients still living in their parents’ households for want of an alternative on account of their drug problems).

Figure 5.6:
Persons entering drug-related treatment or service uptake in 2016; by housing situation and type of service



Source: GÖG/ÖBIG, DOKLI analysis: client year 2016

The educational level of around half of clients in both long-term outpatient and inpatient treatment does not go beyond completion of compulsory school (see Table A5. 5).

Only a small proportion of persons starting drug-related treatment in 2016 have jobs (long-term outpatient treatment: 29%, long-term inpatient/residential treatment: 10%; low-threshold services: 10%; see Table A5. 6).

Immigration background: A possible indicator of immigration background is that DOKLI registers the clients’ nationality – which, however, is only documented in the case of long-term support and treatment services. This, however, does not provide a complete picture of the clients who take up addiction support services. The majority of clients starting long-term treatment in 2016 were Austrian nationals (approximately 84%; see Table A5. 7). Only a small proportion were nationals

of another EU member state or a non-EU country, and none of the clients was stateless. The proportion of non-Austrian nationals thus corresponds to their proportion in the total population of Austria (which is 14.6% according to STATISTICS AUSTRIA). Further research would be needed in order to provide reliable statements on whether service-uptake by this group is in line with their needs – which seems to be unlikely in view of reports from practitioners (see section 5.4).

5.2.4 Treatment modalities

Outpatient drug treatment services

An overview of available specialised outpatient services for clients with drug addiction is provided by the *Suchthilfekompass* register of addiction services⁸⁶, as well as regional information sources. The majority of specialised outpatient services offer advice, support and treatment, i.e. the entire range of health-related measures in accordance with SMG Section 11 (see chapter 2), irrespective of the type of illicit substance used. Often, additional addiction diseases are covered as well (e.g. use of legal substances, as well as non-substance-related forms of addiction such as gambling addiction). Apart from specialised outpatient services, office-based doctors also play an important role with regard to the provision of outpatient treatment and care: this particularly applies to opioid substitution treatment (see 5.2.3).

The range of available specialised outpatient services covers advice on addiction and drug problems (including legal advice), as well as outpatient detoxification, psychosocial counselling and treatment (e.g. sociotherapy, life skills training and (cognitive) behavioural therapy – including the diagnosis of underlying mental diseases). Further relevant services provided by the outpatient centres are referral to inpatient or residential treatment, as well as the corresponding preparatory and after-care, from finding a treatment place to providing assistance in cost-coverage procedures, as well as support during possible waiting times. As a rule, reintegration interventions (including measures to prevent clients from losing their jobs or training places) and specific services for relatives of addicted patients are provided as well.

With the exception of Vienna, the majority of outpatient services cater to inhabitants of the corresponding province. For instance, in order to ensure services near to the clients' places of residence, Lower Austria has continually expanded its outpatient centres over many years and has also established new forms of mobile service provision: for instance, the outpatient centre run by *Grüner Kreis* in Wiener Neustadt also offers mobile preparatory services throughout the province, and staff of *Grüner Kreis* use local offices of the Public Employment Service for the provision of advice and support as well as referral of clients (Hörhan, personal communication). In specific cases, services by the Viennese *Dialog* association are also available.

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Here, all centres officially published in accordance with SMG Section 15 are listed (<http://suchthilfekompass.goeg.at/>).

Examples of specialised outpatient services are, for instance, the cocaine consulting hours at the Innsbruck drug outpatient department, which provide specific medical and therapeutic interventions, or *Beyond the line*, the separate opening hours (consulting hours) that the *Dialog* association reserves for users of cocaine and crystal meth. *Checkit!* runs reduction-of-use groups, which at first mainly addressed cannabis users but have now been organised for users of amphetamine, ecstasy, MMC and cocaine etc. as well⁸⁷.

The goal of specialised centres is to organise groups in line with the degree of severity of the clients' addiction on the one hand, and to make it as easy as possible for clients to take up advisory, support or treatment services on the other. For these reasons, *Dialog* has restructured its ISG open centre for integrative addiction advice at Gudrunstrasse in Vienna, which targets people for whom it is difficult to keep scheduled appointments: it now has separate opening hours for young people and for adults (Verein Dialog 2015).

Having access to gender-related services is particularly important with regard to the treatment of women suffering from addiction. However, specific services for women are not available everywhere. For instance, *Dialog* has opening hours exclusively for women and *Clean Bregenz* runs a group exclusively for women.

Several provinces offer services across different (inpatient and outpatient) settings for pregnant women suffering from addiction, as well as for mothers of young children (e.g. *DESK* in Lower Austria⁸⁸; see also GÖG/ÖBIG 2011). Here addiction-related services are combined with obstetrics, as well as child and youth support services. *DESK* publishes information booklets for their female clients and support staff, organises further training programmes for the professions involved, and coordinates regional services. This is aimed at improving the health situation of addicted mothers and improving the life situation of the children involved, in terms of preventive effects on the children.

Furthermore, several outpatient services specifically target young people – e.g. Lower Austria has six addiction advisory centres which are integrated into general youth advisory services or other services for young people and thus enable low-threshold service uptake; and there are general outpatient centres whose support and treatment services include special offers for young people (e.g. the *Dialog* association).

Furthermore, liaison services are offered to refer addicted clients of a centre to service providers that meet their current needs (see chapter 6).

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For further information please visit <http://www.checkyourdrugs.at/beratung-2/homebase/> (accessed 4 August 2016).

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For further information please visit <http://www.suchtpraevention-noe.at/index.php?nav=1615> (accessed 4 August 2016).

A few centres have waiting lists, with greatly varying waiting times, which depend on a number of factors such as regional availability and the current demand. In times of great influx, several centres give priority to patients with severe or urgent addiction problems. The broad, i.e. non-substance-related approach of the outpatient centres makes it easier to find an adequate place for clients, and to respond to new developments that require adaptations. However, the situation is more difficult for target groups which, for a variety of reasons, require specific and/or separate services.

Inpatient drug treatment services

An overview of specialised inpatient services is provided by the *Suchthilfekompass*⁸⁹ register of addiction services providers and by other regional sources of information (e.g. a list for Styria⁹⁰; a list of inpatient treatment departments that the b.a.s.⁹¹ association publishes on its website; as well as Map A5. 1). In the majority of inpatient centres, addicted patients are treated irrespective of the type of illicit substance used.

Specialised facilities are available particularly for persons who only use legal substances (alcohol). All inpatient centres for users of illicit substances also raise the issue of legal substance use, which is taken into account in treatment if these substances are part of the client's polydrug use. Generally, strategies aimed at treating diverse forms of addiction within the same inpatient departments are growing in importance (see also 5.4). For instance, the Department of Dependence Diseases at the Provincial Hospital of Amstetten-Mauer (Lower Austria) provides detoxification from both illicit substances and pharmaceuticals; in Tyrol, the abstinence-oriented treatment centres of Hall and the Emmaus service are open to patients addicted to alcohol and to opioid users; and the Centre for Addiction Medicine at the Provincial Hospital Graz South-West (Styria), which specialises in substance-related addiction, also integrates patients who are addicted to pharmaceuticals.

The majority of inpatient treatment centres are oriented towards providing a comprehensive support and treatment network, which also offers diverse preparatory and aftercare services, leisure activities and reintegration measures. As a rule, these services are open to persons from all over Austria including clients from abroad. With regard to availability and characteristics of specialised inpatient departments please consult GÖG/ÖBIG 2012, which provides a detailed description of capacities, treatment approaches and the range of services offered – all of which are generally oriented towards all-encompassing forms of treatment.

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It lists all centres officially published in accordance with SMG Section 15 (<http://suchthilfekompass.goeg.at/>).

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<http://www.gesundheit.steiermark.at/cms/beitrag/11656021/72562450> (accessed 4 August 2016).

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http://www.suchtfragen.at/media/pdf/2014-10_stationaere_therapieeinrichtungen_fuer_menschen_in_abhaengigkeit_von_illegalisierten_drogen.pdf (accessed 4 August 2016).

As far as target groups are concerned, *Grüner Kreis* is worthy of mention: it has separate houses for young people, women, parents with their children, and persons in OST. For addicted pregnant women and mothers of young children, services to improve the health situation of the mothers and their babies are provided across different settings. In Vienna, such services are offered in the context of the multiprofessional, interdisciplinary care project of the General Hospital Vienna and the Department of Child and Youth Psychiatry of the Rosenhügel Neurology Centre in cooperation with other service providers (see also GÖG/ÖBIG 2011).

Waiting lists also exist for inpatient treatment, and waiting times may vary greatly (see GÖG/ÖBIG 2012). Again, most of the centres provide a broad range of services that are not related to specific substances, which makes it easier to find treatment places whenever needed. However, it is more difficult to find a treatment place for target groups which, for various reasons, require specific and/or separate services.

Treatment outcomes and recovery from problem drug use

Information on the outcomes of advice, support and treatment services is only available in a few individual studies commissioned or carried out by the respective centres. Some of them conduct catamnestic surveys at regular intervals (e.g. the *Carina* treatment unit), while others have external one-off evaluations of specific services carried out (e.g. *Dialog's* services for young people). The evaluation and catamnestic reports drawn up by Carina have already been described in prior reports on the drug situation; the most recent Carina report is outlined below.

Its data are from the 2016 survey on client satisfaction conducted at the *Carina* treatment unit (Stiftung Maria Ebene 2017a). The results indicate that the respondents are mostly satisfied or rather satisfied with the available treatment options, as well as with the staff's expertise, and with the relationship between the treatment team and the clients. A certain degree of dissatisfaction has been voiced with regard to the work and occupation structures at the treatment unit (26% said they were dissatisfied or rather dissatisfied), as well as with regard to recreational activities (20%). For the items concerning treatment management, access to treatment and effectiveness of treatment, positive answers predominate, but there are also clients who said they were (rather) dissatisfied. Their points of criticism include long waiting times for a treatment place (23%), the house rules (30%), and they seem to be less convinced of the effectiveness of the treatment with regard to improved fitness to work (20%) and coping with problems in life (16%), or ability to remain abstinent (16%). The positive feedback referred to very good personal relationships, the social therapy team, the individual and group psychiatry sessions, and particularly the confrontation and house community groups, equine-assisted activities and a variety of recreational activities. Criticism was also voiced with regard to the balance between work and treatment, as well as certain elements of treatment, the need to file applications, the frequent changes of the placement staff, as well as waiting times and the house rules. The data reveal that 82% of treatments completed in 2016 have been successful, and the average duration of treatment completed as planned has been 4.5 months in 2016.

The data on the *Lukasfeld* treatment unit are not as comprehensive. Out of a total of 158 persons who were newly admitted, 80 patients stayed only for physical detoxification (Stiftung Maria Ebene

2017b). 78% of those completed the treatment successfully. A proportion of 40% of those 78 patients who stayed at the unit for subsequent drug-free treatment completed this stage as planned, whereas 22% were discharged due to non-compliance with the rules, and another 36% dropped out of treatment.

Studies on the outcome of substitution treatment have been repeatedly conducted (e.g. Springer et al. 2008); their results have been discussed in prior reports on the drug situation. GÖG has also regularly analysed the pseudonymised substitution registry to study specific aspects. The results have also been presented in prior reports on the drug situation (e.g. analyses of retention rates or relationships between duration of treatment and crime reports; see Weigl et al. 2015 and 2016).

Social reintegration services for people in drug treatment and other relevant populations

Interventions that help clients (re)gain control over their lives and preserve or restore their social reintegration are carried out in both inpatient/residential and outpatient centres. They include recreational activities, training and education, assistance in finding a job and a flat, as well as occupational programmes and temporary housing. Recreational activities are aimed at improving certain skills (such as stamina and concentration, self-assessing skills and coping with frustration) on the one hand, and they provide opportunities for trying out how to spend one's spare time in a structured way and for establishing social contact on the other. For instance, the Lower Austrian Psychosocial Service runs 'clubs' where social workers attend to clients and where joint leisure activities are organised (Hörhan, personal communication). In addition to labour market integration programmes run by specialised addiction services and social firms (e.g. *fix & fertig* in Vienna⁹²), which offer employment on a per-day basis and temporary employment, other social integration programmes are open to addicted persons as well. To encourage such initiatives, mostly further training programmes for staff are organised in the individual provinces.

Persons with addiction problems can take part in special services aimed at regaining fitness to work – including training-oriented groups and courses (e.g. *Standfest* run by *Dialog* in Vienna). In 2007, Vienna developed a strategy that focuses on services oriented towards the concrete needs of addicted clients, combined with a specialisation in certain target groups by the individual service providers, in order to avoid unnecessary duplication (SDW 2015). In the context of making addiction-oriented diagnoses at the *Institute for Addiction Diagnostics* (ISD), the clients' fitness to work is assessed on the basis of doctors', psychologists' and social workers' input. In 2016, 702 persons were referred to the ISD for the purpose of obtaining an addiction-related diagnosis, and since 2008, their number has totalled approximately 7 000 (SDW 2017). A new structure was established in 2016 in order to improve the employment opportunities for addicted persons (FöBeS; see 5.4).

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For further information please visit <http://www.suchthilfe.at/> (accessed 4 August 2016).

Recent data from Vorarlberg have been made available: 30% of clients of the Carina treatment unit who successfully completed treatment in 2016 were referred to regular jobs (Stiftung Maria Ebene 2017a). 24% started or continued training, 20% were job seekers, and 11% took part in qualification programmes run by the Public Employment Service (AMS). The remaining clients either took up rehabilitation benefits (9%), or ill-health/inability-to-work pensions (6%).

Main providers/organisations providing opioid substitution treatment

The organisation and availability of substitution treatment for opioid users strongly depends on regional strategies (centralised v. decentralised supply structures). Even though specialised outpatient services and outpatient departments of hospitals also deliver opioid substitution treatment, mostly from induction and stabilisation to ongoing care, OST is primarily delivered in doctors' offices. The Narcotic Drugs Regulation (BGBl. II 1997/374) and the Regulation on Further Training in Oral Substitution (BGBl. II 2006/449) stipulate who is entitled to deliver OST and what requirements they have to meet (see chapter 2 and 5.2.5).

Table 5.3 provides an overview of the number and distribution of those doctors in the individual provinces who are entitled to deliver substitution treatment to patients addicted to opioids. According to the BMGF, their total number is 675 in Austria (Bayer, personal communication), with 566 (84%) of them actually delivering opioid substitution treatment by 31 December 2016. When comparing the treatment structures of different provinces, one has to take into account that doctors, particularly in Vienna, often provide services across provincial borders. Table 5.3 compares the number of persons in opioid substitution treatment per province on 31 December 2016 to the number of doctors qualified to deliver, and actually providing OST.

Table 5.3:

Opioid substitution treatment in practice: number of persons receiving OST and number of qualified doctors delivering OST per province (31 December 2016)

Province	Persons in opioid substitution treatment	Doctors according to LISA list*	Doctors actually providing OST
Burgenland	266	20	63
Carinthia	823	24	21
Lower Austria	2 370	84	238
Upper Austria	1 833	76	76
Salzburg	467	12	31
Styria	1 274	46	60
Tyrol	1 093	35	41
Vorarlberg	570	13	14
Vienna	7 846	386	284
Austria	16 542	675**	566***

* LISA = list of doctors qualified to deliver opioid substitution treatment.

** The total number of doctors does not equal the sum of doctors in the individual provinces because 60 doctors in the LISA list have offices in two provinces.

*** The total number of doctors does not equal the sum of doctors in the individual provinces because there are doctors who treat patients from more than one province.

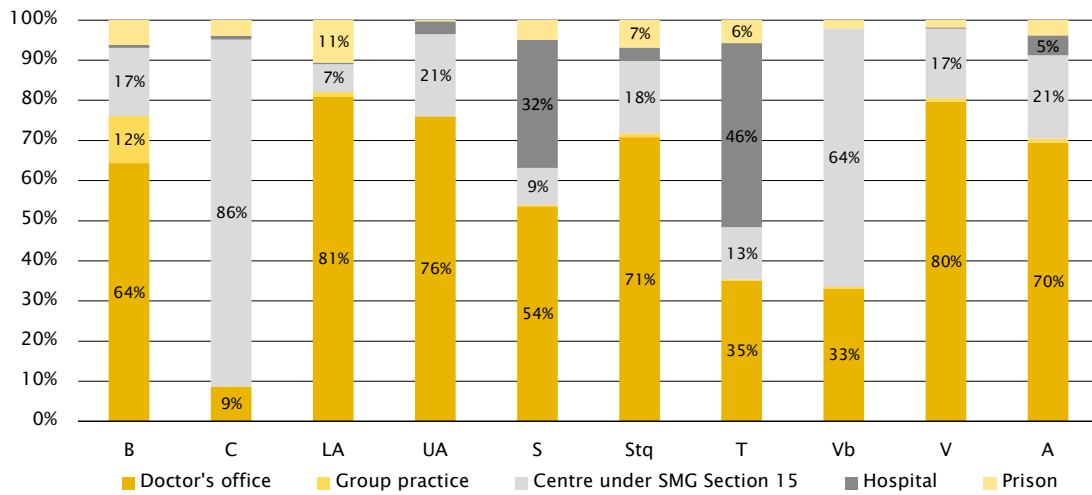
Sources: eSuchtmittel and LISA; calculation and graphic representation: GÖG/ÖBIG

What the table does not specifically show is that not all doctors who are qualified to deliver opioid substitution treatment actually provide OST to patients addicted to opioids. It depends on the region whether OST is easily available or not. A variety of measures have been taken over several years in response to the (impending) bottleneck in OST availability (see section 5.4).

In addition to a sufficient number of doctors who do provide OST, their distribution in the individual provinces is also relevant in order to ensure treatment near the patients' place of residence and to enable access to opioid substitution treatment for all people who need it. This is particularly important for those who hold jobs or whose mobility is restricted for various reasons.

Figure 5.7 shows the type of setting in which opioid substitution treatment is delivered in Austria. The percentages reflect organisational differences in the individual provinces. For instance, Carinthia and Vorarlberg strongly rely on addiction support centres established under SMG Section 15.

Figure 5.7:
Practical delivery of opioid substitution treatment: type of provider by client's place of residence;
in 2016

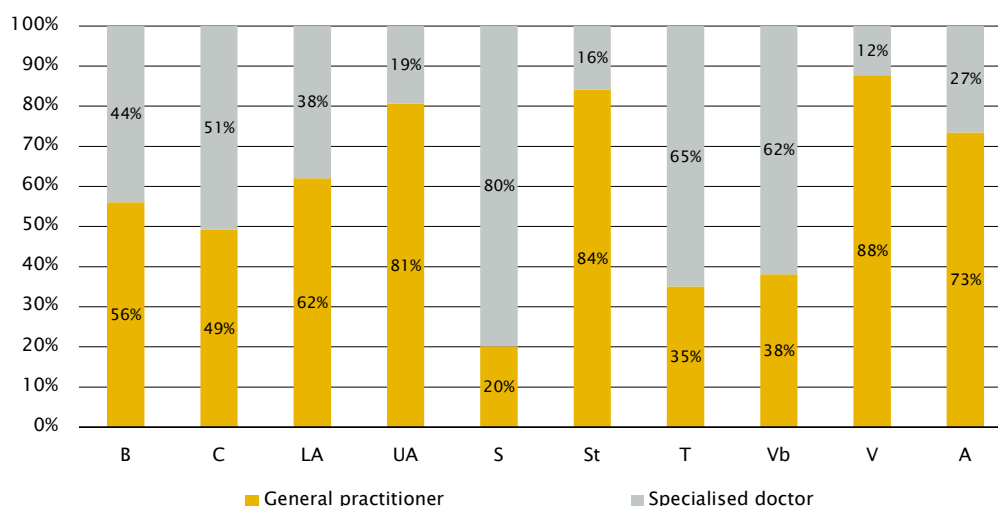


B = Burgenland, C = Carinthia, LA = Lower Austria, UA = Upper Austria, S = Salzburg, St = Styria, T = Tyrol, Vb = Vorarlberg, V = Vienna, A = Austria.

Source: eSuchtmittel; calculation and graphic representation: GÖG

Figure 5.8 shows that general practitioners play an important role in the provision of OST in Austria. However, their distribution differs according to province. In Salzburg, 80% of patients in substitution treatment turn to medical specialists, whereas over 80% of Viennese, Upper Austrian and Styrian patients are treated by general practitioners.

Figure 5.8:
Practical delivery of opioid substitution treatment: patients treated by medical specialists v. general practitioners, by province (31 December 2016)



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

Source: eSuchtmittel; calculation and graphic representation: GÖG

Number of clients in OST

In 2016, a total of 18 222 clients were registered as receiving opioid substitution treatment, and 1 073 of those were first-time OST patients. Table 5.4 shows the distribution of patients in OST in the individual Austrian provinces. Figures on opioid substitution treatment in prison are given in Table 5.2 and chapter 8).

Table 5.4:

Number of persons registered in the BMGF database as patients in substitution treatment for 2016, by first treatment, continued treatment and province

Treatment	B	C	LA	UA	S	St	T	Vb	V	A
Continued treatment	262	820	2 485	1 916	482	1 349	1 130	645	8 060	17 149
First treatment	27	88	198	191	50	61	83	35	340	1 073
Total	289	908	2 683	2 107	532	1 410	1 213	680	8 400	18 222

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

Continued treatment means treatment started before the reporting year or repeated treatment of persons already having undergone opioid substitution treatment in the past.

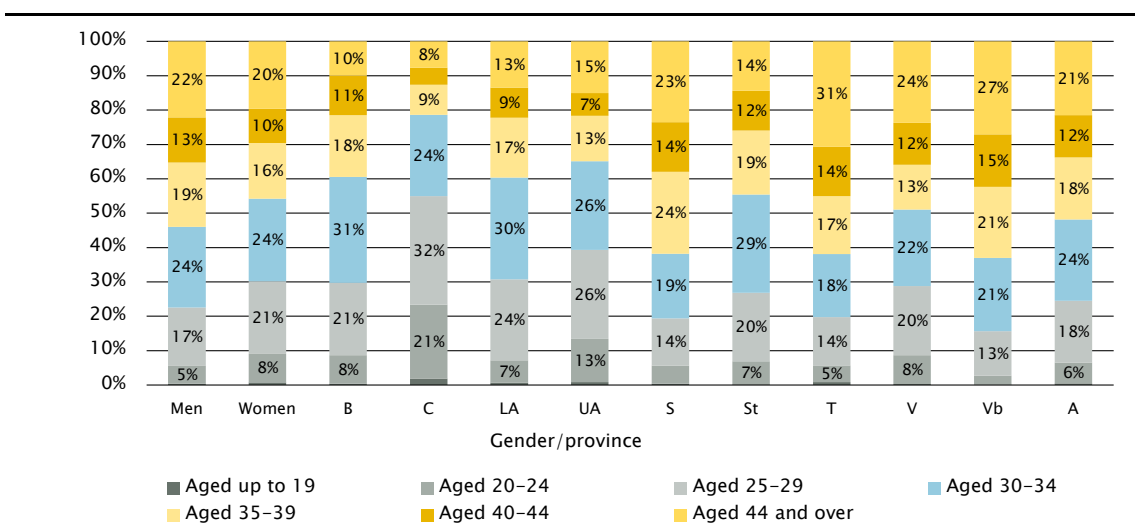
First treatment means treatment of persons who have never been in opioid substitution treatment before.

Source: BMGF; calculation and graphic representation: GÖG

Characteristics of clients in OST

A proportion of 74% of the total of 18 222 people registered as OST patients in 2016 are men, and 26% are women. A similar gender distribution is apparent with regard to the 1 073 persons entering treatment in 2016 (81% men v. 19% women).

Figure 5.9:
Age structure of clients registered as undergoing opioid substitution treatment, by gender and province; in 2016



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

Source: eSuchtmittel; calculation and graphic representation: GÖG

Figure 5.9 represents the age structure of clients registered as undergoing opioid substitution treatment in 2016, by gender and province. Regarding the nationwide situation, 6% of clients in OST are aged under 25, 18% are in the 25 to 29 age group, 42% are aged 30 to 39, and 34% are 40 or older. Female clients tend to be younger than male clients. Differences are also apparent at the regional level: for instance, in Carinthia, more than half of clients in treatment are under 30, while this group accounts for less than one out of five in Salzburg, Tyrol and Vienna.

Further aspects on organisation, access and availability of opioid substitution treatment

In addition to the prerequisites for substitution treatment that have already been mentioned, the Narcotic Drugs Regulation (BGBl. II 1997/374, see also chapter 2 and section 5.4), which was still in force at the time of drawing up the present report, defines further general conditions⁹³. They include the goals of this form of treatment (interim treatment, reduction of use or maintenance

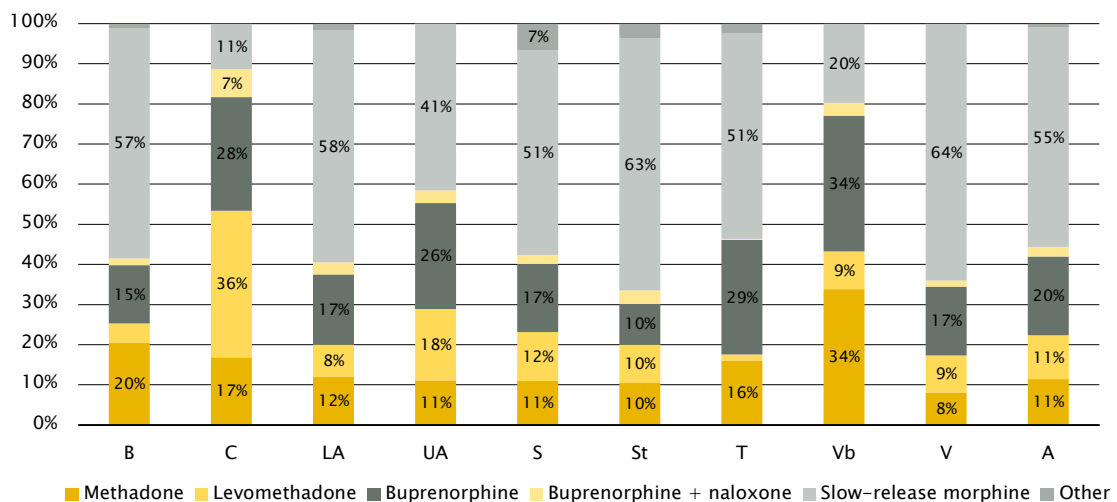
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This will change when the (already adopted) amendment to the SMG and the pertinent regulation enter into force (see T3).

treatment), as well as the conditions under which substitution treatment may be started and which experts have to decide on an indication for OST (SV Sections 23a, b and d). In order to respond to the individual situation and specific needs of patients in the best possible way, various substances with different active ingredients are available. According to SV Section 23c, methadone and buprenorphine are the two medicines of choice, and other substitution medicines are only permitted to be prescribed in the case of intolerance to these two medicines. SV Section 23e stipulates that substitution medicines must be dispensed as daily doses and be taken under supervision, but exceptions to this rule have been defined. If a patient switches to another substitution medicine, the doctor in charge of induction and stabilisation must be consulted (SV Section 23f). A detailed description of the conditions for OST is given in GÖG/ÖBIG 2013c.

Figure 5.10 depicts the distribution of substitution medicines described and the – fairly high– proportion of slow–release morphine (55%), followed by buprenorphine (20%) and methadone (11%) or levomethadone (11%) respectively. However, pronounced differences between the individual provinces are apparent. The distribution of substitution medicines used in prison is described in chapter 8; methadone plays a much more prominent role in prison (38%) than outside prison.

Figure 5.10:
Persons in opioid substitution treatment by substitution medicine and province; in 2016



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

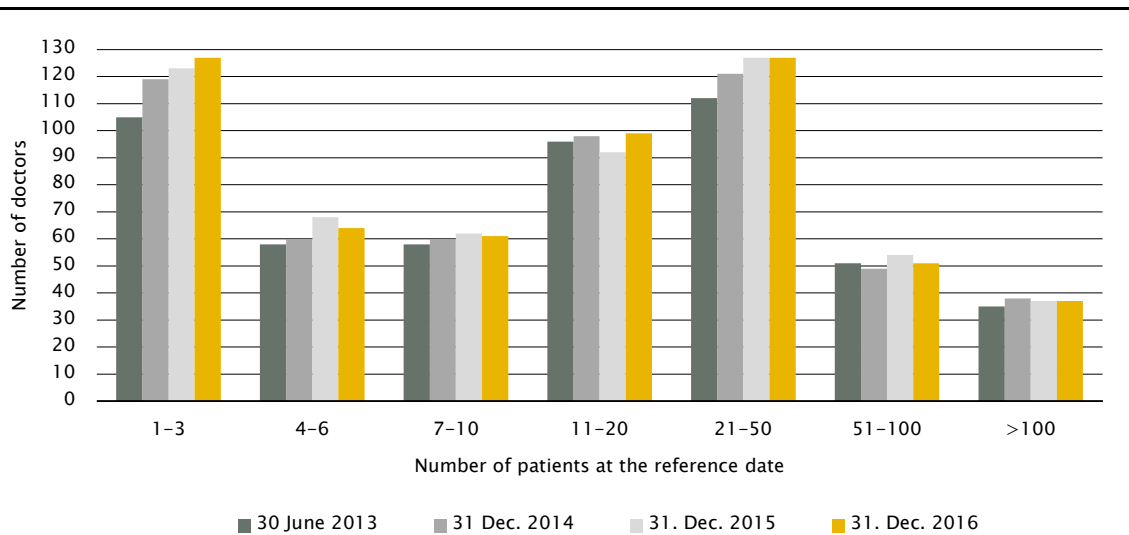
The figures relate to 18 089 of the total of 18 222 OST patients: for the remaining 133 persons (1%), no data on the substitution medicine prescribed are available. If the substitution medicine has been changed in the course of the year, the substance prescribed most recently is entered.

Source: BMGF; calculation and graphic representation: GÖG

Figure 5.11 represents the pronounced differences in, and the development of, the number of patients treated per doctor over the past five years. While 191 doctors (34%) delivered treatment to 6 or fewer patients, 88 doctors (15%) treated more than 50 substitution patients in 2016. A

possible explanation for this is that some of the opioid substitution treatments are delivered by general practitioners in the context of their standard services, while other patients are treated by doctors specialising in OST.

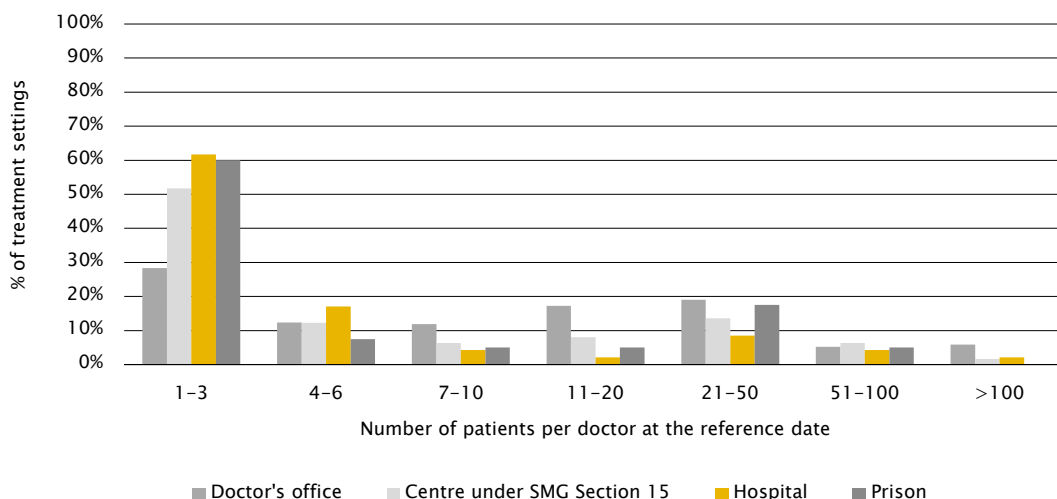
Figure 5.11:
Number of OST patients per doctor; 2013-16



Sources: eSuchtmittel; calculation and graphic representation: GÖG

If the number of patients per doctor is related to the treatment setting (Figure 5.12), it becomes apparent that in 28% of the doctors' offices and in over 50% of the centres established under SMG Section 15, the patient-to-doctor ratio is 3 to 1. However, there are a few focal offices (30% of doctors' offices) in which one doctor treats more than 21 patients. If these offices are situated in rural areas, they play a particularly important role for regional OST provision, and it is therefore essential to ensure long-term continuity. In the case of those doctors who treat only 1 to 3 patients and who are not part of specialised treatment centres but work in a (single) doctor's office, support in the form of an exchange of experience is of great relevance.

Figure 5.12:
Number of substitution patients per doctor according to treatment setting, percentages; in 2016



Sources: eSuchtmittel; calculation and graphic representation: GÖG

5.2.5 Quality assurance in drug treatment

Quality assurance in addiction treatment takes place at very diverse levels and in very diverse ways. The list below thus does not claim to be exhaustive.

A legal basis is provided by the Narcotic Substances Act (BGBl. I 1997/112), the Narcotic Substances Regulation (BGBl. II 1997/374) and the *Regulation on Further Training in Oral Substitution* (BGBl. II 2006/449). They include regulations for treatment and care programmes, for the material, organisational and staffing requirements, for the documentation of centres established under SMG Section 15, as well as their review by the Federal Ministry of Health and Women's Affairs. The latter is legally required to maintain a nationwide substitution registry, in order to prevent multiple treatment with substitution medicines, among other reasons (see chapter 2). With regard to further training for doctors delivering OST, precise regulations have been laid down, too (see chapter 2), which must be implemented by the Austrian Medical Association in cooperation with the regional medical associations.

In addition, centres that are recognised as providers of welfare services are subject to supervision by the provincial government, and are thus inspected with regard to construction-related and technological requirements, as well as to safety and building hygiene; and the district authorities carry out sanitary inspections (supervision of hygiene of care and equipment, as well as with regard to prerequisites for staff, professional care and organisation), in accordance with the Hospitals Act.

Furthermore, quality standards and guidelines have been clearly defined, e.g. in the manual on the uniform enforcement of SMG Section 12 (see chapter 2), the new guideline on quality standards for opioid substitution treatment (see 5.4), the Federal Ministry of Health guideline on responses to harmful use and dependence on benzodiazepines among patients in oral opioid maintenance treatment (see GÖG/ÖBIG 2012), the Lower Austrian quality guidelines for outpatient addiction centres, the Lower Austrian quality guidelines for outpatient addiction advisory services for young people, or the Styrian substitution checklist. In addition, there are consensus papers (e.g. the ÖGABS paper on substitution-assisted treatment of opioid-addicted persons and the ÖGPB paper on substance-related disorders and psychiatric diseases) and position papers (e.g. the ANS-Ost paper on the development of quality standards for services for relatives), which also contribute to standardised procedures.

In the specific case of opioid substitution treatment, SV Section 23g provides for supervision by public health officers (see section 5.2.1).

Finally, a number of bodies are also relevant for quality assurance: for instance, the *Committee on Quality and Safety in Substitution Treatment* (at the Federal Ministry of Health and Women's Affairs), as well as the provincial expert commissions and the regional quality circles for doctors. Further (regional) networking bodies primarily focus on professional exchange.

In addition, further training events are held regularly (e.g. for public health officers or staff of addiction support services in the context of ÖAKDA, and at the regional level, the *Maria Trost addiction talks* and the *interdisciplinary further training programme of upper Styria*); and annual expert meetings are organised (e.g. the ÖGABS substitution forum held at Mondsee, and the interdisciplinary addiction symposium at Grundlsee⁹⁴ or – at regional level – the Tyrolean addiction conference).

Not least, several centres have conducted evaluation studies (see section 5.2.4), whose results are used as input for the further development of advice, support and treatment services.

5.3 Trends

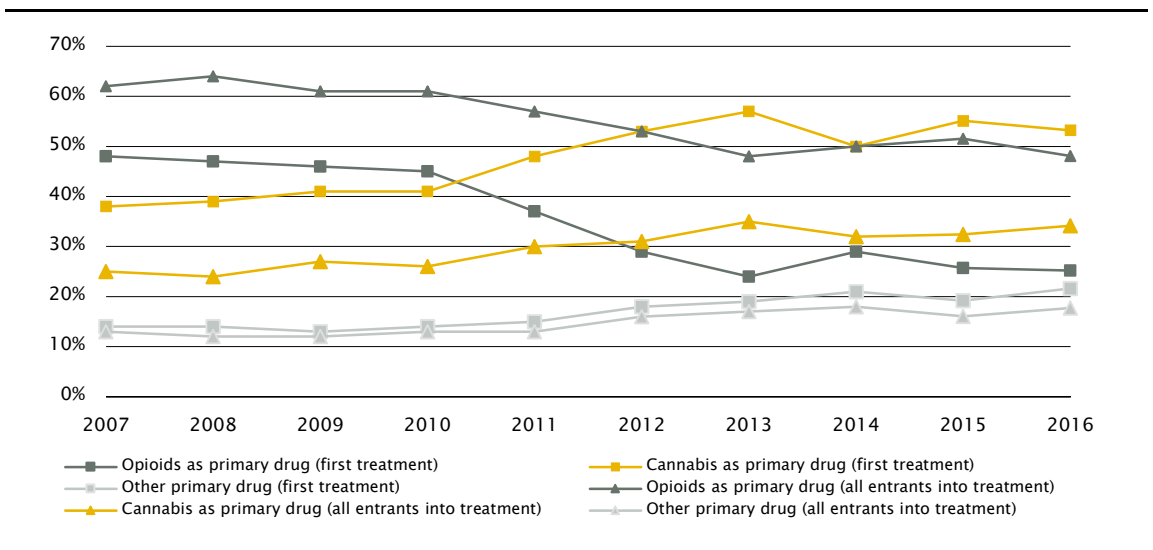
A study of the time series for outpatient services with cannabis or opiates as primary drugs in the DOKLI data when represented according to the primary drug hierarchy reveals a decrease in opioid use up to 2013, paralleled by an increase in cannabis use. This picture is slightly more pronounced in the case of new entrants into treatment than in the total number of persons registered as starting treatment in the respective year (see Figure 5.13). From 2013 to 2016, the above trend has, in fact, not continued or has not been definite. Another development worthy of mention is that

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Organisers in 2015: *MAW International Exhibitions and Advertising*, Johannes Kepler University, Cocoon, the Austrian Medical Association (ÖAK) and the Professional Association of Austrian Psychologists (BÖP).

the proportion of other drugs named as primary drugs rose slightly up to 2014. In this category, cocaine accounts for the largest proportion, followed by stimulants (first treatment: cocaine 10%, stimulants 9%; all entrants into treatment: cocaine 8%, stimulants 6%).

Figure 5.13:
Persons entering outpatient treatment (for the first time), by opioids and cannabis as the primary drug (hierarchical definition); 2007–16

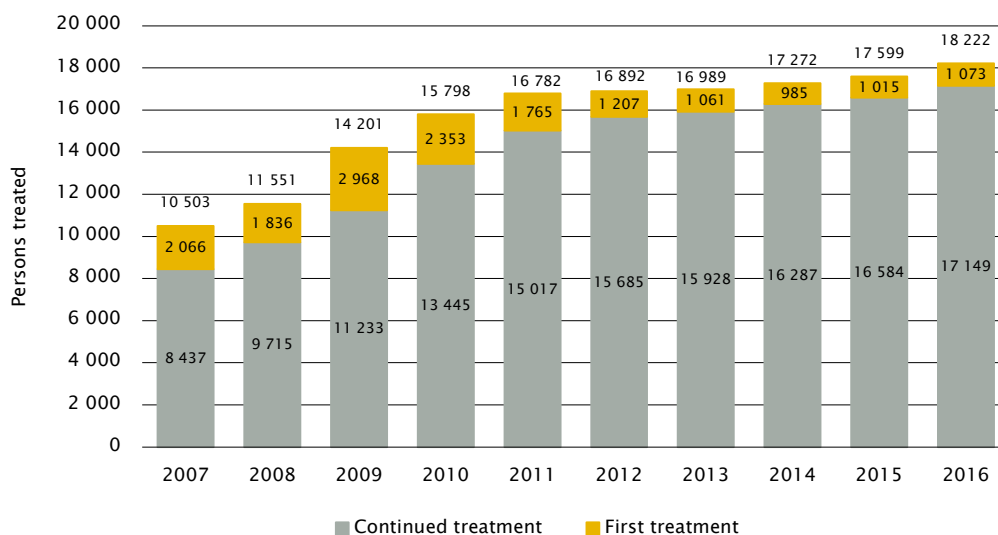


Source: GÖG/ÖBIG, DOKLI analyses from 2007 to 2016

One has to take into account, however, that by far the largest percentage of persons in opioid substitution treatment (problem opioid users) are not covered by DOKLI.

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 5.14).

Figure 5.14:
Annual reports of persons currently undergoing OST, by first treatment and continued treatment; 2006–16



Continued treatment means treatment started before the year concerned, or the repeated treatment of persons already having undergone opioid substitution treatment in the past.

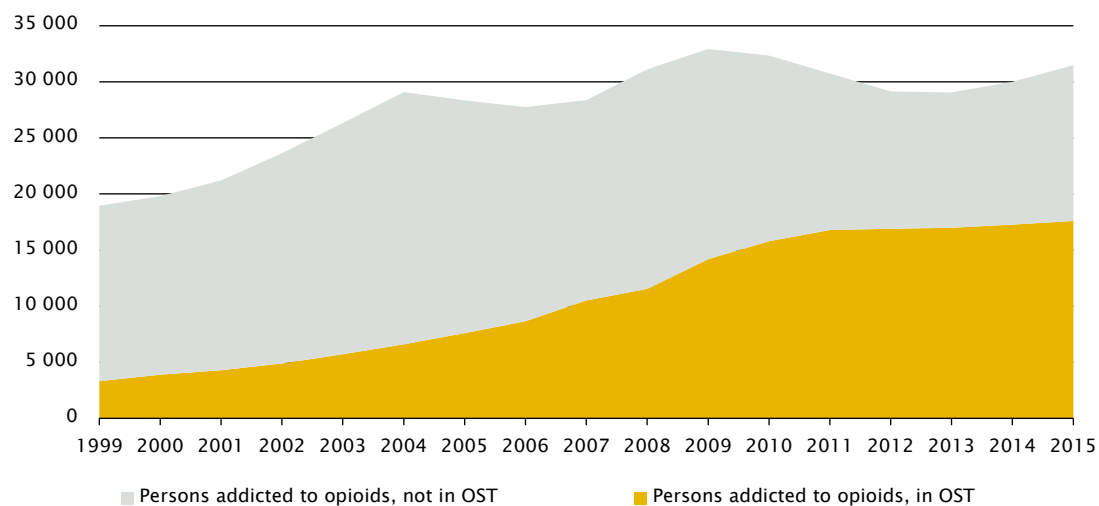
First treatment means the treatment of persons who have never been in opioid substitution treatment before.

Source: eSuchtmittel; calculation and graphic representation: GÖG

The slower increase in persons registered as undergoing oral opioid substitution treatment is probably due to a saturation effect (of the existing system): the majority of persons for whom OST is an option have already entered treatment. It is not certain, however, whether further changes in the opioid substitution treatment system, such as a further diversification of the available range of substitution medicines (e.g. other routes of administration) or structural improvements, would result in a further increase in the number of opioid substitution treatments.

If the treatment figures are related to the current prevalence estimates from 2016, it becomes apparent that in-treatment rates have considerably risen over time (Weigl et al. 2016). While the estimated number of persons with problem patterns of drug use (opioid use) has gone up by only 50% since 1999, the number of persons currently in OST is almost five times as high as it was then. In sum, a proportion of 53% to 61% of the estimated total of 29 000 to 33 000 high-risk opioid users have meanwhile been in opioid substitution treatment (see Figure 5.15), and between 60% and 68% take up addiction services (Busch et al. 2016). This is, without doubt, a very favourable development.

Figure 5.15:
Persons addicted to opioids, by integration into substitution treatment; 1999–2015



Source: eSuchtmittel, 2016 prevalence estimate; calculation and graphic representation: GÖG

5.4 New developments

Regarding the **basis for and quality assurance of** drug-related treatment, a variety of activities at the federal level have taken place. Under the legal amendments that have been planned but not yet adopted at the time of drawing up the present report (see chapter 2), the details of medical treatment will no longer be governed by the Narcotic Drugs Regulation. Instead, reference is made to a medical guideline adopted by four medical associations and published by the Ministry of Health. The guideline on *quality standards for opioid substitution treatment*⁹⁵ was prepared over several years, following an expert forum on quality and safety in opioid substitution treatment held in March 2013. Experts from relevant medical fields (including public health officers), as well as from psychosocial work and law, were involved in the elaboration of recommendations for opioid substitution treatment of assured quality, in the present structural framework. The working groups derived evidence-based recommendations from the available literature, as well as from their own experience (ÖGABS, ÖGAM, ÖGKJP and ÖGPP 2017). The guideline first discusses the positions of doctors and the ethical basis, as well as the progress of opioid dependence. Then the different forms of opioid substitution treatment (OST) are discussed, and finally, specific steps for the implementation of each individual step are described. Other diseases and interventions, additional drug use and abuse as well as specific situations in life are also taken into account. It also includes an outlook for a possible expansion of the existing treatment options. The guideline, as

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To download the German version of the guideline go to <http://oegabs.at/de/Leitlinien> (accessed 28 June 2017).

well as the legal amendments that have been adopted in 2017, can contribute to the goal of approaching OST in the same way as any other pharmacological treatment. This constitutes an important step towards the destigmatisation of opioid addiction and can also influence the willingness of doctors and pharmacists to take part in OST delivery.

In this context, the evaluation and revision of the manual on the enforcement of SMG Section 12 (see chapter 2) is also worthy of mention. At the regional level, relevant activities have, for instance, been undertaken in Vienna: in 2016, a brochure with recommendations for the prescription of benzodiazepines was issued (see chapter 6), and the minimum standards for inpatient treatment modules were revised (SDW 2017). In 2016, the KONNEX liaison service, which supports the general health and social care system with regard to addicted persons, by providing individual expert consulting and practical information, conducted a survey on satisfaction with its services: the staff in the health and social care sector indicated that this form of support was very helpful, and the majority of them said they would recommend these services to others. Further themes that the Vienna Addiction and Drug Coordination Office (SDW) is addressing at present are the issue of social insurance after release from prison, as well as current positions regarding cannabis. The *Dialog* association obtained ISO 9001:2015 certification in 2016, as one of the first service providers in the entire health and social care system (Verein Dialog 2017).

With regard to the preparation and implementation of **integrated plans** for addiction services, Salzburg's new framework plan 2016–20 (see also chapter 1) is worthy of mention. It is aimed at establishing integrated care structures for people with addiction diseases (Land Salzburg 2016). The individual fields of specialised services are organised as modules with clearly defined ranges of activity and conditions for access. The field of advisory services is covered by the modules of addiction advice and case-related services. In the addiction advice module, with its gate-keeping function, basic addiction-related medical services need to be available immediately, but patient referral in terms of intervention planning is equally important. The case-related services module includes long-term coordination and support over the entire treatment period. The field of therapy and rehabilitation includes outpatient or inpatient modules respectively, each of which consists of specific standardised combinations of various types of intervention. The specialised modules of the outpatient module include opioid substitution treatment and the treatment of (high-)risk pattern substance users who are not (yet) addicted to these drugs. Whereas the outpatient services can be aimed at controlled drug use and a sustainable reduction of use, the inpatient services continue to be abstinence-oriented. The field of post-treatment services, with the housing support and aftercare modules, complements the range of available services.

Styria's new regional structural plan on health 2025 (Gesundheitsfonds Steiermark 2017) is aimed at providing outpatient services throughout the province, with well-functioning links to inpatient structures to ensure an integrated, uninterrupted provision of services near the clients' place of residence. It explicitly states that this requires a firmly established network of centres providing opioid substitution treatment. In order to achieve this, outpatient services outside the provincial capital of Graz are needed – for instance, the integration of psychosocial advice centres and social psychiatry outpatient clinics. With regard to inpatient structures, a general psychiatry department has been established at the Hochsteiermark provincial hospital in Bruck/Mur, where up to six beds can be used for detoxification.

Vienna's *Alcohol 2020* project, which as of May 2017 has been continued as a permanent service under the name *Alkohol. Leben können* [Alcohol – being able to live], is part of the provincial target control agreement on health (see chapter 1) and has been expanded in 2016. As a result, addiction support centres that have so far only provided (treatment) services for drug users now have to accept clients with alcohol addiction as well. For instance, the experience of the *Dialog* association has shown that this expansion has required not only new forms of cooperation and an orientation towards a new, heterogeneous group of clients, but that *Dialog* itself had to reconsider its work and its positions (Verein Dialog 2017). Their clients have become more heterogeneous, characterised by highly diverse situations in life and experiences with addiction services, as well as diverse problems, opinions and prejudices. This can result in dynamics in the waiting area that need to be responded to, and that call for a specific waiting area management. As a result of the Viennese programme, *Schweizer Haus Hadersdorf* has started to provide outpatient services for both clients addicted to illicit drugs and clients addicted to alcohol. While the two groups of clients do not share all areas, the garden is open to all and both groups can jointly take part in recreational activities (Gegenhuber, personal communication).

In Vorarlberg, the Maria Ebene Foundation has expanded its services for different types of addiction and offers a wide range of measures that vary in their degree of intensity (Stiftung Maria Ebene 2017b). For instance, the non-smoking project *Wieder frei atmen!* [Breathing freely again!], which is run in cooperation with other hospitals, offers advice and support for smokers; as well as outpatient smoking groups and individual therapy. At the Maria Ebene hospital, inpatient non-smoking treatment for three weeks is also available. Its services also include the use of medicines to help patients quit smoking, as well as acupuncture and dietary advice for the period after quitting. The two treatment units continue to expand their services. Whereas the Carina unit has expanded its equine-assisted activities, the Lukasfeld unit has focused on a better integration of the clients' individual situation, by drawing up individual treatment plans. Since 2016, Lukasfeld has also offered therapeutic climbing.

Drug users with an **immigration background**, particularly asylum seekers, have as of 2015 increasingly been the focus of addiction support and treatment services. For instance, in 2016 the Tyrolean Addiction Advice Association held workshops addressing unaccompanied refugee minors (URM; Suchtberatung Tirol 2017). They employed interpreters, and in addition to traditional subjects also covered approaches to drugs in the participants' countries of origin. Assistance is also needed for the staff of URM services who have to define the rules and consequences for non-compliance. This became apparent during the REITOX Academy of the Austrian REITOX Focal Point in December 2016 (see chapter 4). The Tyrolean Addiction Advice Association has, since recently, been able to use an online interpreting system and can thus provide services to clients for whom speaking German is difficult. Language skills in addiction support and treatment services, as well as differences between countries of origin have also been discussed by the Vienna Addiction and Drug Coordination Office (SDW 2017). *Dialog* has been able to integrate video interpreting into their standard services (Verein Dialog 2017).

With regard to **services** for persons addicted to opioids who are in **opioid substitution treatment**, the existing or imminent lack of doctors providing OST (e.g. due to retirement) continues to be a key issue (see also 5.2.3). The provinces have made endeavours to respond to this problem and

to improve the treatment situation (see also prior reports). For instance, the Tyrolean Addiction Advice Association has since 2015 scheduled drug-specific consulting hours once a week in Imst, to enable access to opioid substitution treatment near the clients' place of residence (Suchtberatung Tirol 2017). In close cooperation with the B3 specialised drug department at the provincial hospital of Hall, it is thus possible to ensure induction and stabilisation, as well as continuing treatment and psychosocial advisory services. This cooperation also facilitates the transition to inpatient treatment or aftercare respectively. However, the services offered do not seem to be sufficient to meet the demand in the western part of Tyrol: long waiting times have been reported. The Klagenfurt drug outpatient clinic reports much interest in its evening consulting hours, which enable clients with jobs, in particular, to undergo opioid substitution treatment (Prehslauer, personal communication). Similarly, evening consulting hours have been scheduled in Burgenland, at Mattersburg and Oberpullendorf (Schmidl-Mohl, personal communication). In addition, opioid substitution treatment at the centres of Burgenland Psychosocial Services (PSD) has been organised in such a way as to ensure that difficult OST cases in all centres are attended to by the PSD's medical supervisor.

A master's thesis (Schwarzenbrunner 2017) has investigated the level of OST patients' satisfaction with their treatment in Upper Austria, and concludes that the majority of respondents are generally satisfied with the treatment (80% agreement). However, the thesis also points out that satisfaction with treatment has decreased compared to the results of a similar survey in 2006, whereas satisfaction has increased both with regard to the medicine administered (93% agreement) and with regard to interactions with the persons and institutions involved in the treatment. The majority of respondents are satisfied with oral administration (86%) and the current doses (84%); the degree of satisfaction is smallest with regard to methadone doses (71% agreement). A small number of patients reported massive side effects (10%). Again, methadone, and particularly levomethadone, are the substances most often indicated in this respect. The majority of respondents are also satisfied with their family relationships and their housing situation (80%), whereas satisfaction with their psychological well-being and their training and job situation is considerably smaller. Positive developments resulting from opioid substitution treatment have been reported with regard to their financial, psychological and physical situation, and negative developments primarily concern relationships with friends and acquaintances, recreational activities and intimate partnerships. The reasons most frequently indicated for entering opioid substitution treatment are to find a way out of illegal structures, financial problems and health reasons. Most clients say that access to and supervision of opioid substitution treatment are adequate. Regarding substance use before and during opioid substitution treatment, no plausible results have been obtained, which is attributed to the setting of the survey. Positive experiences have specifically been indicated with regard to contact with doctors and staff of the advisory centres. Further positive responses include favourable developments due to the opioid substitution treatment, as well as decriminalisation. Negative experiences primarily relate to organisational procedures and attitudes towards OST patients. The respondents' suggestions for improvement mostly concern the possibility of injecting use (e.g. dispensing of heroin) and less complicated take-home regulations, as well as the organisational efforts OST requires, and attitudes towards clients.

The Tyrolean addiction conference⁹⁶ of 2016 focused on the role of occupation, cooperation between addiction services and occupational services, as well as improved **social reintegration** measures. In Vienna, the new FöBeS project was started, which is aimed at improving the occupation opportunities for the target group of addicted patients (with a focus on alcohol) and in which medical interventions can be combined with labour market policy programmes (SDW 2017). A central contact point is in charge of a comprehensive assessment of the addiction disease, draws up a plan of action and, whenever needed, refers clients to medical treatment and/or social reintegration services, which range from daily structure programmes and acquisition of key social skills, low-threshold occupation and work training, to individual assistance with regard to job application and referral to the regular labour market. Access to FöBeS is possible via the *Alkohol. Leben können* [Alcohol – being able to live] service. In 2016, a total of 839 clients were referred to further services after a plan of action had been drawn up, and for 287 clients, an additional medical plan of action was prepared. Another example in this field is the new workshops that *Dialog* has organised for its *addiction and occupation* centre to contribute to the clients' stabilisation and to improve their employability (Verein Dialog 2017).

Further changes in the area of addiction advisory and treatment services:

- » The office at Hallein run by the drug advisory service of the City of Salzburg had to be closed as the room is no longer available (Schabus-Eder, personal communication).
- » In Styria, the approach of providing addiction advice services at doctors' offices has been implemented in one town, and has met with great interest (b.a.s. 2016). According to the monitoring report on the health target control agreement (Bachner et al. 2017), 12 new day clinic places were established at the addiction medicine centre in the South Unit of the Provincial Hospital of Graz South-West.
- » In Lower Austria, in accordance with the *Lower Austrian addiction strategy*, the addiction advisory services for young people have been expanded and now include a new advisory centre at Wieselburg, the advisory centres of PSZ will be adapted to serve as outpatient clinics, and additional partial withdrawal services will be made available (Hörhan, personal communication).
- » As of January 2017, the Tyrolean Addiction Advice Association expanded the services of its advisory centre at Reutte. In order to respond to insufficient services for young people in Tyrol outside Innsbruck, a plan for improved cooperation with providers of youth work services in recreational settings and other actors has been drawn up.
- » In recent years, an increasing number of addiction support centres have integrated the KISS (self-controlled substance use) programme into their range of services, e.g. the Z6 centre. It is a behavioural self-control training with individually set goals to help clients reduce their use of legal and illegal narcotic substances, and is implemented in both individual and group settings (Z6/Drogenarbeit 2017). Over a period of four to five months, 12 one-hour structured sessions take place.

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Please consult <http://www.kontaktco.at/suchttagung/> (accessed 4 July 2017).

5.5 Sources and methodology

Sources

Clients of drug support and treatment services

Since 2006, data on clients of drug-related services have been obtained from the DOKLI nationwide documentation system, which covers the majority of relevant centres that deliver support and treatment services in Austria (see ST TDI). The data gathered include all questions defined by the EMCDDA, and in addition, data on infectious diseases (also in accordance with EMCDDA guidelines) and ICD-10 codes are collected on a voluntary basis. For further information, including on coverage, please consult Anzenberger et al. (2017).

When interpreting the results, one has to bear in mind that, while double counts of the clients from one and the same centre can be ruled out, due to the aggregate character of the data, double counts of clients who visited several centres in 2016 cannot be avoided (with the exception of Vienna). The percentage of such cases of multiple treatment can only be guessed at. The 2011 report of Vienna's BADO Basic Documentation gives a general idea of the magnitude of this aspect as in the case of BADO, double counts of clients who contacted several drug support centres during the reporting period can be detected by means of an identifier. In 2010 approximately 22% of clients registered in BADO took up services by more than one centre (two centres: 13.5%; more than two centres: 7.6%; IFES 2012). However, as drug support and treatment services are more easily accessible in Vienna due to its higher geographical density compared to rural areas, the percentage of persons contacting more than one centre is slightly smaller in the rest of Austria.

Opioid substitution treatment

The national monitoring of substitution treatment is performed by the Ministry of Health and Women's Affairs, and until 2009 was based on reports from the treating doctors. Since then, reports by the competent district authorities have been used. Before the implementation of *eSuchtmittel* data collection system, the reports were not always complete or else were not provided in due time (see ÖBIG 2003, GÖG/ÖBIG 2010). This restriction has been eliminated since *eSuchtmittel* was introduced in spring 2011. The quality assurance measures taken in the context of *eSuchtmittel* have considerably improved the conclusiveness of the corresponding data (see GÖG/ÖBIG 2013b and GÖG/ÖBIG 2011).

Methodology

The method for **estimating the prevalence of high-risk opioid use** has been described in chapter 3.

The *Carina* treatment unit uses a questionnaire to **survey patient satisfaction** after the completion of treatment, which is oriented towards the *Viennese patient satisfaction inventory* (WPI), the *Verona Service Satisfaction Scale* (VSSS) and the *questionnaire for assessing patient satisfaction* (ZUF-

8; Stiftung Maria Ebene 2017a). The Carina questionnaire was revised in 2016. The patients' responses are entered into the medical documentation system soon after the survey, and analysed shortly after the end of treatment.

The **master's thesis by Schwarzenbrunner** includes an analysis of 860 questionnaires that were issued to all patients in opioid substitution treatment in Upper Austria in 2014 (i.e. a total of 1 430 persons) in the context of authorising their substitution medicines (Schwarzenbrunner 2017). The completed anonymous questionnaires were collected in closed envelopes and passed on to the Health Department of the Province of Upper Austria.

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5.8 Personal communications (alphabetical order)

Name	Institution or function
Raphael Bayer	Federal Ministry of Health and Women's Affairs
Barbara Gegenhuber	Schweizer Haus Hadersdorf
Ursula Hörhan	Addiction Coordinator, Lower Austria
Brigitte Prehslauer	Drug Coordinator, Carinthia
Franz Schabus-Eder	Addiction Coordinator, Salzburg
Brigitte Schmidl-Mohl	Burgenland Psychosocial Services

5.9 Annex

Table A5. 1:
Persons starting drug treatment or support service uptake in 2016, by age and gender
(percentages)

Age (years)	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient/residential treatment		
	Gender		Total	Gender		Total	Gender		Total	Gender		Total
	M	F		M	F		M	F		M	F	
0 to 4	0	0	0	0	0	0	0	0	0	0	0	0
5 to 9	0	0	0	0	0	0	0	0	0	0	0	0
10 to 14	1	3	1	0	0	0	1	2	1	0	0	0
15 to 19	17	24	19	3	5	3	14	15	14	5	8	6
20 to 24	21	16	20	8	14	9	19	19	19	19	17	19
25 to 29	18	17	18	20	24	21	19	20	19	28	26	28
30 to 34	15	16	15	26	21	25	17	20	18	22	22	22
35 to 39	11	11	11	18	17	18	12	9	11	12	13	12
40 to 44	7	4	7	11	8	11	7	5	7	7	7	7
45 to 49	5	4	4	7	8	7	5	4	5	4	4	4
50 to 54	3	3	3	3	2	3	4	3	3	1	3	2
55 to 59	1	1	1	2	0	1	1	2	1	0	1	0
60 to 64	0	0	0	1	0	1	0	0	0	1	1	1
65 to 69	0	0	0	0	0	0	0	0	0	0	0	0
70 to 74	0	0	0	0	0	0	0	0	0	0	0	0
75 to 79	0	0	0	0	0	0	0	0	0	0	0	0
80 and over	0	0	0	0	0	0	0	0	0	0	0	0
Valid responses	3 539	877	4 416	1 383	434	1 817	2 850	788	3 638	652	172	824
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Missing	-	-	-	-	-	-	-	-	-	-	-	-

M = male, F = female.

All lines except Valid responses, Unknown and Missing give percentages that relate to the number of valid responses.

Unknown means that the field 'Unknown' was indicated and Missing means that no response was given.

Sampled population = all clients.

Sources: Anzenberger et al. 2017, DOKLI analysis of client year 2016;
graphic representation: GÖG

Table A5. 2:

Persons starting drug treatment or support service uptake in 2016, by primary drug(s) and gender (percentages)

Primary drug (multiple responses admissible)	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient/ residential treatment		
	Gender		Total	Gender		Total	Gender		Total	Gender		Total
	M	F		M	F		M	F		M	F	
Opioids total	31	38	32	84	74	82	46	58	48	65	66	65
Heroin	23	29	24	67	55	64	39	46	40	48	54	50
Methadone	3	4	3	11	10	11	4	5	5	6	5	5
Buprenorphine	4	4	4	11	4	9	6	6	6	4	2	3
Slow-release morphine	9	14	10	26	30	27	14	20	15	28	24	27
Other opioid	2	2	2	0	0	0	2	2	2	1	2	1
Cocaine group	14	8	13	2	2	2	14	7	12	36	36	36
Cocaine	14	8	13	2	2	2	14	7	12	36	36	36
Crack	0	0	0	0	0	0	0	0	0	1	2	1
Other cocaine	0	0	0	0	0	0	0	0	0	0	0	0
Stimulants total	12	15	13	3	1	2	9	10	9	21	18	20
Amphetamine (e.g. speed)	9	11	9	2	1	2	7	7	7	18	14	17
MDMA (ecstasy) + derivatives	4	6	4	1	1	1	4	3	4	8	7	8
Other stimulant	3	3	3	0	0	0	2	3	2	1	2	2
Tranquillisers/hypnotics total	6	8	7	8	10	8	10	14	11	26	27	26
Benzodiazepines	6	8	7	8	10	8	10	14	11	26	27	26
Barbiturates	0	0	0	0	3	1	0	0	0	0	0	0
Other hypnotics /tranquillis- ers	0	0	0	0	1	0	0	0	0	0	0	0
Hallucinogenic drugs total	1	1	1	1	0	0	1	1	1	8	6	7
LSD	1	1	1	0	0	0	1	1	1	7	6	7
Other hallucinogenic drug	0	1	0	1	0	0	0	0	0	1	0	1
Cannabis	65	52	62	11	19	13	51	39	48	47	40	46
Solvents and inhalants	0	0	0	0	0	0	0	0	0	0	1	0
Alcohol	10	8	9	2	13	5	6	6	6	24	26	24
Other drugs	1	0	1	3	2	2	1	1	1	3	5	4
Primary drug (responses)	3 089	720	3 809	516	169	685	3 963	1 068	5 031	1 134	313	1 447
Primary drug indicated (per- sons)	2 025	475	2 500	353	113	466	2 494	667	3 161	436	124	560
Only legal problems (per- sons)	230	72	302	43	16	59	77	23	100	17	2	19
No primary drug indicated (persons)	1 261	317	1 578	983	305	1 288	255	91	346	4	3	7
Missing	23	13	36	4	0	4	24	7	31	195	43	238

M = male, F = female.

Sampled population = all clients.

All lines except Primary drug (responses), Primary drug indicated (persons), Only legal problems (persons), No primary drug indicated (persons) and Missing give percentages that relate to the number of valid responses.

Missing means that no response was given. Bold type indicates main categories.

Source: Anzenberger et al. 2017, DOKLI analysis of client year 2016; graphic representation: GÖG

Table A5. 3:

Persons starting drug treatment or support service uptake in 2016, by injecting drug use and gender (percentages)

Injecting drug use	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term residential/inpatient treatment		
	Gender		Total	Gender		Total	Gender		Total	Gender		Total
	M	F		M	F		M	F		M	F	
No	76	71	75	30	27	29	68	61	66	48	44	47
Yes	24	29	25	70	73	71	32	39	34	52	56	53
Valid responses	3 231	770	4 001	1 133	364	1 497	2 734	768	3 502	446	131	577
Unknown	280	94	374	227	62	289	94	14	108	21	9	30
Missing	28	13	41	23	8	31	22	6	28	185	32	217

M = male, F = female.

All lines except Valid responses, Unknown and Missing give percentages that relate to the number of valid responses.

Unknown means that the field 'Unknown' was indicated and Missing means that no response was given.

Sampled population = all clients.

Sources: Anzenberger et al. 2017, DOKLI analysis of client year 2016; graphic representation: GÖG

Table A5. 4:

Persons starting drug treatment or support service uptake in 2016, by current housing situation and gender (percentages)

Current housing situation	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient/residential treatment		
	Gender		Total	Gender		Total	Gender		Total	Gender		Total
	M	F		M	F		M	F		M	F	
Stable (e.g. flat of their own)	-	-	-	55	58	56	83	83	83	64	71	66
Unstable (e.g. homelessness)	-	-	-	38	34	37	8	9	8	17	15	17
Institution (e.g. hospital, treatment centre) plus additional stable housing (e.g. flat)	-	-	-	2	2	2	1	1	1	10	7	9
Institution (e.g. hospital, treatment centre), no additional stable housing	-	-	-	5	5	5	1	1	1	6	4	6
Assisted housing, plus additional stable housing (e.g. flat)	-	-	-	0	0	0	1	2	1	0	2	1
Assisted housing, no additional stable housing	-	-	-	0	0	0	3	4	3	1	0	1
Prison	-	-	-	0	0	0	4	1	3	1	0	1
Valid responses	-	-	-	1 120	357	1 477	2 743	772	3 515	470	138	608
Unknown	-	-	-	229	63	292	59	6	65	3	1	4
Missing	-	-	-	28	11	39	48	10	58	179	33	212

M = male, F = female.

All lines except Valid responses, Unknown and Missing give percentages that relate to the number of valid responses.

Unknown means that the field 'Unknown' was indicated and Missing means that no response was given.

Sampled population = all clients.

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

Sources: Anzenberger et al. 2017, DOKLI analysis of client year 2016; graphic representation: GÖG/ÖBIG

Table A5. 5:

Clients aged over 20 starting drug-related treatment support service uptake in 2016, by highest educational level completed and gender (percentages)

Highest educational level completed	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient/ residential treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
No completed education	-	-	-	-	-	-	2	2	2	4	3	4
Primary school/4 years special education school	-	-	-	-	-	-	1	1	1	1	2	1
Compulsory school	-	-	-	-	-	-	43	52	45	41	47	43
Apprenticeship completed	-	-	-	-	-	-	42	31	39	40	26	37
Secondary technical/vocational school	-	-	-	-	-	-	3	6	4	4	6	5
Academic secondary school/ college for higher vocational education	-	-	-	-	-	-	6	8	7	6	12	8
University (of applied science),	-	-	-	-	-	-	2	2	2	3	3	3
Valid responses	-	-	-	-	-	-	2 271	625	2 896	446	125	571
Unknown	-	-	-	-	-	-	90	19	109	5	3	8
Missing	-	-	-	-	-	-	68	8	76	168	31	199

M = male, F = female.

All lines except Valid responses, Unknown and Missing give percentages that relate to the number of valid responses.

Unknown means that the field 'Unknown' was indicated and Missing means that no response was given.

Sampled population = all clients.

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

Source: Anzenberger et al. 2017, DOKLI analysis of client year 2016

Table A5. 6:
Persons starting drug treatment or support service uptake in 2016, by employment and gender
(percentages)

Livelihood/employment	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient/residential treatment		
	Gender		Total	Gender		Total	Gender		Total	Gender		Total
	M	F		M	F		M	F		M	F	
Gainful employment	-	-	-	11	7	10	31	22	29	9	13	10
Unemployed	-	-	-	49	45	48	38	32	37	58	43	55
Means-tested minimum income	-	-	-	17	24	19	11	18	13	10	11	10
Child, (school) student (='persons for whom support obligations exist')	-	-	-	1	3	1	4	6	4	0	1	0
Military service, alternative civilian service, parenthood leave, retired	-	-	-	6	10	7	5	13	7	5	17	7
Household, retraining, other source	-	-	-	13	12	13	12	12	12	4	7	5
No gainful employment and other source unknown	-	-	-	25	23	25	15	18	16	29	29	29
Number of persons with valid responses	-	-	-	1 158	369	1 527	2 703	765	3 468	515	139	654
Unknown	-	-	-	192	54	246	75	11	86	17	9	26
Missing	-	-	-	27	8	35	72	12	84	120	24	144

M = male, F = female.

All lines except Valid responses, Unknown and Missing give percentages that relate to the number of valid responses. Unknown means that the field 'Unknown' was indicated and Missing means that no response was given.

Sampled population = all clients.

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

Sources: Anzenberger et al. 2017, DOKLI analysis of client year 2016; graphic representation: GÖG

Table A5. 7:

Persons starting drug treatment or support service uptake in 2016, by nationality and gender (percentages)

Nationality	Short-term contacts			Low-threshold services			Long-term outpatient treatment			Long-term inpatient/residential treatment		
	Gender			Gender			Gender			Gender		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Austria	-	-	-	-	-	-	82	92	84	83	88	84
Other EU country	-	-	-	-	-	-	5	5	5	5	6	6
Non-EU country	-	-	-	-	-	-	13	4	11	11	5	10
Stateless	-	-	-	-	-	-	0	0	0	0	0	0
Number of persons with valid responses	-	-	-	-	-	-	2 756	766	3 522	462	139	601
Unknown	-	-	-	-	-	-	42	11	53	1	0	1
Missing	-	-	-	-	-	-	52	11	63	189	33	222

M = male, F = female.

All lines except Valid responses, Unknown and Missing give percentages that relate to the number of valid responses.

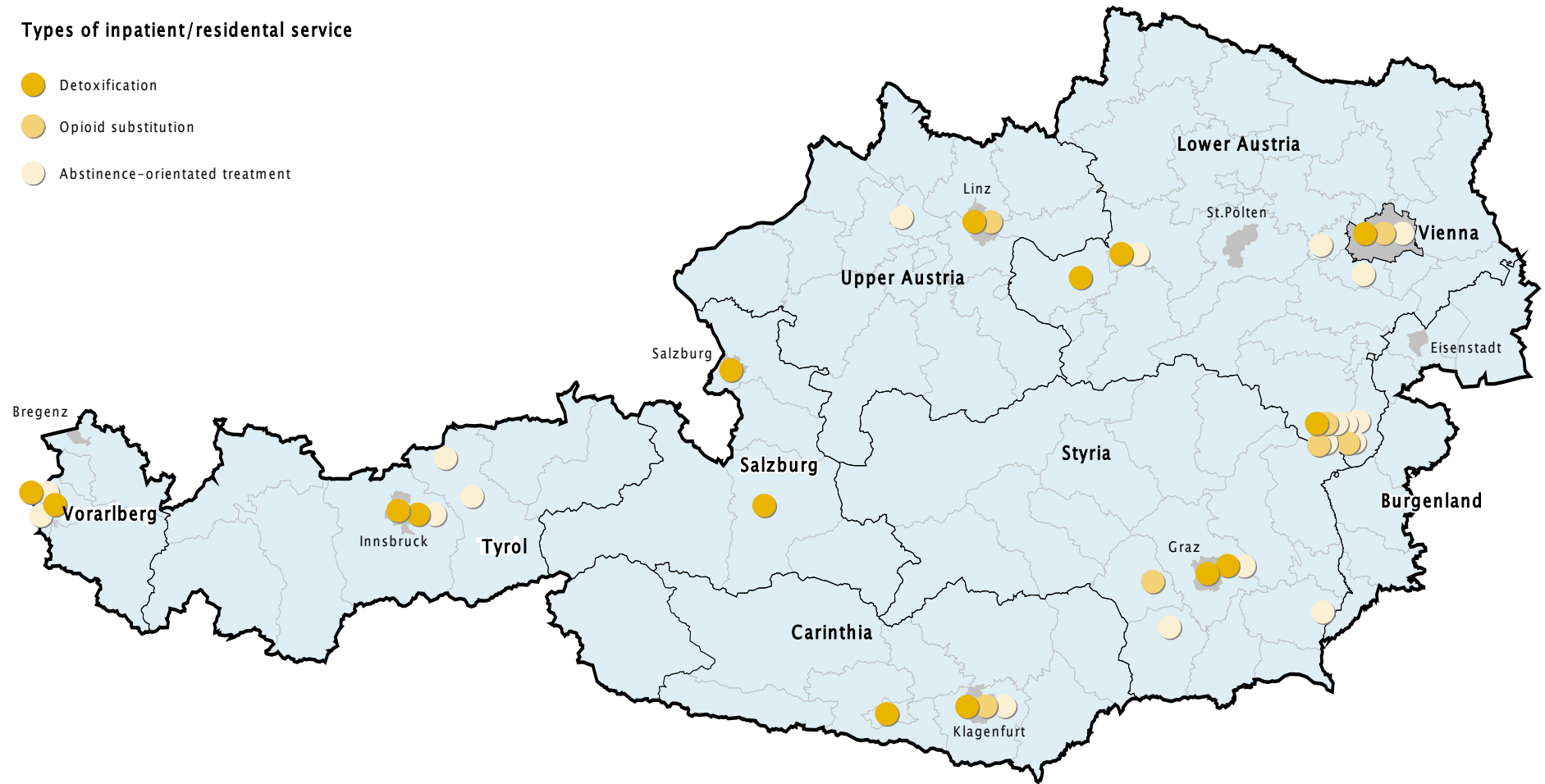
Unknown means that the field 'Unknown' was indicated and Missing means that no response was given.

Sampled population = all clients.

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

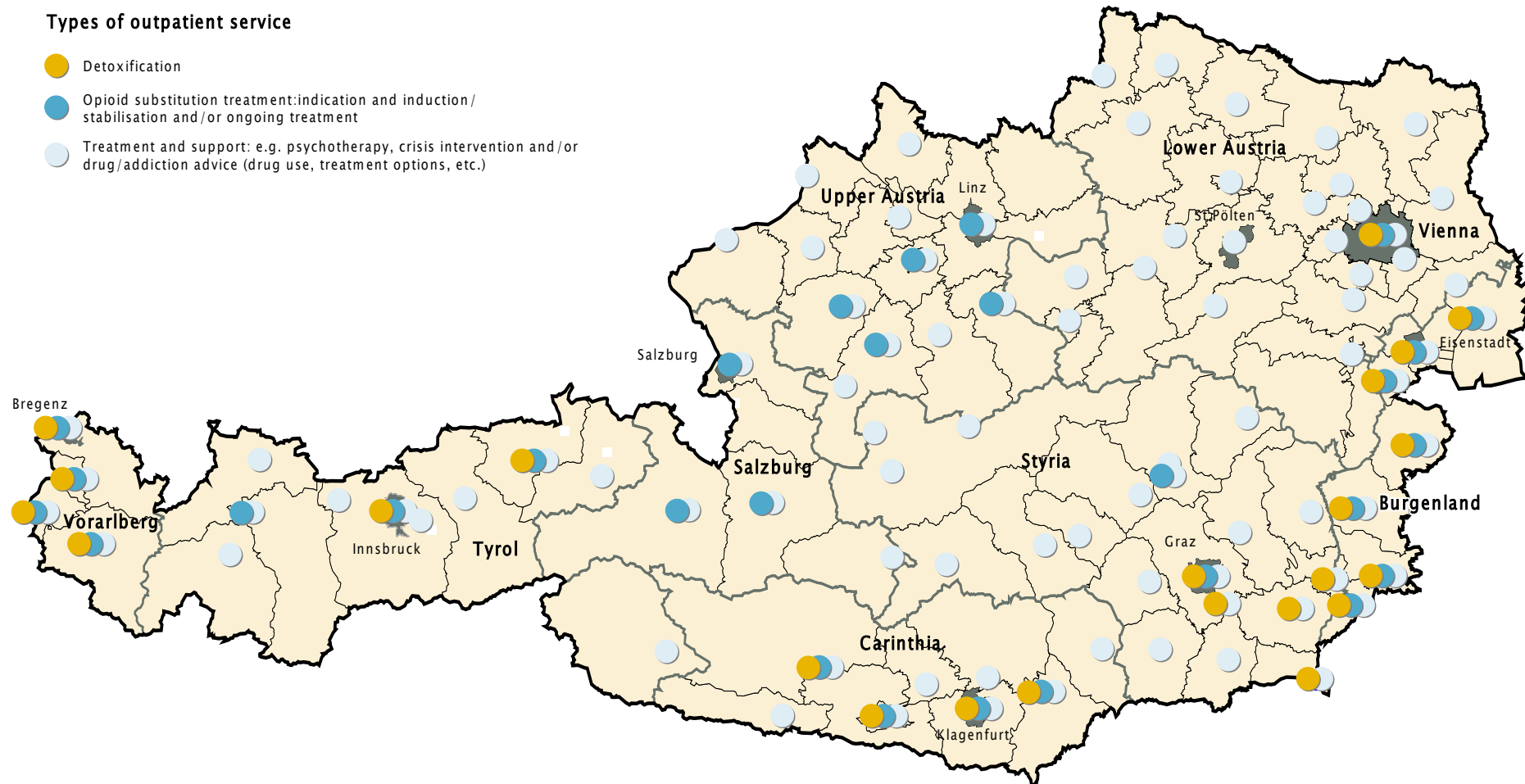
Sources: Anzenberger et al. 2017, DOKLI analysis of client year 2016; graphic representation: GÖG

Map A5. 1:
Specialised inpatient/residential treatment services for addiction patients in Austria; in 2017



Source: GÖG in cooperation with the provincial addiction and drug coordination offices; graphic representation: GÖG

Map A5. 2:
Specialised outpatient support and treatment services for addicted clients in Austria; in 2017



Harms and harm reduction

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6 Harms and harm reduction

6.1 Summary

National profile and trends harms

In 2016, a total of 146 fatal drug overdoses were recorded in the context of autopsies. Another 19 deaths, for which no autopsies (but only external post-mortem examinations) were performed, are also most likely to have resulted from overdoses. Therefore, a total of 165 drug-related deaths due to drug overdoses is assumed for 2016 (2015: 153 cases).

In 2016, the number of drug-related deaths was higher than in 2013, 2014 and 2015. The proportion of persons aged under 25 (15% of all drug-related deaths) has moderately decreased as against the past few years (2015: 21%, 2014: 19%; 2013: 18%), but is significantly smaller than in the period from 2005 to 2008 (approx. 40%), as well as from 2009 to 2011 (26% to 30%). The smaller proportion seems to result mainly from a smaller number of persons taking up opioid use (see chapter 3).

With regard to infection rates, considerable differences have become apparent both within and between the available sources of data. It is obvious, however, that hepatitis C constitutes a massive problem among injecting drug users. The proportion of hepatitis C infections in this group has been high for many years (up to 83% in 2016, depending on the source of data). However, the figures on HIV prevalence have continued to be low in the past 10 years (2016: 0% to 4%). The hepatitis B prevalence rates among injecting drug users have been fairly constant for many years (2016: 12% to 29%).

No data on drug-related acute emergencies have been made available.

National profile and trends harm reduction

The Austrian *Addiction Prevention Strategy*, as well as the nine provincial strategies, form the basis for harm reduction interventions.

The majority of the corresponding services are provided in low-threshold settings. Exchange and sale of syringes, which is available in seven out of nine provinces – primarily cities – plays a key role here. In addition, the low-threshold support services offer further measures to prevent infections (e.g. free testing and HAV/HBV vaccination programmes), as well as assistance from social workers and medical specialists. Opioid substitution treatment can also be regarded as a (higher-threshold) harm reduction intervention; the corresponding guidelines have been discussed in chapter 5.

New developments

The treatment options for drug users with HCV infections continue to be developed further: treatment is available both in hospitals in Vienna, Graz and Innsbruck – usually in cooperation with low-threshold centres – and also directly in the low-threshold setting of the Viennese *ambulatorium*, as a *directly observed therapy* combined with opioid substitution treatment. As a result of the cooperation with a number of pharmacies, patients undergoing opioid substitution treatment can regularly get their hepatitis C medicine at the pharmacy together with their substitution medicine.

The criteria for cost coverage by the health insurance funds of treatment with new direct-acting antivirals have also been continually eased. The degree of fibrosis that has to be diagnosed as a prerequisite for cost coverage has been increasingly lowered. However, there still is a group of patients who are not eligible for cost coverage.

For 2016, data on coinfection with syphilis have for the second time been made available by a low-threshold centre (i.e. *Vienna ambulatorium*; see section 6.2.3).

6.2 National profile

6.2.1 Drug-related deaths

In 2016, a total of 146 fatal drug overdoses were recorded in the context of autopsies (for 140 of them, toxicological analyses were performed). An additional 19 deaths – for which no autopsies were performed – are very likely to result from drug overdoses (narcotic drug poisoning given as the cause of death in the confirmation-of-death certificate after external post-mortem examination)⁹⁷. A total number of 165 deaths that are directly related to overdoses (= directly drug-related deaths) is therefore assumed for 2016 (see Table A6. 1).

The grouped median⁹⁸ of the age at death was 34.1 in 2016, which is moderately higher than in the past year (2015: 32.9, 2014: 34.8; 2013: 32.0). The proportion of women in directly drug-related deaths is 23%, which is slightly above the long-term average, but slightly below the figures

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

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

of the previous year (25.5%; see Table A6. 4). In eight cases, suicide was most likely (mentioned in the autopsy report, e.g. suicide note).

The results below relate to cases for which conclusive toxicological analyses have been made available (140 cases). In 5%, only opioids were detected. In 86% of cases, poly-substance poisoning involving opioids was found (i.e. opioids combined with alcohol, psychopharmaceuticals or other narcotic drugs). As in the previous years, poly-substance poisoning involving opioids predominates (see Figure 6.2). Patterns of poly-substance use involving opioids, where the effects of different substances may be potentiating and which are thus difficult to control, continue to be widespread and constitute serious health risks (see Table A6. 1).

With regard to distinguishing between heroin, morphine and slow-release morphine (e.g. the substitution medicine of Substitol®), the following factors have to be taken into account: there are no markers with which the presence of slow-release morphine can definitely be identified in the organism, it is therefore listed as morphine. However, in some cases, fatal heroin poisoning is also found in this category, for the following reason: heroin is also converted into morphine in the body, but in the case of heroin use, the typical 6-MAM marker can be detected by urinalysis. In Austria, no uniform testing routines for this metabolite of heroin have been established, and forensic autopsies differ from those carried out by the health officials⁹⁹. Only cases in which tests for the heroin marker have been performed and mentioned in the report can thus be listed as heroin poisoning in the statistics. The 18 deaths involving heroin thus represent the minimum number of deaths (overdoses solely of heroin: 1 case) All other cases have been entered under morphine, and only 4 in a total of 76 cases involving morphine have been attributed to exclusive morphine use (without the involvement of any other narcotic drug, alcohol or psychopharmaceutical).

In 32 cases of death, cocaine was detected, and in 6 cases, cocaine was the only illicit substance found.

In 20 cases, **amphetamines** (including ecstasy, methamphetamine and NPS containing cathinones) were identified (14%). In 13 of these cases, several narcotic drugs (including opioids) were found, and in 4 cases, several narcotic drugs (but no opioids). In terms of percentages, this represents a slight increase as against the previous year (11%). **MDMA** (or MDA or MDE) was detected in a total of 10 cases, and in 2 cases as the only illicit drug. Again, a comparison with prior years indicates an increase at a very low level (2015: 3 mono-poisonings, 4 poly-substance poisonings; 2014: 2 mono-poisonings, 1 poly-substance poisoning; 2013: 4 poly-substance poisonings; 2012: 1 mono-poisoning, 4 poly-substance poisonings; 2011: 4 poly-substance poisonings. In 7 of these 10 cases, the quantities detected were toxic to lethal. This seems to be connected with the prob-

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According to information from several forensic institutes, 6-MAM tests are routinely carried out, even though the results are not always explicitly included in the reports.

lem that very potent ecstasy pills have increasingly often been in circulation. In 5 cases, **methamphetamine** was detected in addition to other narcotic drugs (2015: three 3; 2014: 4 cases; 2013: 1 case; 2012: 2 cases).

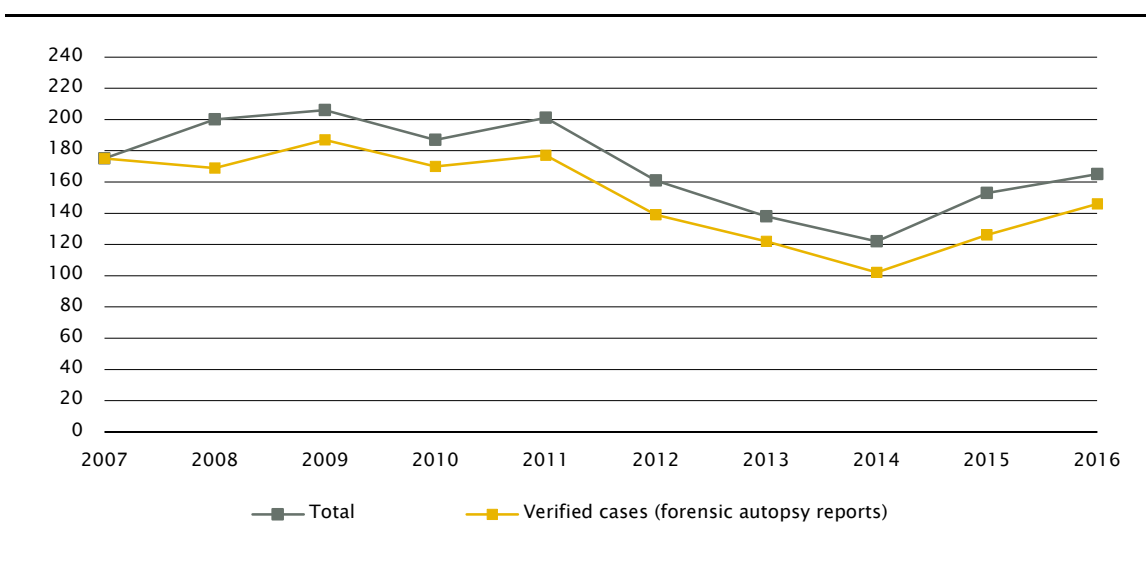
In two cases of overdose deaths, new psychoactive substances (NPS) were involved. NPS thus continue to be insignificant with regard to fatal overdoses. In one case, GHB was detected.

There are no uniform testing routines for stimulants (e.g. MDMA) in Austria. The statistics thus include only those cases in which the autopsy report mentions that tests have been carried out.

Trends: Development of drug-related deaths

A decline in the number of drug-related deaths was apparent from 2011 to 2014. In 2014, it was at the lowest level in over 10 years (see Figure 6.1). Since 2015, a rise has again been recorded. The figures for the individual provinces are given in Table A6. 2 and Table A6. 3 in the Annex).

Figure 6.1:
Directly drug-related deaths in Austria; total figures and figures verified by autopsy reports;
2007-16

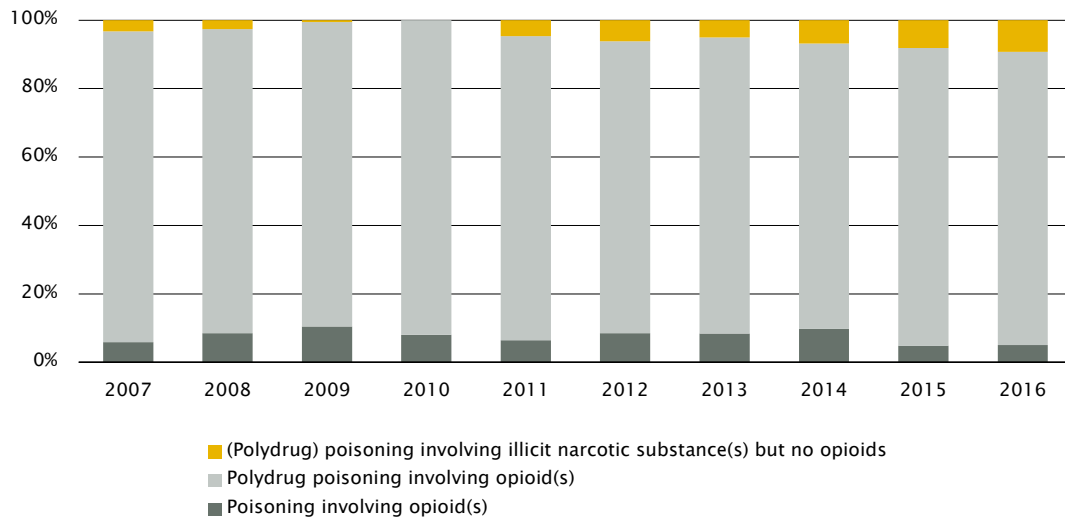


Source: Statistics on drug-related deaths; calculation and graphic representation: GÖG

The proportion of people aged under 25 of the total number of 165 directly drug-related deaths in 2016 has decreased to 15%, which is the smallest percentage of the past 10 years (see chapter 3 and Table A6. 4). The percentage of women (23%) is slightly above the long-term average (see Table A 6. 4).

In the past 10 years, the proportion of opioid poisonings has always been over 90% (see Figure 6.2), whereas (polydrug) poisoning not involving opioids plays a minor role.

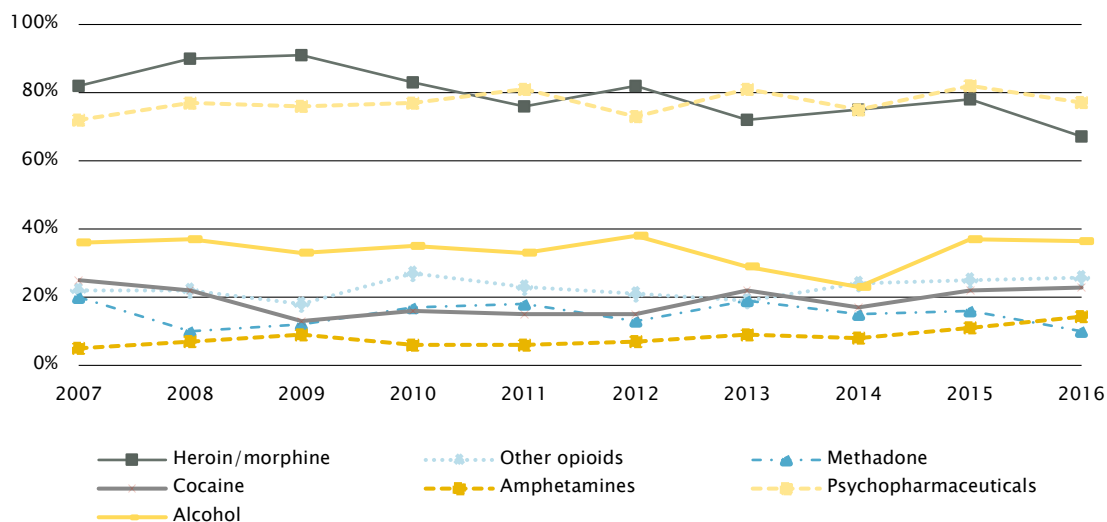
Figure 6.2:
 Percentage of directly drug-related deaths in Austria (confirmed by toxicological analysis), by
 cause of death; 2007–16



Source: Statistics on drug-related deaths; calculation and graphic representation: GÖG

The proportion of verified drug-related deaths (i.e. toxicological analysis) in which stimulants were detected has been fairly stable for many years; in 2016 it was 23% for cocaine and 14% for amphetamines (see Figure 6.3 and Table A6. 5).

Figure 6.3:
Substances identified in drug-related deaths; 2007-16



The category of amphetamines includes amphetamine, methamphetamine, MDMA/MDA/MDE, mephedrone/3MMC and NPS of the amphetamine group (e.g. 4-methylethylcathinone and other cathinones).

Source: Statistics on drug-related deaths; calculation and graphic representation: GÖG

6.2.2 Drug-related acute emergencies

No routines for the systematic recording of data on drug-related acute emergencies exist at present, and individual reports relating to NPS have not been made available either. It is not possible to analyse hospital discharge diagnoses with regard to drug-related emergencies, as in the case of overdoses not only T diagnoses under ICD-10¹⁰⁰ are entered, but in fact (particularly in the case of patients suffering from addiction diseases) F10-F19 diagnoses are also used, which relate to mental and behavioural disorders due to psychoactive substance use.

6.2.3 Drug-related infectious diseases

Main drug-related infectious diseases among drug users – HIV, HBV, HCV

The following results are based on a variety of data sources that are given in the overview of Table 6.1. As these data come from only a small number of drug support centres, as well as from the

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T36-T50: Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (particularly T40, T42, T43 and T50).

statistics on drug-related death, and differ greatly, it is impossible to give precise prevalence rates and trends. However, differences in the frequency of certain infectious diseases have nevertheless become apparent.

In 2016, the hepatitis B prevalence rates ranged from 12% to 29%, depending on the available source of data. In the majority of cases one can rule out the possibility that any positive test results may be due to previous vaccination (see also legend to Table 6.1).

In the past few years, the hepatitis B prevalence rates in injecting drug users have remained fairly constant: the figures from the available sources of data go back to 2009 and range from 0% to 36%.

In this report, hepatitis C prevalence is derived from positive tests for HCV antibodies (HCV–Ab), because this yields the largest amount of data. If hepatitis C antibodies can be detected in tests, this indicates acute, chronic or past HCV infections. In order to diagnose acute or chronic HCV infections, a positive HCV antibody result must be verified by a further examination. By means of HCV–PCR (polymerase chain reaction) testing, genetic HCV material (HCV RNA/hepatitis C virus ribonucleic acid) can be detected in blood samples.

In 2016 the HCV–Ab prevalence rates were 14% to 83%. Regarding HCV–RNA results, a high proportion of patients testing positive for HCV–Ab display a chronic development of the disease (e.g. *Kontaktladen*, Graz: 40%; *Vienna ambulatorium*: 73%; see ST9).

Table 6.1:

Hepatitis B, hepatitis C–Ab and HIV infection rates among injecting drug users in Austria; in 2016

Source of data	HBV rate	HCV–Ab rate	HIV rate
<i>Lukasfeld</i> treatment unit, Vorarlberg	29% (24/84) ¹	60% (50/84)	0% (0/84)
<i>Vienna ambulatorium</i>	22% (44/204) ²	83% (203/244)	0% (0/258)
<i>Kontaktladen</i> ³ , Graz	12% (10/81) ⁴	68% (55/81)	0% (0/81)
DOKLI ⁵	– (0/1)	47% (15/32)	0% (0/30)
Drug-related deaths (incl. toxicological testing) in 2016	not available	14% (19/140) ⁶ 38% (19/50) ⁶	1% (2/140) ⁶ 4% (2/50) ⁶

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

² This percentage relates to persons who had definitely had contact with hepatitis B.

³ In prior reports referred to as *Caritas Marienambulanz*.

⁴ This percentage relates to persons in whom both HBVc and HBVs antibodies were found. Persons who tested positive only for anti–HBVs were not counted because this results from HBV vaccination.

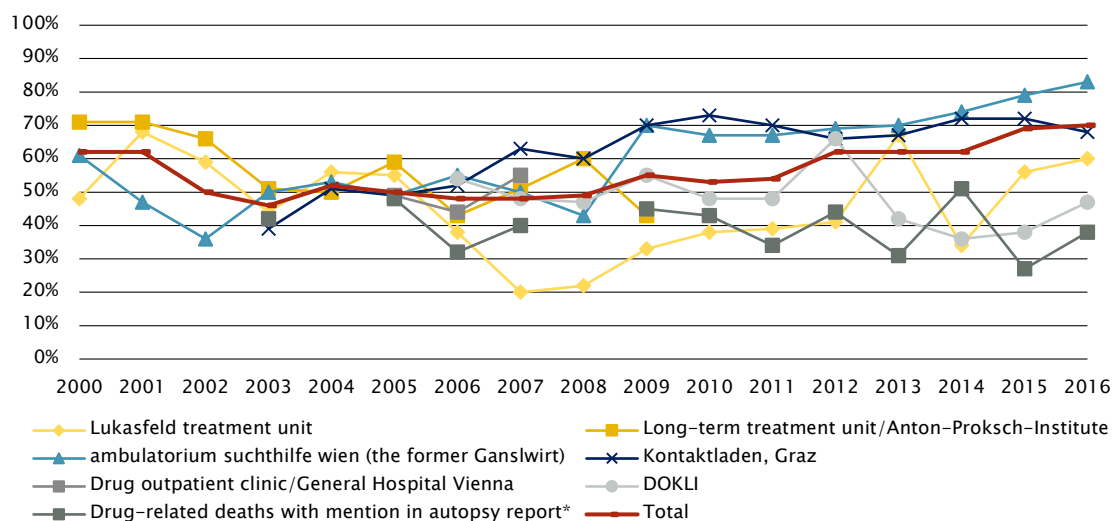
⁵ The DOKLI data on tested clients are gathered only sporadically and on a voluntary basis, and thus cannot be regarded as representative (see also T4).

⁶ Out of a total number of 140 forensic reports on directly drug-related deaths that included toxicological testing, only 50 explicitly mentioned the presence or absence of HCV–Ab or HIV infections. In the remaining cases it is not clear whether no tests for the relevant infections were carried out or whether the results were negative and thus not mentioned. The two percentages given therefore indicate maximum and minimum levels of HCV–Ab and HIV infection prevalence rates.

Source: ST9; calculation and graphic representation: GÖG

In the past few years, the HCV–Ab prevalence rate has remained fairly stable at approximately 50%. In 2014 it was between 20% and 74%, depending on the data source, and in 2015 between 12% and 79%. Figure 6.4 illustrates the development of HCV infection rates recorded by various data sources since 2000.

Figure 6.4:
HCV infection rates in Austria ; 2000–16



*Statistical population in 2016: 50 reports mentioning HCV.

Source: ST 9, DOKLI and Schmutterer/Busch 2016; calculation and graphic representation: GÖG

In the group of injecting drug users, the HIV prevalence rate was between 0% and 4% in 2016.

Whereas in the early 1990s, the HIV prevalence rate among injecting drug users was still around 20%, it has been at a lower level since then, with the highest levels detected among drug-related deaths. Here, slightly elevated figures have repeatedly been registered in recent years (e.g. in 2013 and 2014: 4% to 11%; 2015: 4% to 9%; see Weigl et al. 2014, Weigl et al. 2015 and Weigl et al. 2016).

Prevalence data of drug-related infectious diseases outside the routine monitoring (Optional)

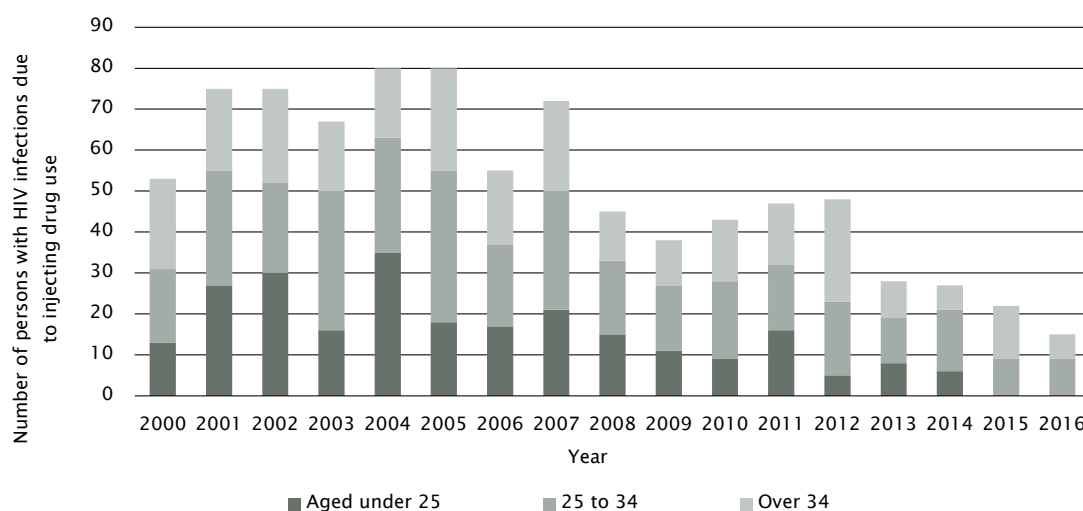
In 2016, 15 persons with HIV infections resulting from injecting drug use were included in the Austrian HIV cohort study. In that year, a total of 255 persons were entered into the Austrian HIV cohort study. In the case of 55%, MSM is assumed to be the route of infection, in 27%, heterosexual contact, and in 6%, injecting drug use. In 12 cases, the infection route is unknown, and in 0.4%,

the infection results from vertical¹⁰¹ transmission (AHIVCOS and Zangerle, personal communication).

The number of persons with HIV infections due to injecting drug use who have been included in Austria's HIV cohort study (AHIVCOS) has gone down in recent years. Another interesting point is that since 2015, no person aged under 25 has been entered into AHIVCOS (see Figure 6.5).

Figure 6.5:

AHIVCOS: Number of persons in Austria who have probably been infected with HIV due to injecting drug use, by age and year¹⁰²; 2000–16



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

The national statistics on AIDS cases have lost their importance since highly active antiretroviral treatment (HAART) has become available; only a few new AIDS cases have been reported. Due to lack of epidemiological relevance, these statistics have no longer been published by the BMGF (Benka, personal communication).

Data from the *Action Hepatitis C* database indicate that currently injecting drug use is the predominant infection route for hepatitis C. Whereas in the past, infection via the administration of blood products was the most frequent cause of infection, in the present day, this mainly applies

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In this context, vertical transmission refers to transmission from an HIV-infected mother to her child during pregnancy, or during or after birth (e.g. breastfeeding).

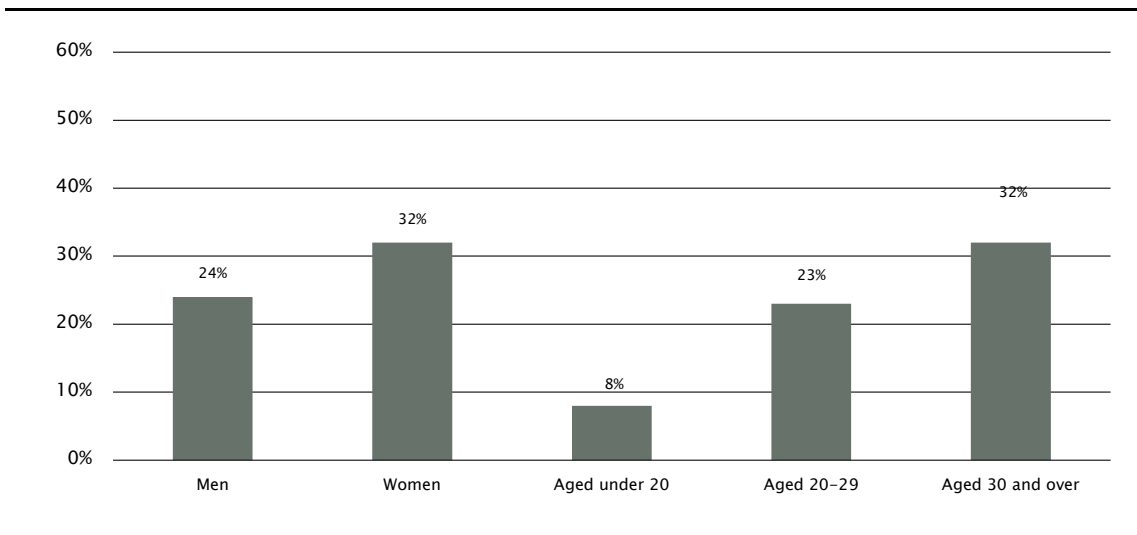
102

The data differ slightly from those provided for the reports of previous years. This is due to a new form of analysis in 2016, which also includes patients whose infections are likely to result from injecting drug use (e.g. methadone + HCV + injecting drug use; opioid addiction + HCV + injecting drug use).

to older persons, in whom the disease has progressed further. In the case of younger persons, whose infection thus dates back only a shorter time, injecting drug use definitely predominates as the infection route. However, one has to bear in mind that in the majority of documented cases, the most probable cause of infection is either unknown or has not been specified (Action Hepatitis C Datenbank 2012).

Since 2014, DOKLI has also collected data on *needle-sharing*. The following figures refer to Austria, not counting Vienna¹⁰³. In 2016, a proportion of 26% of outpatients who indicated injecting drug use said they had already shared needles, as against 33% of inpatients. However, in most cases, this had happened over a year previously (outpatients: 81%; inpatients: 94%). Women indicate needle-sharing slightly more often than men. With regard to age, the expected trend, i.e. that answers indicating needle-sharing increase with age, has been confirmed (see Figure 6.6).

Figure 6.6:
Needle-sharing (at least once) among persons starting outpatient treatment/service uptake in 2016, by gender and age



Source: DOKLI analysis of client year 2016; graphic representation: GÖG

Other drug-related infectious diseases

Data on other drug-related infections are available for tuberculosis (TB) and syphilis. In the reporting year, no person out of a total of 26 whose current TB status was entered in the DOKLI data set had a history showing a positive TB test result. Four further persons in the DOKLI data set were tested for TB in the reporting year, with a negative result in both cases.

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In the new Viennese DOKU-Neu system, these data are not collected.

Four per cent (10/269) of the clients tested for syphilis at the Vienna *ambulatorium* in 2016 had positive TPHA¹⁰⁴ test results¹⁰⁵.

6.2.4 Other drug-related health harms

Addiction often goes hand in hand with numerous somatic diseases, which can be the cause, concomitant and/or the consequence of chronic substance use. For instance, approximately half of patients at the Maria Ebene support and treatment centres¹⁰⁶ also suffer from organic diseases, approximately 40% have orthopaedic problems, 35% suffer from mental disorders, and more than 10% have skin diseases. This is paralleled by a number of social problems such as unemployment, intimate partnership conflicts or loneliness (Stiftung Maria Ebene 2015).

As far as psychiatric comorbidity of addiction diseases and other mental disorders requiring treatment is concerned, personality disorders, schizophrenia and bipolar disorders predominate. In 2016, the I.K.A low-threshold centre in Graz registered 231 patients with a total of 283 diagnoses of psychiatric comorbidity (89 clients without comorbidity diagnoses, and not indicated in 2 cases; I.K.A. 2017).

According to the statistics on problems addressed in the advice and counselling sessions at the Vienna *jedmayer* service, health is the third-most important theme, after the two main issues of money/debt and housing/accommodation: both physical problems and very often also mental comorbidity are addressed in this context (SHW 2017a). At the *change* service in Vienna, the situation is similar. In 2016, physical health was discussed in 23% of a total of 1 230 advisory talks, and the clients' mental health in 22% of talks (SHW 2017a).

Physical comorbidity (concomitant organic diseases) is analysed annually on the basis of test results (macroscopic and microscopic histological analyses of internal organs) obtained in the context of forensic examinations of DRD cases. In 2016, as in previous years, these findings reveal pronounced organic damage among drug users (Anzenberger et al. 2017a). In the majority of indirectly drug-related deaths¹⁰⁷ (65 persons), the cause of death was a disease (49 persons) such

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Treponema pallidum particle agglutination assay.

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In all 10 cases with positive TPHA results, the VDRL test was non-reactive and the TP-IgM-AB ELISA test was negative. In 5 cases, a syphilis treatment could be confirmed. In the other 5 cases, the treatment status is unknown.

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They provide treatment to persons addiction to alcohol, medicines and drugs, as well as gambling, and to patients suffering from eating disorders.

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In the case of indirectly drug-related deaths, the cause of death is not acute fatal poisoning involving a narcotic drug but, due to the patients' history of drug use, their death could be related to drug use.

as myocarditis or cirrhosis, mostly resulting from hepatitis C. One person died of AIDS, and for a further 12 persons, other causes of death are known (e.g. suicide or accident).

It is not possible to make any precise statements on the nationwide prevalence of psychiatric or physical comorbidity: one reason is that the samples in question are not representative.

6.2.5 Harm reduction interventions

The Austrian Addiction Prevention Strategy published in 2016 definitely endorses emergency services and harm reduction, as well as an orientation of addiction policy measures towards specific target groups. One of the goals set is to reduce to a minimum the negative consequences and problems that result from the use of psychotropic substances and behavioural addictions, and to provide services in the context of the health and social care system to support addicted persons, whose disease often takes a chronic course, in line with their needs (BMG 2016; see also chapter 3). In the provincial addiction or drug strategies (see chapter 1) harm reduction is regarded as an integral part of a diversified system of support and treatment. Harm reduction is offered in low-threshold services in the form of social work interventions as well as medical care and treatment for high-risk users. Opioid substitution treatment can also be regarded as a harm reduction intervention (see chapter 5).

In Austria, the implementation of harm reduction interventions rests exclusively with the provinces, and comprises diverse services, which are provided primarily by centres specialising in work with addicted clients. In most cases, such agencies are owned by independent organisations that run one or several centres and cooperate with the provincial drug/addiction coordinators. The funding for harm reduction interventions comes from the budgets of various provincial departments (see chapter 1).

Low-threshold drug support services are available in seven of the nine Austrian provinces, primarily in the provincial capitals. In Upper Austria, Salzburg and Vorarlberg, additional services are provided in certain smaller towns where specific drug scenes have become established. The harm reduction interventions are primarily carried out by charities or, in the case of Vienna, by a non-profit enterprise owned by the City of Vienna. In Lower Austria, harm-reduction interventions are provided by the addiction support services, and in Burgenland, by the provincial Psychosocial Service.

Generally speaking, the harm reduction interventions mainly focus on the prevention of drug-related infectious diseases, particularly by means of the exchange of syringes, HIV and hepatitis testing, HAV/HBV vaccinations, as well as information on safer use/safer sex and the prevention of emergencies (see SQ23/29). These interventions are primarily covered by low-threshold and outreach services (street work). In a few cases, syringe exchange is offered by services that do not

As these cases can only be included in the corresponding statistics if suspicion of an indirect relation to drug use is reported, the available data cannot be assumed to be complete (see GÖG/ÖBIG 2007).

specialise in addiction such as the *AIDS Hilfe* assistance service, or by private enterprises (e.g. a syringe vending machine owned by a pharmacy). Treatment of health consequences is mostly provided by the general health-care system (e.g. emergency physicians, psychiatrists) and, to an increasing extent, also in the context of the consulting hours of general practitioners/medical specialists at low-threshold centres who liaise with higher-threshold medical care services (e.g. referral to hepatitis C treatment).

The **prevention of infections** plays an important role in low-threshold centres and outreach work: in this context, the **exchange and sale of syringes** is of great relevance. This type of service is provided in all provinces except Lower Austria and Burgenland; sterile injection equipment is available at 16 locations in 13 towns and cities. Several centres both offer an exchange of syringes and dispense syringes through vending machines. The return rate of used syringes is over 98% at the majority of centres and has been at a very high level for many years (see SHW 2017a). In addition to syringe exchange, it is possible in five provinces (Upper Austria, Salzburg, Styria, Vorarlberg and Tyrol) to buy syringe sets at 21 vending machines in 17 towns and cities. In Styria, Vorarlberg and Vienna, sterile syringes are also available through outreach services (drug street work; see ST 10).

In quantitative terms, the majority of syringes are issued at drug support centres: in 2016, a total of over 6 000 000 syringes were distributed (see Table A6. 6). In addition, around 147 000 syringe sets were sold through vending machines, and over 167 000 syringes were provided in the context of outreach drug street work¹⁰⁸. In the vending machines, the syringes are usually sold as part of safer use kits, which – depending on the service in question – include various accessories besides syringes and needles in order to ensure sterile injecting and other safe forms of use: for instance, sterile cups or spoons, distilled water and micro filters, or adhesive strips and alcohol pads for wound care. Some sets also contain condoms, safer use information, or information on drug emergencies (see SQ 23/29). In addition to the established programmes for the exchange and sale of syringes that are run at the provincial level, it is also possible to buy syringes and needles at pharmacies in Austria. Sales figures in this area have not been made available.

Many centres also offer individual advice in the context of syringe exchange, and some of them organise safer use and safer injecting training lessons. Exact data on the number of trainings and the number of clients have not been made available. Interventions in the area of *peer involvement*, as well as outreach health education approaches, do not play an important role in Austria.

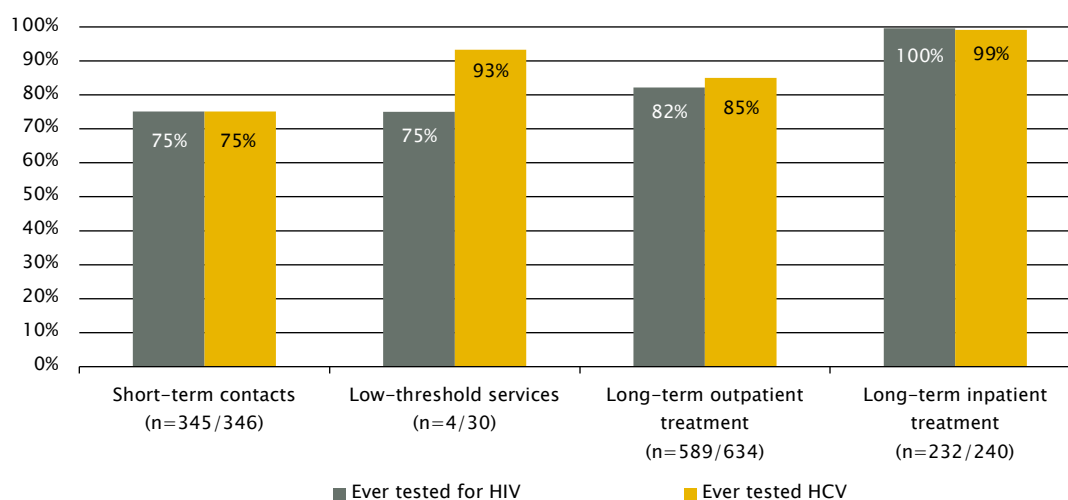
12 low-threshold services in 6 provinces offer free **HIV and hepatitis testing** as a further significant factor in the prevention of infections.

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The figures relate to the whole of Austria. Syringes distributed through drug street work in Vorarlberg are not covered by these data. Their number is included in the sets issued by drug support services.

The DOKLI data sets permit statements on prior HIV and HCV testing of injecting drug users¹⁰⁹. Figure 6.7 reveals the high testing frequency with regard to both HIV and HCV in the individual support and treatment settings. Particularly in inpatient settings, the majority of clients indicate having been tested (for HIV and HCV) in the past 12 months (Anzenberger et al. 2017b).

Figure 6.7:
HIV and HCV testing prevalence among persons entering treatment in 2016 who indicate injecting drug use at least once, by type of setting



Source: GÖG/ÖBIG, DOKLI analysis of client year 2016; graphic representation: GÖG

A total of 10 low-threshold centres in Carinthia, Upper Austria, Styria, Vorarlberg and Vienna provide free **HBV and HAV vaccinations** for drug users. In the context of the infection prevention project of *Vienna ambulatorium*, 90 persons received at least one dose of hepatitis A/B vaccine in the reporting year. 47 persons of this group completed the full immunisation process (SHW 2017a).

The DOKLI data set on hepatitis A (HAV) vaccinations includes 278 people, and regarding HBV vaccinations, 276 people. In 2016, the **immunisation coverage** was 32% for HAV and 33% for HBV¹¹⁰. The TB immunisation rate derived from the DOKLI data set is based on information provided by 232 persons. 5% of respondents indicated having immunisation against TB. Still, these figures reflect previous vaccinations rather than the present status of immunisation.

¹⁰⁹

These data have been collected for DOKLI since the client year 2014, in accordance with TDI standard protocol 3.0. However, neither the test result nor the time of testing are included.

¹¹⁰

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

The **treatment of hepatitis C** in drug users has played an increasingly important role in Austria. In low-threshold settings, centres in Vienna and Graz endeavour to make it as easy as possible for clients to enter treatment by running hepatitis outpatient clinics and by closely cooperating with hospitals. At present, the cost of treatment with modern DAA¹¹¹ is taken over by the health insurance funds, depending on the genotype, either irrespective of the degree of fibrosis (in the case of Type 1 and Type 4) or if advanced fibrosis of at least stage F2 has been diagnosed (in the case of Type 2 and 3; see HVB 2017). From an epidemiological perspective it would, however, be advisable to aim to treat all patients simultaneously in order to prevent the spreading of HCV through needle-sharing in the context of injecting drug use (see Haltmayer and Zangerle respectively, personal communication). In this way, HCV could be eliminated in this group of patients.

In Vienna, the *ambulatorium* low-threshold centre cooperates with the Dialog association, the 4th medical department of the Viennese Wilhelminen Hospital as well as several pharmacies in Vienna and Lower Austria, which enables low-threshold access to treatment with modern DAA. The target group of this cooperation comprises patients with current or prior injecting drug use and with a chronic hepatitis C infection who are undergoing opioid substitution treatment. The strict adherence to the daily doses of the substitution medicine helps them keep the regular schedule that is required for successful hepatitis C treatment. By 31 December 2016, a total of 78 patients started treatment, and 65 of them completed the treatment as well as the 12-week follow-up check. In all of these patients, their hepatitis C infection was cured in virological terms (SVR12 rate: 100%; SHW 2017a).

At the federal level, the **reduction of drug-related deaths** and emergencies continues to be a key issue. In addition, the national Addiction Prevention Strategy defines harm reduction and emergency services as important fields of intervention (see chapter 1 and BMG 2016).

Specific initiatives aimed at preventing overdoses and responding to emergencies are primarily found in the low-threshold sector. Here, information and advisory services, as well as first aid courses for drug users and staff of low-threshold services are offered. Information on responses to emergencies is also available on specialised websites.¹¹²

Naloxone is a prescription-only substance in Austria; it is exclusively dispensed through doctors, and it is part of the standard equipment of emergency physicians and ambulances. However, it is not directly dispensed to drug users, or to people close to them, as an emergency prophylaxis in the case of overdoses. Styria has begun to discuss starting a take-home naloxone programme (Caritas Diözese Graz Seckau 2017a).

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Direct-acting antiviral agents.

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E.g. <http://www.drogenarbeit6.at/substanzen/erste-hilfe.html>; <http://www.doit.at/ueberdosis-notfaelle.html>; <http://www.checkyourdrugs.at/infos/gesundheitstipps/ueberdosierung-notfalle/> (all websites accessed 14 July 2016).

Drug checking continues to be important for **preventing and reducing emergencies in party settings** but is only available in Vienna (*checkit!*) and Tyrol (*Z6 Drogenarbeit*; see SHW 2017b and Z6/Drogenarbeit 2017). Both services report their results to the Austrian information and early warning system for specific health hazards in the context of illicit substance use (see chapter 3 and chapter 7). For a description of the results of the pharmacological analysis see chapter 7. In Tyrol the Z6 drug support service was present at 17 events in the capital of Innsbruck and 9 events in other towns in 2016. A total of 286 substances were handed over for testing (2015: 124 samples), with 135 of these assessed as highly dangerous. The users had to be warned of the ingredients of 222 samples, and 143 samples had been adulterated¹¹³. 56 samples were both adulterated and contained very high doses of the ingredient. Lab scales were procured to improve the procedure for handing in ecstasy pills, which resulted in a considerable increase in ecstasy samples submitted for testing (2016: 51 pills; 2015: 20 pills; see Z6/Drogenarbeit 2017). In the case of 73% of the 51 ecstasy pills tested, the users were warned of (extremely) high doses of the active ingredient (over 100 mg).

In the reporting year 2016, the Viennese *checkit!* service analysed 1 219 samples at 18 event days (14 events; 2015: 1 041 samples). In 15% of samples, a warning had to be issued due to ingredients/combinations of substances that posed particular health hazards. 51% of samples analysed contained only the expected ingredient. In more than half (56%) of the samples, high amounts of the active ingredient were detected, particularly in those samples that contained the expected ingredient. Almost one out of five (19%) of the total of 328 pills bought as 'ecstasy' and submitted for testing were regarded as involving considerable health risks due to high doses of the active ingredient. 8% of the samples bought as 'speed' (n = 289) were regarded as posing health risks. Many samples bought as 'cocaine' (n = 211) contained more than two unexpected ingredients, and usually the pharmaceutical levamisole was among those substances. The most dangerous side effect that levamisole may have is a change in the blood composition and a weakened immune system, which may in turn cause potentially lethal infections. 19% of the samples bought as cocaine and submitted for analysis were regarded as posing considerable health risks (SHW 2017b).

Drug consumption rooms do not exist in Austria.

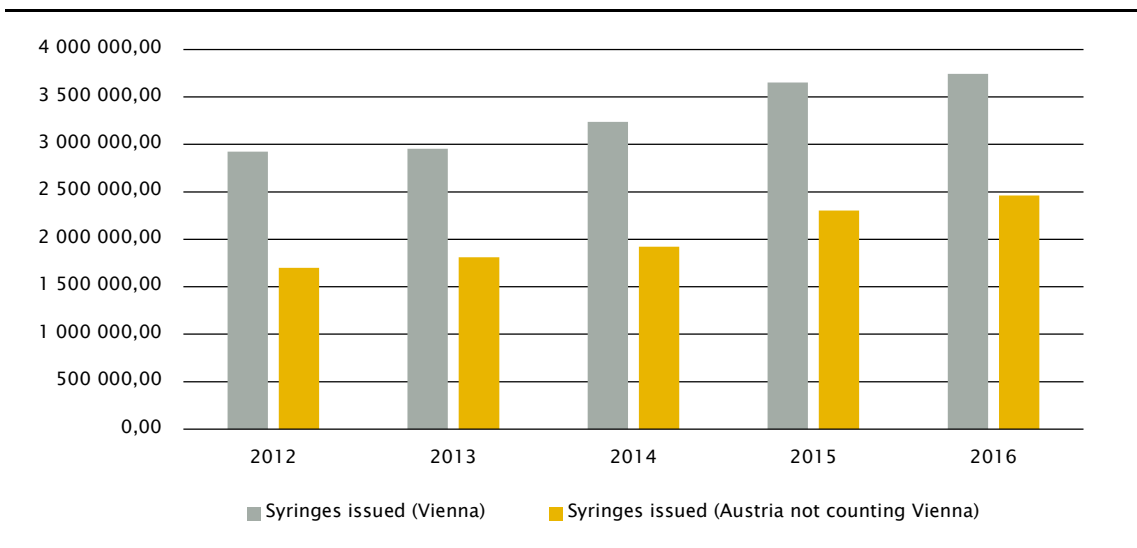
The guideline for the provision of advice, support and treatment to addicted pre-trial detainees, penal prisoners and detainees in non-punitive detention in Austria stipulates cooperation with local addiction support centres during the preparatory stage before release from prison. This cooperation is aimed at improving the transition between imprisonment and access to appropriate services after release, and has already been implemented in several prisons (BMJ 2015; see chapter 8).

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'This means that, in addition to the indicated active ingredient, at least one adulterant that influences the effect of the substance or poses a health risk was detected in the substance tested, or that the substance tested did not contain the indicated active ingredient.' (Z6/Drogenarbeit 2017).

The number of syringe sets issued in the context of syringe exchange or sale has been continually growing in the past five years, from 4 625 121 in 2012 to 6 205 356 in 2016 (see Figure 6.8 and Table A6. 6).

Figure 6.8:
Number of syringes issued in Vienna, and in Austria not counting Vienna; 2012–16



Source: ST10, Syringe availability

6.2.6 Targeted interventions for other drug-related health harms

The activities of many drug-related treatment centres include interventions with regard to psychiatric comorbidity (see Weigl et al. 2014). In this context, responses to young high-risk users continue to be discussed by experts. The treatment of clients suffering from psychotic disorders is a particular challenge for the support and treatment services, as these patients need psychiatric treatment in addition to addiction-related services. The issue of integrating people with addiction diseases into the general medical care system is gaining importance, against the background of a broad concept of addiction. For instance, in Styria the plans for outpatient (social) psychiatric care structures specifically take addicted patients into account in a separate chapter (Joanneum Research undated). The *framework plan 2016–20* of the province of Salzburg is another model of integrated care structures encompassing different substances, with services provided through the general health and social care system whenever possible, and with good coordination structures between medical treatment and psychosocial care provision. Links with low-threshold services are defined as a key area of action (Land Salzburg 2016).

Interventions and activities that focus on the general state of health of drug users are integrated into all services delivered by the drug support and treatment centres, with different focuses depending on the setting in question. Mental and physical health are central issues in the advice sessions at low-threshold agencies (see section 6.2.4).

At the *jedmayer* social medicine centre in Vienna, outpatient treatment in the form of single-caseworker support has been provided since 2014. It addresses addicted clients with multiple problems who are motivated to embark on individual stabilisation with regard to drug use, social situation and health. In 2016, 118 treatment modules were started. For 49 modules, the medical part (including opioid substitution treatment) was covered by the *Vienna ambulatorium* (SHW 2017a; Weigl et al. 2016).

In the context of *ambulatorium's* low-threshold basic medical services, 15 104 medical consultations were registered during the reporting year (SHW 2017a). The doctors at the *Kontaktladen* low-threshold centre in Graz reported 652 consultations with clients in 2016 (516 of them were men). The focus was on general medical treatment, treatment of drug-related conditions such as extravasation or purulent skin lesions, as well as testing and advice with regard to infectious diseases, such as harm reduction, safer use and hygiene measures (Caritas Diözese Graz-Seckau 2017a).

The Viennese *CONTACT* hospital liaison service provides advice and support to addicted patients of Viennese hospitals, and refers them to specialised addiction support services. In 2016, *CONTACT* provided services to 733 users of illicit substances. In the context of the *Alkohol. Leben können* [Alcohol – being able to live] programme, *CONTACT* has, since October 2014, also visited patients with alcohol addiction in several hospitals (SDW 2017).

6.2.7 Quality assurance of harm reduction services

Specific quality assurance standards for harm reduction interventions have not been defined either at the federal level or by the provinces. However, some of the quality assurance measures mentioned in chapter 5 apply, e.g. SDW's support guidelines, and centres officially published in accordance with SMG Section 15 (e.g. the *Vienna ambulatorium*), must meet certain quality criteria. The guidelines for harm reduction interventions in prison are described in chapter 8. For Vienna, a guideline on *quality standards for opioid substitution treatment* has been drawn up, which specifically mentions the treatment of psychological/psychiatric as well as physical comorbidity (see ÖGABS et al. 2017 and chapter 5).

In addition to Styria's *benzodiazepine guideline* and the *guideline on responses to harmful use and dependence on benzodiazepines among patients in oral opioid maintenance treatment* issued by the Ministry of Health (see Weigl et al. 2016), the Vienna Addiction and Drug Coordination Office has also issued a booklet with recommendations for the prescription of benzodiazepines. It is aimed at raising awareness of the problems connected with the prescription and use of ben-

zodiazepines, and at offering the doctors expert assistance and orientation with regard to approaches to benzodiazepines. The booklet describes the modes of action, indication areas and the treatment of benzodiazepine addiction (see SDW 2016 and chapter 5).

6.3 New developments

Compared to the previous year, the absolute number of drug-related deaths has again seen a slight rise, from 153 to 165 cases. The proportion of people aged under 25 among drug-related deaths has decreased to 15%, which is the smallest percentage of the past 10 years.

The proportion of stimulants involved in overdoses has remained stable over the past 10 years, at a rather low level. However, it has slightly increased compared to the previous year: amphetamines (including MDMA, methamphetamine and NPS containing cathinones) were detected in 14% of cases (as against 11% in the previous year). MDMA rose from 5% in 2015 to 7% in 2016. The figures for cocaine have remained roughly the same: 23% compared to 22% in the previous year (see Figure 6.3).

Opioid overdoses – including polydrug overdoses involving opioids – again accounted for slightly over 90% of all cases (91%). However, both methadone (10%) and morphine/heroin (67%) were detected less often than in 2015 (with 16% and 78% respectively).

In order to increase the drug users' awareness of the issue of hepatitis C and particularly the available treatment options, the *Kontaktladen* low-threshold centre in Graz started a hepatitis C campaign in 2016. For this purpose, posters were put up in public toilets in Graz in order to address drug users who had not visited *Kontaktladen* so far. In addition, safer-use packages and puncture-proof plastic containers for used syringes were issued, and two booklets on hepatitis C and safer use were published, which are available as hard copies and for download (see Caritas der Diözese Graz Seckau 2016, 2017b).¹¹⁴ In 2016, a total of 37 clients were referred to the Hör-gas-Enzenbach provincial hospital for further HCV treatment (Caritas Diözese Graz 2017a).

In Vienna, the cooperation between *ambulatorium*, the *Dialog* association and the 4th medical department of Wilhelminen Hospital has been expanded to include a few selected pharmacies in order to enable assisted access to services for a further group of opioid substitution patients (SHW 2017a).

In the reporting period, a regional interdisciplinary service network for problem substance users was established in Feldkirchen (Carinthia). This *addiction services network in Feldkirchen* was run as a pilot project with a duration of one year at first, and comprises social work services for the

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<https://www.caritas-steiermark.at/fileadmin/storage/steiermark/documents/Hilfe-und-Angebote/Menschen-In-Not/Ge-sundheit/Sucht/Kontaktladen/Aktuelles/hepatitis-c/20170314-HepCBroschuere-kontaktladen-c-caritas.pdf> (accessed 11 July 2017).

clients, including stabilisation of their situation in life (e.g. housing, financial problems), but its main goal is to make medical treatment available for several hours per week in Feldkirchen, which had been lacking until then. The project has met with much interest and will be extended. The provision of medical treatment on the spot has not been possible for lack of funding, but links to the nearest drug outpatient department have been established (Drobesch–Binter, personal communication).

In the reporting period, the following new developments with regard to harm reduction interventions have been reported.

In Summer 2017, an additional low–threshold contact point was opened in Steyr (Upper Austria). As well as basic services such as washing facilities, food and drink, it also offers exchange of syringes, psychosocial advice and basic medical treatment. Outreach social work to establish contact with the street scene is also part of its range of services (Schwarzenbrunner, personal communication).

January 2017 saw the second round of the Styrian further training course in *social psychiatry and addiction* organised by the addiction outpatient clinic of the Hochsteiermark provincial hospital and the addiction support centre of upper Styria on behalf of the Provincial Addiction Coordination Office of Styria (see Weigl et al. 2016, Ederer, personal communication).

6.4 Additional information

The 5th study days held by the *caritas akademie* of Caritas of the Diocese of Graz–Seckau, under the name *A good life – complex addiction services*, were aimed at improving the quality of life of addicted people. The study days were jointly organised by the Diocese and the I.K.A low–threshold centre in Graz.¹¹⁵

The electronic recording of accident data started in Austria in 2012 shows that alcohol, drugs and medicines are the probable main cause of only 3.8% of fatal road accidents. According to these statistics, the main causes are rather inattentiveness/distracted driving (30.6%) and speeding (24.1%), followed by non–yielding of the right of way to pedestrians (11.3%), overtaking (8%) and other reasons (BMVIT 2016).

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<https://www.caritas-steiermark.at/studientage/> (accessed 10 July 2017).

6.5 Sources and methodology

Sources

In Austria, the Ministry of Health has been collecting data on **drug-related deaths** (DRDs) since 1989. The corresponding reporting requirements are specified in section 24c of the Narcotic Substances Act: the Ministry of Health and Women's Affairs (BMGF) therefore receives information by the police on possible drug-related deaths, autopsy reports and confirmation-of-death certificates. For a classification of the 'verified cases' of DRD, the (forensic) autopsies that include chemical and toxicological analyses are used. In cases in which the post-mortem examination does not include an autopsy, the confirmation-of-death certificate is used for classification (non-verified cases). In addition to information from the police, Statistics Austria provides a separate list of cases entered as drug deaths in the general cause-of-death statistics. The term 'directly drug-related death' refers to people whose death is a direct consequence of narcotic drug use, i.e. caused by acute drug poisoning (overdoses; SMG section 2). The annual statistics also include fatal overdoses of NPS, which are, however, counted separately.

The data collected are entered into an online registry and are analysed annually. At its meeting in November 2016, the working group¹¹⁶ on drug-related deaths discussed overdoses of prescription-only analgesics containing opioids (without the involvement of other narcotic drugs). The background to the discussion is that the statistics and analyses of drug-related deaths are oriented towards studying high-risk drug use – which, combined with four additional epidemiological key indicators, permits an assessment of the drug situation. Persons outside the 'drug scene' who, for instance, commit suicide using a prescription-only opioid (but none of the substances covered by the SMG or the NPSG) are not counted in this context. The working group thus decided not to include in the statistics those cases where there is strong doubt (based on a combination of various indications) as to whether the person was a member of the drug scene. However, for reasons of transparency and in order to keep track of the development of the situation, such cases are described separately. Regarding deaths in 2016, eight persons who died after an overdose of prescription-only analgesics containing opioids (e.g. fentanyl or tramadol) without any other opioids involved were excluded from the statistics, as there was no indication of contact to the drug scene. Two persons who died due to drug overdoses in 2016 were non-Austrian nationals and had no place of residence in Austria. As in previous years, such cases have not been included in the statistics because they do not permit any conclusions with regard to the current drug situation in Austria. In another case of possible drug involvement, the body was putrefied and the cause of death could thus not be determined.

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This working group, which meets annually, is composed of experts from various fields (addiction support services, BMGF, BMJ, BMI, forensic institutes) who discuss current topics connected with drug-related deaths.

As data from various sources are included (Ministry of the Interior, forensic institutes, private forensic experts, health administration authorities of all provinces, and Statistic Austria) it is safe to assume that the statistics on drug-related deaths cover all cases.

Austria has no uniform definition of, and does not routinely collect data on, **drug-related emergencies** either at the federal or at the provincial level. Data on prevention and reduction of emergencies in party settings are presented in the annual reports of the *checkit!* and *Z6/Drogenarbeit* services (see also chapter 3).

The data on **infectious diseases** among injecting drug users are inadequate; they are not by any means representative (see ST9) and only refer to samples from treatment centres or low-threshold services, as well as to the statistics on drug-related deaths. The two main data sources are the DOKLI nationwide documentation system of clients of Austrian drug services (see also chapter 5) and the reports from three drug services (*Vienna ambulatorium*, *Lukasfeld* treatment unit in Vorarlberg and *Kontaktladen* in Graz). In both cases, not all clients are tested, and one has to take into account that the motivation for testing can depend on the status of infection of the client in question. The DOKLI data on tested clients are gathered on a voluntary basis and only sporadically, and thus cannot be regarded as representative. While such a bias does not apply to drug-related deaths, the problem here is that not all autopsy reports specify whether or not HCV and HIV infections were found, and this group of drug users are likely to have followed high-risk patterns of use. The autopsy reports do not include information on HBV and TB. The lack of a reliable monitoring system for drug-related infectious diseases is a considerable limitation and makes it very difficult, or impossible, to provide statements on incidence, prevalence, as well as trends. In order to obtain reliable figures on the prevalence of infectious diseases in persons with drug problems, it would be very important to improve the national monitoring routines.

The data on immunisation coverage come from DOKLI. They are based on information that is provided voluntarily by the clients and may thus be of limited reliability. Data on general vaccination rates regarding hepatitis A and B are given in the *2009 health report on Austria* (GÖG/ÖBIG 2009). However, they relate to the year 2007 and are thus useful only to a limited extent.

The *Action Hepatitis C* database was established in 2004 in order to obtain more insight into the epidemiology of hepatitis C in Austria. The participating centres registered and documented cases of chronic hepatitis C. The data thus generated provided useful information on questions such as possible infection routes and genotype distribution. Regrettably, the database was closed at the end of 2014 due to the continually decreasing amount of data provided by the participating centres. The latest analysis, which is still fairly representative, dates back to 2012, and has been used for the present report (Bauer, personal communication).

2016 saw the publication of a study on the current data situation regarding the incidence and prevalence of hepatitis C in Austria. It describes databases and data sources from the areas of addiction and health reporting with regard to hepatitis C, analyses the available data and relates them to each other. In addition, a scenario for improving the data situation has been created. The report on the study includes a chapter on hepatitis C among injecting drug users, and provides an

overview of data from 2000 to 2004 drawn from DOKLI, individual support and treatment services, and the statistics on drug-related deaths (Schmutterer/Busch 2016).

No routine data on **harm reduction interventions** and psychiatric comorbidity in the context of drug addiction are available. The information provided is primarily based on annual reports of low-threshold services. Regrettably, these data sources have become increasingly scarce in recent years. *Standard Table 10* gives annual figures on syringe exchange and syringes issued (see Table A6. 6, ST10 and SQ 23/29).

Methodology

At present, the most important information on HIV epidemiology in Austria comes from the Austrian HIV cohort study (AHIVCOS), which currently includes data from eight treatment centres. The Austrian HIV cohort study was started in 2001 at five Austrian HIV treatment centres (General Hospital Vienna, Vienna Otto Wagner Hospital, General Hospital Linz, Provincial Hospital Innsbruck and the Provincial Hospital Graz-West). Since 2008, the Provincial Hospitals of Salzburg and Klagenfurt have also taken part in AHIVCOS. In 2016, Vienna's Kaiser Franz Josef Hospital was included. A special software (HIV Patient Management System) was developed for the study. By 1 July 2016, a total of 8 914 patients with HIV infections had been included in the cohort. The study team assumes that the cohort covers 76% of all HIV patients in anti-retroviral treatment (ART) and about 60% of all patients with HIV infections (including undiagnosed cases) in Austria. The study analyses both the presumed modes of transmission and sociodemographic characteristics of clients, as well as numerous medical parameters. Other behaviour-related data on injecting drug users have not been covered by the study (AHIVCOS 2016).

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6.7 Referenced Federal and Provincial Acts

SMG BGBl. I 1997/112. Bundesgesetz über Suchtgifte, psychotrope Stoffe und Drogenausgangsstoffe (Suchtmittelgesetz – SMG)

6.8 Personal communications (alphabetical order)

Name	Institution or function
Bernd Bauer	Hörgas-Enzenbach Provincial Hospital
Bernhard Benka	Federal Ministry of Health and Women's Affairs
Barbara Drobesch-Binter	Agency for Addiction Prevention, Carinthia
Klaus Peter Ederer	Addiction Coordinator, Styria
Hans Haltmayer	Suchthilfe Wien addiction services
Thomas Schwarzenbrunner	Drug Coordinator, Upper Austria
Robert Zangerle	Innsbruck University Hospital, Department of Dermatology and Venereology

6.9 Annex

Table A6. 1:
Number of directly drug-related deaths in Austria, by cause of death; 2007–16

Cause of death	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Opioid poisoning	9	13	18	13	11	11	10	10	6	7
Polydrug poisoning involving opioid(s)	138	136	153	148	151	111	103	85	107	120
(Polydrug) poisoning involving narcotic drug(s) or NPS without opioid(s)	5	4	1	0	8	8	6	7	10	13
Fatal poisoning of unknown type	23	16	15	9	7	9	3	0	3	6
Verified directly drug-related deaths, total	175	169	187	170	177	139	122	102	126	146
Drug-related deaths without verification by autopsy ¹	–	32	19	17	24	22	16	20	27	19
Drug-related deaths, total	175	201	206	187	201	161	138	122	153	165

¹ see GÖG/ÖBIG 2010

Source: Statistics on drug-related deaths; calculation and graphic representation: GÖG

Table A6. 2:
Directly drug-related deaths 2007–16, by province (per 100 000 persons aged 15 to 64)

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Burgenland	2.7	0.5	0.5	3.2	2.1	1.0	0.5	1.0	1.6	1.6
Carinthia	1.1	1.9	1.6	1.6	1.1	1.9	1.9	1.4	2.4	3.0
Lower Austria	2.6	3.3	2.7	2.9	2.7	2.1	1.8	0.8	1.9	1.4
Upper Austria	1.3	3.0	3.0	1.3	1.5	2.0	1.5	0.6	0.8	1.6
Salzburg	0.8	3.1	3.6	5.0	1.7	2.7	1.1	1.1	0.6	1.4
Styria	2.0	2.6	1.2	1.4	2.0	0.9	0.7	1.3	1.1	1.6
Tyrol	2.3	3.8	3.1	3.7	4.7	2.9	2.9	2.4	2.8	4.8
Vorarlberg	2.8	0.8	5.6	4.0	3.2	2.8	4.0	3.2	5.9	4.3
Vienna	7.8	6.6	7.7	6.4	8.2	6.0	5.3	5.4	5.8	5.3
Unknown	–	–	–	–	–	–	–	–	–	–
Austria	3.1	3.6	3.7	3.3	3.5	2.8	2.4	2.1	2.6	2.8

Source: Statistics on drug-related deaths, ST.AT – population statistics; calculation and graphic representation: GÖG

Table A6. 3:
Directly drug-related deaths 2007–16, by province

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Burgenland	5	1	1	6	4	2	1	2	3	3
Carinthia	4	7	6	6	4	7	7	5	9	11
Lower Austria	27	35	29	31	29	23	19	9	21	15
Upper Austria	12	28	28	12	14	19	14	6	8	16
Salzburg	3	11	13	18	6	10	4	4	2	5
Styria	16	21	10	11	16	7	6	11	9	13
Tyrol	11	18	15	18	23	14	14	12	14	24
Vorarlberg	7	2	14	10	8	7	10	8	15	11
Vienna	90	77	90	75	97	72	63	65	72	67
Unknown	0	1	0	0	0	0	0	0	0	0
Austria	175	201	206	187	201	161	138	122	153	165

Source: Statistics on drug-related deaths; calculation and graphic representation: GÖG

Table A6. 4:

Number of (verified) directly drug-related deaths in Austria (by age group, total and by gender); 2007-16

Age group	2007		2008		2009		2010		2011		2012		2013		2014		2015		2016	
	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%	abs.	%
Aged 19 and under	24	13.7	22	13.0	18	9.6	12	7.1	23	13.0	10	7.2	6	4.9	9	7.4	4	2.6	10	6.1
Aged 20-24	46	26.3	45	26.6	39	20.9	36	21.2	33	18.6	23	16.5	18	14.8	14	11.5	28	18.3	15	9.1
Aged 25-29	23	13.1	37	21.9	35	18.7	41	24.1	31	17.5	31	22.3	34	27.9	22	18.0	21	13.7	25	15.2
Aged 30-34	35	20.0	21	12.4	28	15.0	17	10.0	29	16.4	25	18.0	31	25.4	15	12.3	34	22.2	35	21.2
Aged 35-39	22	12.6	16	9.5	22	11.8	17	10.0	13	7.3	15	10.8	11	9.0	14	11.5	19	12.4	26	15.8
Aged 40 and over	25	14.3	28	16.6	45	24.1	47	27.6	48	27.1	35	25.2	22	18.0	48	39.3	47	30.7	54	32.7
Total	175	100.0	169	100.0	187	100.0	170	100.0	177	100.0	139	100.0	122	100.0	122	100.0	153	100.0	165	100.0
No DRD verification by autopsy¹	-	-	32	-	19	-	17	-	24	-	22	-	16	-	20	16.4	27	17.6	19	11.5
Male	136	77.7	134	79.3	150	80.2	140	82.4	135	76.3	111	79.9	98	80.3	97	79.5	114	74.5	127	77.0
Female	39	22.2	35	20.7	37	19.8	30	17.6	42	23.7	28	20.1	24	19.7	25	20.5	39	25.5	38	23.0

¹ Due to the decrease in autopsy rates since 2008, cases not verified by autopsy have been listed separately as of that year. Since 2014, these cases have also been integrated into the statistics.

Source: Statistics on drug-related deaths; calculation and graphic representation: GÖG

Table A6. 5:

Development of substances detected among directly drug-related deaths (confirmed by toxicological analysis); 2007-16, percentages

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Heroin/morphine	82	90	91	83	76	82	72	75	78	67
Other opioids	22	22	18	27	23	21	19	24	25	26
Methadone	20	10	12	17	18	13	19	15	16	10
Cocaine	25	22	13	16	15	15	22	17	22	23
Amphetamines ¹	5	7	9	6	6	7	9	8	11	14
of these: methamphetamine	0	1	1	0	1	2	2	4	2	4
Psychopharmaceuticals	72	77	76	77	81	73	81	75	82	77
Alcohol	36	37	33	35	33	38	29	23	37	36

¹ The category of amphetamines includes amphetamine, methamphetamine, MDMA/MDA/MDE, mephedrone/3MMC and NPS of the amphetamine group (e.g. 4-methylethylcathinone and other cathinones).

Source: Statistics on drug-related deaths; calculation and graphic representation: GÖG

Table A6. 6:

Exchange and sale of syringes by number of provision points and province; in 2016

Province	Number of syringe provision points	Number of vending machines	Number of syringes provided (exchanged or sold)
Burgenland	0	0	0
Carinthia	2	0	71 223
Lower Austria	0	0	0
Upper Austria	4	3	617 516
Salzburg	1	2	8 000 ¹
Styria	2 ²	3	813 389
Tyrol	2	6	540 492
Vorarlberg	4	7	411 801
Vienna	3 ²	0	3 742 935
Total	18	21	6 205 356

¹ Estimate.² Includes one streetwork service.

Source: ST10 Syringe availability 2017; calculation and graphic representation: GÖG

Drug market and crime

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7 Drug market and crime

7.1 Summary

National profile

Austria is a country of drug use and drug trafficking, and due to its geographical situation on the Balkans route, at the same time a drug transit country as well. In addition, Vienna International Airport serves as a pivot of drug smuggling. The importance of virtual drug markets has generally been found to increase, which increasingly influences the behaviour of both traders and users. Drug manufacturing (of cannabis and synthetic drugs) plays a minor role in Austria.

In 2016, a total of 35 857 crime reports in Austria concerned narcotic drugs, and the majority of those (30 184) related to cannabis or cannabis combined with other narcotic drugs. The number of reports due to misdemeanours (33 704) was higher by far than the reports due to felonies¹¹⁷ (2 153). Any changes in the number of crime reports can also be connected with the amendment to the SMG that entered into force in 2016.

In 2016, a total of 27 896 reports concerned driving under the influence of alcohol, compared to 1 491 reports relating to impaired ability to drive due to narcotic drugs.

Measures aimed at reducing drug supply are taken by the police. Apart from surveillance, they also comprise the confiscation of drugs and of medicines containing psychotropic substances. This also includes seizures of new psychoactive substances. Enterprises that manufacture, or trade with, precursor substances must inform the Drug Precursor Reporting Agency (new name since 1 May 2016: Precursor Competence Center) at the Federal Criminal Agency whenever they suspect that substances have been diverted for the illegal production of narcotic substances. In addition, international projects have increasingly focused on drug trafficking in the *deep web* or *darknet*. A task force specialising in illicit drug trafficking in the darknet has also been established.

Trends

The development of crime reports indicates increases with regard to certain substances such as ecstasy and cannabis. Seizures of both substances have also increased. The number and quantities of medicines containing narcotic drugs (including substitution medicines) seized have declined.

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Misdemeanours relate to illicit handling of drugs (SMG Section 27) and felonies to preparation for drug trafficking (SMG Section 28), as well as drug trafficking itself (Section 28a). However, the offence described under Section 28, para. 1 cannot in fact be classified as a felony. In order to avoid unnecessary complication, here all crime reports relating to violations of Sections 28 and 28a of the SMG are referred to as 'felonies', and all reports relating to Section 27 are referred to as 'misdemeanours'.

Whereas the maximum (street-level) prices – particularly of amphetamine, methamphetamine and ecstasy – rose up to 2014, the maximum price of ecstasy has halved from 2015 to 2016.

Average (street-level) purity has further increased for all substances (particularly cocaine and methamphetamine) except cannabis resin, amphetamine and ecstasy.

New developments

In 2015 and 2016, interviews with drug users were conducted in the context of a KIRAS project (i.e. the VIDRO project) on virtual drug trafficking to survey their experience of drug purchases on the internet (Schmutterer 2016). The results of the overall VIDRO project, as well as of the German DROK partner project (on organised crime and drug trafficking) were presented at a concluding conference in November 2016.¹¹⁸

7.2 National profile

7.2.1 Drug markets

Domestic production of drugs in Austria

Austria is a country of drug transit and drug use but does not play a significant role as a country where illicit drugs are produced. The quantities of cannabis of Austrian origin are in no way comparable to those from typical producing countries such as Morocco. The majority of producers in Austria grow between 10 and 100 cannabis plants. Professional indoor cultivation with over 10 000 plants is the exception: two large-scale seizures in Lower Austria (10 600 plants) and Vienna (several thousand plants and seedlings) have been recorded. Cannabis grown in smaller units is mostly intended for personal use or small-scale trafficking. Outdoor cultivation of cannabis plays a minor role in Austria, probably also due to climatic reasons (BMI 2015, BMI 2017).

In 2016, a total of 9 laboratories for the production of illicit synthetic substances were discovered, in Lower Austria (2), Upper Austria (3), Salzburg (1) and Vienna (3). They mainly focused on synthesising methamphetamine and amphetamine. The narcotic substances produced were intended for personal use or for a limited regional group of buyers (BMI 2017).

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For details of the papers presented please visit

<http://www.frankfurt-university.de/fachbereiche/fb4/forschung/forschungsinstitute/isff/veranstaltungen.html>.

Routes of trafficking for drugs imported into Austria

Heroin is primarily transported to Western Europe via the traditional Balkans route, through Turkey, Bulgaria, Serbia, Croatia, Slovenia and Austria. The Austrian black market for cocaine is supplied through Vienna International Airport, with the cocaine coming from Southern and Central America. Cocaine is also transported by train and long-distance bus. Cannabis products, both for personal use and for trafficking, are mostly produced in Albania, and to an increasing extent, in Austria. Morocco is a source mainly of cannabis resin, which is smuggled to Austria via Western Europe (Spain and France). Amphetamine, ecstasy and MDMA are mainly imported to Austria from the Netherlands, through Germany, and part of the amphetamine also comes from Poland, via the Czech Republic or Germany. Methamphetamine is easily available as numerous labs are operated in Slovakia and the Czech Republic. *New psychoactive substances* have increasingly often been ordered on the internet, from Chinese sources, and delivered by post or as parcels from Europe and Asia, on a prepayment basis. Precursor substances¹¹⁹ are also ordered on the internet, usually in large quantities, rather than obtained through traditional trade (BMI 2015. BMI 2017).

Wholesale drug and precursor market

Table 7.1 below provides an overview of the wholesale prices of various drugs. For each drug, minimum and maximum prices, as well as typical prices, are given.

Table 7.1:

Prices (EUR per kilogram or per 1 000 pills) of various drugs at wholesale level in Austria; in 2016

		Herbal cannabis*	Cannabis resin*	Brown heroin*	Cocaine*	Amphetamine*	Methamphetamine*	MDMA (ecstasy)**
Price	Minimum	1 500	2 500	18 000	40 000	1 500	20 000	1 000
	Maximum	8 000	8 000	70 000	80 000	20 000	60 000	9 000
	Typical	4 000	4 000	25 000	50 000	7 000	35 000	6 000

* Price per kilogram.

** Price per 1 000 pills.

The data on wholesale prices provided by the Ministry of the Interior are based on information obtained by undercover police agents and during interrogations. No statistics on the number of cases/samples and their assessment have been made available.

Source: BMI/.BK; graphic representation: GÖG

Retail drug market and purity of illicit substances

Table 7.2 provides information from the BMI on the purity and street-level prices of various drugs (see also ST14 and ST16). Here, considerable variations regarding both purity and price are apparent.

Table 7.2:
Purity and street-level prices (EUR per gram/pill/unit) of various drugs in Austria; in 2016

		Herbal cannabis*	Cannabis resin*	Brown heroin*	Cocaine*	Amphetamine*	(Meth-)amphetamine*	Ecstasy**
Purity	Minimum	0.62%	0.25%	0.11%	0.11%	0.06%	0.09%	0.1 mg
	Maximum	33.49%	52.31%	57.36%	87.69%	82.05%	81.9%	88.27 mg
	Median	10.92%	13.45%	12.76%	43.01%	8.48%	64.03%	40.29 mg
Price	Minimum	6	6	25	50	10	25	3
	Maximum	15	20	90	150	60	130	15
	Typical	8	8	60	100	40	90	7

* Price per gram.

** Price per pill.

The data on prices provided by the Ministry of the Interior are based on information obtained by undercover police agents and during interrogations.

The purity of cannabis products is given as % THC, and the purity of ecstasy as mg MDMA base per unit.

Source: BMI/.BK; graphic representation: GÖG

In the context of the *checkit!* project, 1 219 samples were analysed for psychoactive substances in Vienna and Lower Austria in 2016¹²⁰. The samples were submitted for testing during 14 recreational events or, in the case of imminent danger, directly at the homebase. A proportion of 18% of the samples analysed contained the expected ingredients in the 'anticipated' dose. Another 33% contained the expected ingredient, but in very high doses. Approximately one in three (34%) of the samples contained unexpected ingredients, and in the case of 15% of the samples, it was necessary to warn users due to highly hazardous ingredients (SHW 2017 and chapter 6).

Approximately 89% of the total of 328 samples **bought as 'ecstasy' and submitted for testing** did not contain pharmacologically active substances other than the expected ingredient of MDMA¹²¹ (or MDE/MDA; see Table A7. 9). None of the pills sold as ecstasy that were tested in the reporting year contained paramethoxyamphetamine (PMA)¹²². Approximately 84% out of a total of 166 samples bought as '**MDMA**' in powder, crystal or capsule form that were handed over for analysis

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1 217 samples were included in the regular analysis.

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3,4 methylenedioxy-N-methylamphetamine.

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In the past, paramethoxyamphetamine (PMA) and paramethoxymethylamphetamine (PMMA), a substance related to PMA, have in several instances led to the death of users in Europe, including Austria.

contained only the expected ingredients (see Table A7. 10). In approximately 9% of samples, substances of the NPS group were detected. Approximately 25% of the 289 samples bought as '**speed**' and analysed by *checkit!* contained only amphetamine as their sole pharmacologically active component. A combination of amphetamine and caffeine was identified in 59% of samples) (see Table A7. 11). The proportion of speed samples in which *new psychoactive substances* (NPS) were detected was 1%. None of the samples were found to contain methamphetamine.

Around 26% of a total of 211 samples **bought as 'cocaine'** and analysed by *checkit!* actually contained cocaine without any other pharmacologically active substance. Many samples contained more than two unexpected ingredients, and usually the pharmaceutical levamisole was among those substances.

New psychoactive substances (NPS) were detected in almost 5% of all samples tested, either as an expected or as an unexpected ingredient. In 3.2% of the samples, NPS were identified as an unexpected ingredient. The proportion of samples bought as NPS and handed over for testing was 1.6% in 2016.

In 2015, the drug-checking pilot project in Tyrol which had been started in March 2014 was integrated into the regular services of the Z6 drug support centre, and is operated in cooperation with the Innsbruck Department of Forensic Medicine and *checkit!* in Vienna. During the reporting year, 286 samples were submitted for testing at *MDA basecamp* (see Drogenarbeit Z6 2017 and chapter 6).

A proportion of 73% of a total of 51 samples bought as '**ecstasy**' contained (extremely) high doses (over 100 mg). One sample that was supposed to contain **MDMA** in powder or crystal form actually did not contain MDMA, and five samples were adulterated. Their average purity was 71%, which is considerably below the percentage found in *checkit!* tests in Vienna (84%). One of the 57 supposed to be **speed** and handed over for testing did not contain amphetamine; however, almost all samples (53) also contained adulterants – 51 of them at least caffeine. Again, the degree of purity (approx. 20%) was below the degree determined in Vienna (25%). All of the 58 samples supposed to be **cocaine** actually contained cocaine, but 39 of them were adulterated. 30 samples were both adulterated and contained high doses of cocaine. The average degree of purity was approx. 63%. 25 samples were submitted to *MDA basecamp* as NPS – however, four of them contained other substances.

During the reporting period, the Austrian Agency for Health and Food Safety (AGES) analysed three samples that had been seized by the police or customs authorities due to suspected violation of the *New Psychoactive Substances Act* (NPSG) and that actually contained NPS. The substances identified included plant material, MDMB-CHMICA, AB-FUBINACA and mitragynine (kratom).

In 2016, a total of 165 samples were analysed by the Federal Criminal Agency in connection with suspected violation of the NPSG, and the results were reported to the Austrian information and early warning system on specific health hazards in the context of illicit substance use, to enable monitoring. A total of 100 different substances or combinations of substances were identified.

The substance most frequently detected was GBL, i.e. in 13% of all samples, followed by ketamine (10%) The proportions of all other substances found were under 5%.

7.2.2 Drug-related crime

Drug law offences

In 2016, 36 235 crime reports related to violation of the Narcotic Substances Act (SMG; see also Table A7. 1). A total of 35 857 reports concerned narcotic drugs (see also Table A7. 2). The other 378 reports related mostly to psychotropic substances (see Table A7. 3). Regarding type of report (see Figure 2.3), it is apparent that the number of reports that concern misdemeanours (33 704; illicit handling of narcotic drugs/SMG Section 27) are significantly more frequent than reports due to felonies (2 153; preparation for drug trafficking/SMG Section 28, or drug trafficking/SMG Section 28a).

In terms of substances involved (see Table A7. 5 and Figure 7.4), crime reports relating to cannabis or cannabis combined with other narcotic drugs account for more than four out of five reports (30 184). Reports relating to cocaine and crack (3 211; approx. 9%) rank second, followed by reports due to amphetamine, heroin and opioids (approx. 6% each). Proportions (considerably) under 4% are accounted for by the other individual substances. In 2016, the number of crime reports due to violations of the *New Psychoactive Substances Act* (see Table A7. 4) played an insignificant role (78 reports) compared to the other substances.

In 2016, a total of 36 235 crime reports led to 2 285 detentions in connection with the Narcotic Substances Act. However, no further details regarding these detentions, such as type of offence or substances involved, can be provided. Any changes in the number of crime reports can also be connected with the 2016 amendment to the SMG (see chapter 2).

Drug-related crime outside of drug law offences

Data on drug-related crime that does not relate to drug legislation, e.g. offences to support drug habits and other offences associated with drug use, are provided in the 2014 report on the drug situation (Weigl et al. 2014). This type of offence has primarily been registered in large cities. Many victims do not report such offences for fear of subsequent charges against themselves.

The Federal Ministry of the Interior provides data on crime reports relating to driving while in an impaired mental state (Road Traffic Act section 5) broken down by drugs and alcohol, as well as crime reports relating to Section 14 (8) of the Driving Licences Act (Schranz, personal communication and Schmid, personal communication). Further available data concern the temporary withdrawal of driving licences or moped permits in accordance with Driving Licences Act (FSG) Section 39, which, however, are not disaggregated by offence: in 2016, 14 789 temporary withdrawals were registered, as against 14 207 in 2015 and 17 290 in 2014 (Schranz, personal communication). Table 7.3 below lists the number of crime reports relating to Section 5 of the Road Traffic

Act (StVO), i.e. driving under the influence of narcotic drugs or alcohol in Austria, from 2014 to 2016. The number of reports relating to drunk driving is many times higher than reports relating to drugs. One has to bear in mind that these figures also reflect activities on the part of the police (e.g. special operations) as well as the available technological equipment (e.g. preliminary drug-analysing devices).

Table 7.3:

Number of crime reports relating to alcohol in accordance with StVO Section 5 and FSG Section 14(8), as well as relating to narcotic drugs in accordance with StVO Section 5; 2014–16

Reports	2014	2015	2016
Narcotic drugs in road traffic (StVO Section 5)	847	1 068	1 491
Alcohol in road traffic (StVO Section 5 and FSG Section 14(8))	33 418	26 327	27 896
Total	34 265	27 395	29 387

Source: BMI; graphic representation: GÖG

7.2.3 Drug supply reduction activities

In Austria, measures aimed at reducing drug supply are taken by the police. As well as surveillance, they also comprise the confiscation of drugs and of medicines containing psychotropic substances. Three out of four seizures in 2016 (16 697) related to cannabis, followed by cocaine (1 315, i.e. approx. 6%) and amphetamine (828; approx. 4%). The seizures of other substances are (sometimes considerably) lower than these figures (see Table A7. 7). For instance, as a result of seizures in 2016, approx. 1 082 kg of cannabis products (not counting cannabis plants), almost 30 000 ecstasy pills and 4 820 units of medicines containing narcotic drugs were confiscated (see Table A7. 8). The Federal Ministry of the Interior has not been able to provide definitive figures for seizures of *new psychoactive substances* in 2016.

The diversion of certain chemicals that can be used for the illicit production of narcotic substances (e.g. synthetic drugs such as ecstasy) can be reported to the Federal Criminal Agency. Enterprises that manufacture, or trade in, precursor substances must inform the Drug Precursor Reporting Agency (new name since 1 May 2016: Precursor Competence Center) at the Federal Criminal Agency whenever they suspect that substances have been diverted for the illegal production of narcotic substances (BMI 2015 , BMI 2016a, and BMI 2017).

Further information on the availability of drugs has been provided in the 2014 report on the drug situation (Weigl et al. 2014). The report described how easy/difficult it is from the point of view of young people in Austria to obtain illicit drugs, alcohol or cigarettes.

Activities to reduce drug supply are organised by the Federal Ministry of the Interior (Federal Criminal Agency, Subdepartment 3.3/Drug-Related Crime). At the provincial level, this is the task of the nine provincial criminal agencies in charge of drug crime. The drug crime departments of city police directorates are also active in this field. And finally, drug supply reduction is one of the tasks of every police station (Mader, personal communication). In sum, 10 criminal prosecution

units in Austria, with approximately 350 specially trained officers, are working in the area of drug law enforcement, which is slightly less than 1.5% of the entire police staff. The officers who permanently work in the drug crime sector are part of the criminal investigation department. Further information in this field is provided by an EMCDDA publication on this theme (EMCDDA 2013).

Austria has participated in several international projects aimed at combating drug-related crime: for instance, from February 2015 to January 2017 Austria and Germany cooperated in the JICDT-VM project Joint investigation to combat drug trafficking via the virtual market (darknet) within and also into the EU. Its focus was on drug trafficking on the darknet¹²³ and the close cooperation of drug police agents and undercover agents in both real life and in the virtual world, as well as between IT experts and cyber crime investigators (see also T3; BMI 2016b, BMI 2017).

7.3 Trends

Short-term trends

The following section discusses long-term developments with regard to seizures, prices and purity of illicit substances, as well as crime reports connected with those substances in Austria. Short-term trends are not discussed here.

Long-term trends

The trends described below primarily reflect the intensity and focuses of police activities (BMI 2016a).

Figure 7.1 illustrates the trend concerning seizures over the past 10 years. Slight declines have become apparent for mephedrone, medicines containing narcotic drugs and precursor substances. For all other substances, increases to different degrees have been recorded: the number of cannabis and amphetamine seizures have more than doubled since 2012 (see Table A7. 7).

The **quantities of cannabis confiscated** have been fairly stable during the past 10 years, with only small variations (see Table A7. 8). The above rise in the number of seizures indicates that cannabis quantities per seizure have massively decreased. In the case of the other substances seized, the corresponding quantities have occasionally varied considerably over time (see Table A7. 8). The rise in the quantities of ecstasy seized has been particularly high. Increases, e.g. regarding ecstasy

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In computer science, the term 'darknet' refers to a digital network whose users create connections between them **manually**. This distinguishes the darknet from conventional networks, where contact with the clients of unknown users is usually initiated **automatically and randomly**. Security on the darknet is thus much greater for the users as it is not easily possible for attackers to access the network, and in the most darknet-favourable conditions, they do not even know of the existence of the network, which is mainly used for illicit trade. In order to integrate new users into the darknet, they have often to be invited or accepted by its users. In some cases, only participants with higher privileges can add new members.

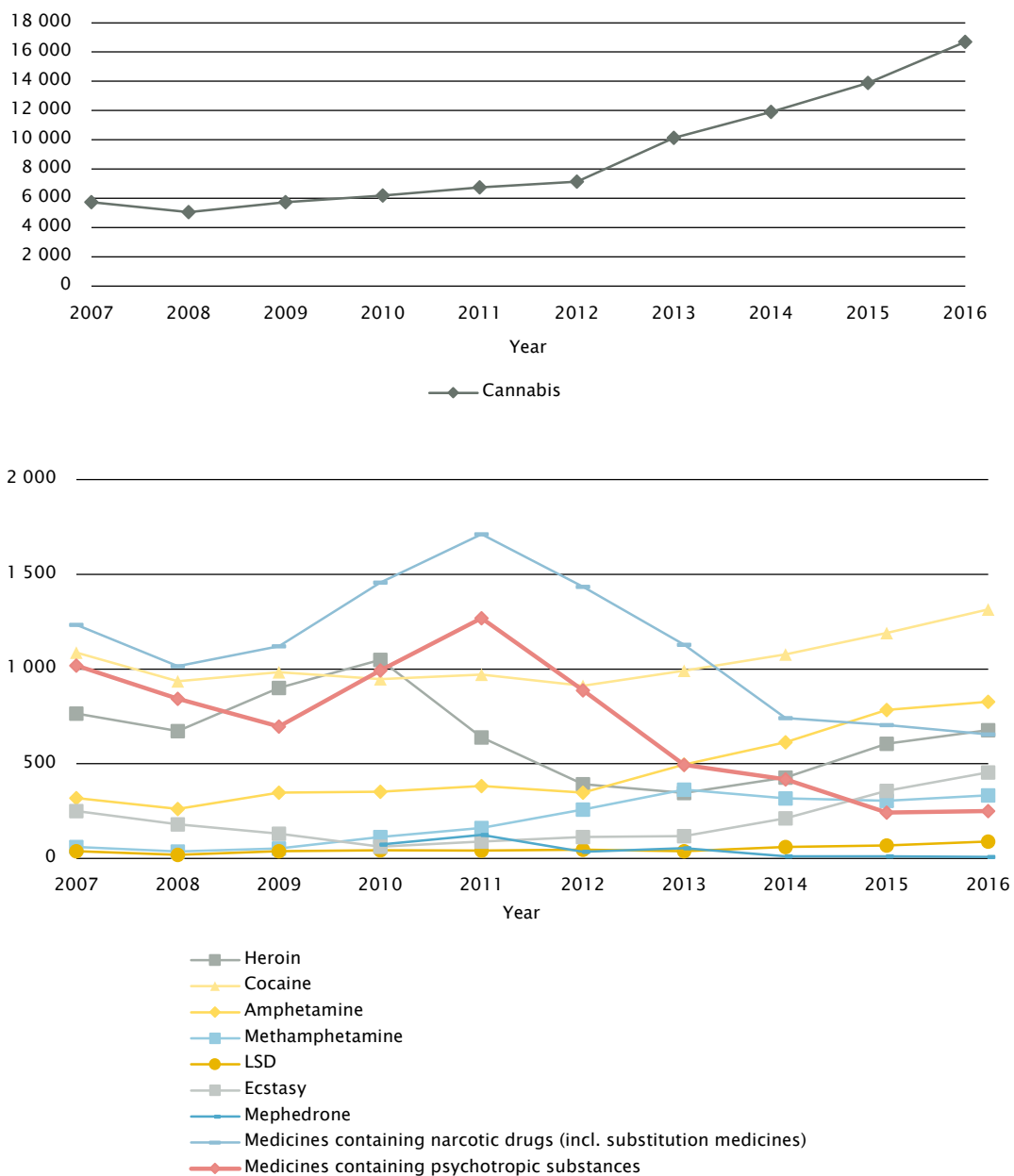
and amphetamine, often go hand in hand with an increase in the corresponding crime reports (see Table A7. 5). However, one has to bear in mind here that individual seizures of large amounts, which are not necessarily intended for Austria (transit), can distort the general picture.

2016 saw a massive increase in the seizures of drugs and new psychoactive substances that were dispatched and transported by mail (+50%) and express delivery service. The quantities confiscated in single seizures have also risen: amphetamine seizures amounting to 100 grams per shipment have been more frequent. On average, approximately 1 to 10 grams of illicit drug or new psychoactive substance are found per seizure. The corresponding substances are primarily ordered by young people on the internet or darknet, paid for with the virtual bitcoin¹²⁴ currency and transported by mail or express delivery service. The senders are usually located in Spain, the Netherlands, Belgium and China. In the case of one Austrian dealer of illicit drugs sold through the darknet, 300 grams of amphetamine was seized initially (in Germany). Finally, proof of a total ordering quantity of 5 kilograms of amphetamine, intended for sale in Vorarlberg, was established (BMI 2017).

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Bitcoin is the digital currency unit of a worldwide decentralised payment system. Transactions take place on the internet, through a network of connected computers, based on a special peer-to-peer system, so that – unlike traditional bank transactions – no central repository is needed. Credentials for bitcoin holdings are stored in one's personal digital wallet. The exchange rate against other currencies depends on demand and supply.

Figure 7.1:
 Number of seizures of narcotic drugs and medicines containing psychotropic substances in
 Austria; from 2007-16



Due to the large amounts of cannabis confiscated, the corresponding figures are provided in a separate diagram.

Source: BMI/.BK; graphic representation: GÖG

Parallel to quantities, the black market prices of the main substances seized have also greatly fluctuated over time (see Table 7.4).

Table 7.4:
Black market value of substances seized (in EUR); 2007-16

Substance	2007	2008	2009	2010	2011	2013	2014	2015	2016
Cannabis	12 763 000	8 738 000	11 390 000	12 920 000	9 200 000	14 934 500	10 608 000	9 112 000	8 936 000
Heroin	9 953 500	8 320 000	18 960 000	6 720 000	3 888 000	4 800 000	3 360 000	4 176 000	4 080 000
Cocaine	4 295 500	7 056 000	7 462 000	28 920 000	12 510 000	1 875 000	3 100 000	11 970 000	8 640 000
Ecstasy	661 675	453 345	58 470	72 750	457 800	34 608	45 009	91 341	188 972
Amphetamine	440 000	258 000	958 500	660 000	107 200	945 000	636 000	2 668 000	3 504 000
Methamphetamine	47 974	2 402	12 779	28 931	48 379	568 049	425 790	261 000	432 000

The data on black market prices provided by the Ministry of the Interior are based on information obtained by undercover police agents and during interrogations. No statistics on the number of cases/samples and their assessment have been made available.

Source: BMI/.BK; graphic representation: GÖG

Variations, often to a marked degree, in the **maximum (street-level) purchasing prices** have become apparent only in recent years: for instance, the price of ecstasy, after doubling in 2014 (30 euros per pill), again fell by half in 2016 (see Table 7.5). Regrettably, average prices have not been available for the entire period of observation.

Table 7.5:
Maximum street-level price of narcotic drugs/substances (in EUR) in Austria; 2007-16

Narcotic drug/substance	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Cannabis resin (1 gram)	10	10	10	9	9	8	12	15	15	20
Herbal cannabis (1 gram)	10	10	10	10	10	10	12	12	12	15
Brown heroin (1 gram)	85	80	100	60	60	60	100	100	100	90
Cocaine (1 gram)	90	90	140	90	90	100	130	150	150	150
Amphetamine (1 gram)	25	20	15	20	20	30	60	60	60	60
Methamphetamine (1 gram)	25	20	15	20	20	30	120	130	130	130
Ecstasy (1 pill/unit)	10	10	10	10	10	10	12	30	30	15

Source: BMI/.BK; graphic representation: GÖG

The **average (street-level) purity** of the substances tested has seen significant variations over time. In the long term, increases in the content of active ingredient have been apparent for all substances (see Table 7.6). In the case of all substances except herbal cannabis and brown heroin, an increase in maximum purity was found, followed by a decline in 2016 (see Table 7.8 and Figure 7.2).

In the samples bought as '**ecstasy**' and analysed in the context of the *checkit!* project, the proportion of pills containing high doses of MDMA (over 100 mg) has markedly risen – from 48% in 2015 to 66% in 2016 (2013: 26%). The proportion of pills high doses of which pose a **health hazard** (over 200 mg) has seen a further rise: from 6% (2014) to 14% (2015), then to approx. 21% of all pills submitted for testing in 2016. In the case of doses of 200 mg or more, as well as in the case

of ingredients or combinations of substances¹²⁵ that pose particular health risks, *checkit!* explicitly warns the users. In 2016, in 19% of cases an explicit warning against the consumption of the substance tested was given ('test result indicates considerable health risks' (2015: 18%). As in 2015, none of the pills sold as 'ecstasy' that were tested in the reporting year contained PMA¹²⁶ (see Table A7. 9).

In the past two years, the proportion of samples analysed by *checkit!* in which **NPS** were detected has been considerably lower than in prior years. While in 2010 a proportion of 19% of samples handed in contained NPS as (expected or unexpected) ingredients, this applies to only 5.8% in 2015 and 4.8% in 2016. New psychoactive substances have further declined in importance as additives to typical recreational drugs (from 13.3% in 2011 to 3.2% in 2016). The proportion of samples bought as NPS and handed over for testing was 1.6% in 2016.

Table 7.6:
Mean purity of street-level narcotic drugs/substances tested in Austria; 2007–16

Narcotic drug/substance	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Cannabis resin (% THC)	10.0	10.9	9.8	12.2	9.1	11.0	9.8	12.0	15.2	15.1
Herbal cannabis (% THC)	6.7	7.2	5.9	7.5	7.0	9.7	9.6	8.9	9.8	10.8
Brown heroin (%)	9.1	11.3	12.9	12.9	5.8	6.4	7.6	11.9	13.7	13.7
Cocaine (%)	32.6	32.1	27.6	27.3	27.5	28.1	26.1	31.6	33.4	45.9
Amphetamine (%)	12.8	9.1	7.3	7.8	7.9	8.4	9.5	10.6	18.5	14.5
Methamphetamine (%)	24.4	46.3	58.4	56.7	52.0	54.4	56.0	63.5	51.5	58.7
Ecstasy (mg MDMA base per unit)	37.6	38.3	41.1	90.7	63.4	50.7	46.0	44.6	48.7	47.7

Source: BMI/.BK; graphic representation: GÖG

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If men take MDMA doses over 1.5 mg per kg body mass, and women, doses of more than 1.3 mg per kg body mass, the negative effects of MDMA predominate, and neurotoxic effects are more likely to occur.

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In the past, paramethoxyamphetamine (PMA) and paramethoxymethamphetamine (PMMA), a substance related to PMA, have in several instances led to the death of users in Europe, including Austria.

Table 7.7:

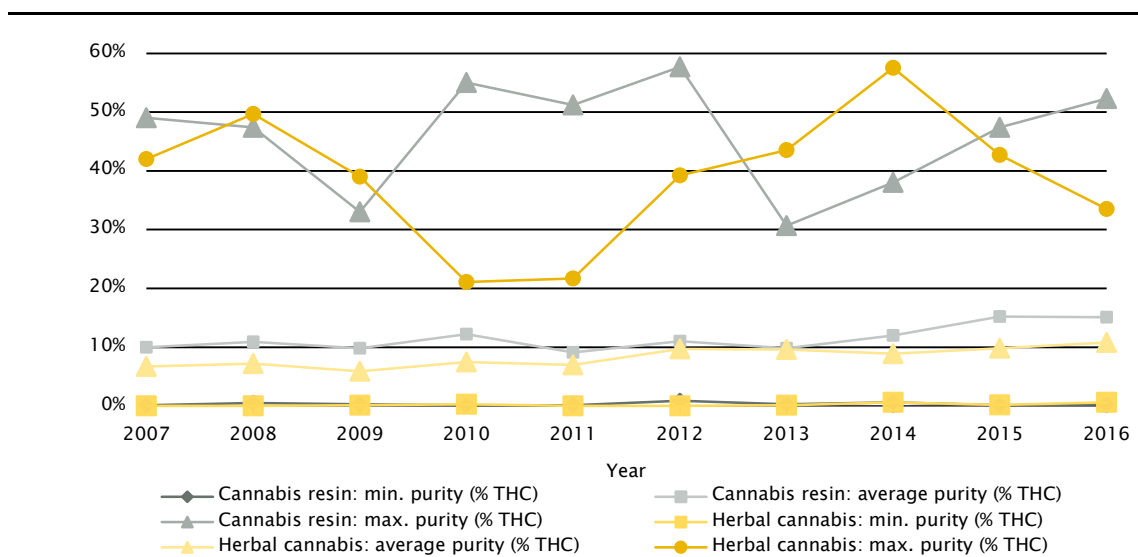
Maximum purity of street-level narcotic drugs/substances tested in Austria; 2007–16

Narcotic drug/substance	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Cannabis resin (% THC)	49.0	47.4	33.0	55.0	51.2	57.7	30.7	38.0	47.4	52.3
Herbal cannabis (% THC)	42.0	49.7	39.0	21.1	21.7	39.2	43.5	57.5	42.7	33.5
Brown heroin (%)	57.0	71.0	52.8	50.0	42.6	30.9	55.1	57.2	58.5	57.4
Cocaine (%)	98.0	96.0	95.9	93.50	83.5	87.3	74.8	84.9	83.1	87.7
Amphetamine (%)	60.0	66.0	42.6	27.3	28.5	56.9	59.8	66.4	73.8	82.1
Methamphetamine (%)	94.0	99.0	99.1	100.0	80.3	81.3	80.3	80.6	81.9	81.9
Ecstasy (mg MDMA base per unit)	100.0	100.0	66.3	100.0	83.8	96.7	83.2	90.5	87.3	88.3

Source: BMI/.BK; graphic representation: GÖG

Figure 7.2:

Minimum, average and maximum purity of cannabis resin and herbal cannabis in Austria, as % THC; 2007–16



Source: BMI/.BK; graphic representation: GÖG

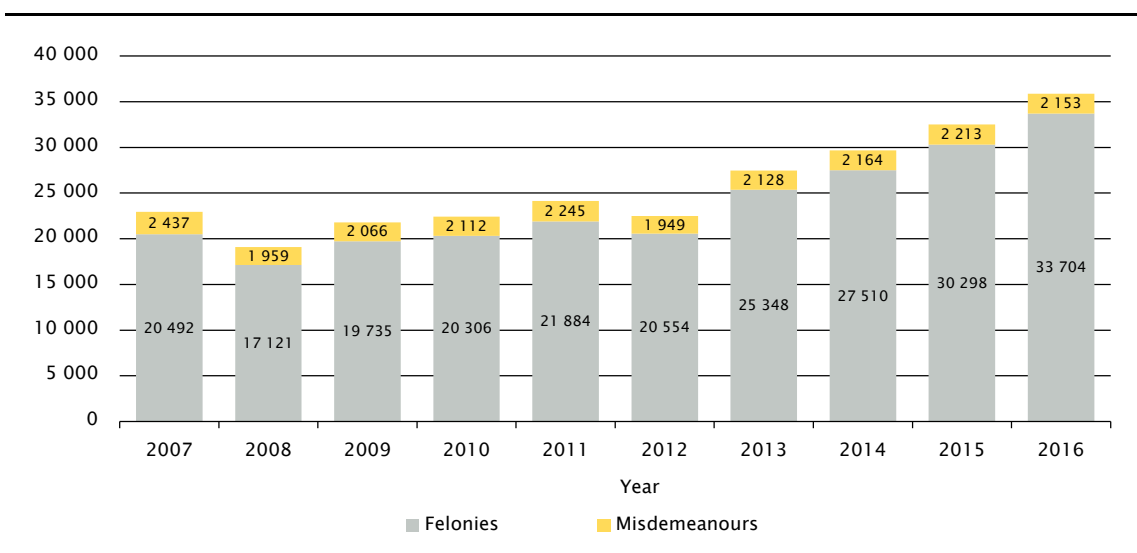
Figure 7.2 represents the minimum, maximum and average purity of cannabis resin and herbal cannabis in Austria, expressed as % THC. Over the past 10 years, considerable variations with regard to maximum purity have been apparent for either substance, whereas the minimum purity figures have been fairly constant, near the base line. The average purity of cannabis resin was around 10% up to 2013, and has seen a continuous rise since then, up to a 10-year maximum of 15.1% in the past year (cannabis resin: 15.1%; herbal cannabis: 10.8%). In the case of herbal cannabis, a rise, with smaller variations, from 6.7% in 2007 to 10.8% in 2016 has been recorded (see Tables 7.2, 7.6 and 7.7).

Comments on long-term trends in any other drug-related crime data

Figure 7.3 below illustrates the long-term development in the number of crime reports relating to violation of the Narcotic Substances Act, by misdemeanours and felonies. The figures given concern only narcotic drugs. The trend was fairly constant from 2005 to 2012, with a drop in 2008, which can be explained by a shift in police activities due to the European Football Championship in Austria. Since 2013, particularly the number of reports relating to misdemeanours have risen massively, with this trend continuing in 2016 too. Compared to the previous year, the number of felonies has, for the first time since 2012, seen a decrease.

Figure 7.3:

Development of the number of crime reports relating to violations of the Narcotic Substances Act (narcotic drugs only), by misdemeanours and felonies; 2007-16



Source: BMI/.BK; graphic representation: GÖG

Figure 7.4 shows the development in reports to the police due to violations of the Narcotic Substances Act by type of drug. Whereas the number of reports has shown a continuous decline from 2007 to 2013 for many drug types, a pronounced rise, for instance, regarding amphetamine and ecstasy, has since become apparent. In the case of cannabis, the rise observed since 2013 has continued, at a high level. In the past year, the most pronounced increases in terms of percentages concern 'other drugs'¹²⁷ (+64%)¹²⁸, LSD (+26%), as well as heroin and opioids (+25%), whereas the most significant declines are seen in precursor substances (-38%) and psychotropic substances (-20%). In 2016, the total number of reports relating to medicines containing narcotic drugs has been the lowest in the past 10 years, while the number of reports concerning cannabis has continued to be the highest, accounting for approximately 72% of the respective crime reports (see Table A7. 5). At the provincial level, the distribution of crime reports differs widely according to province (see Table A7. 6).

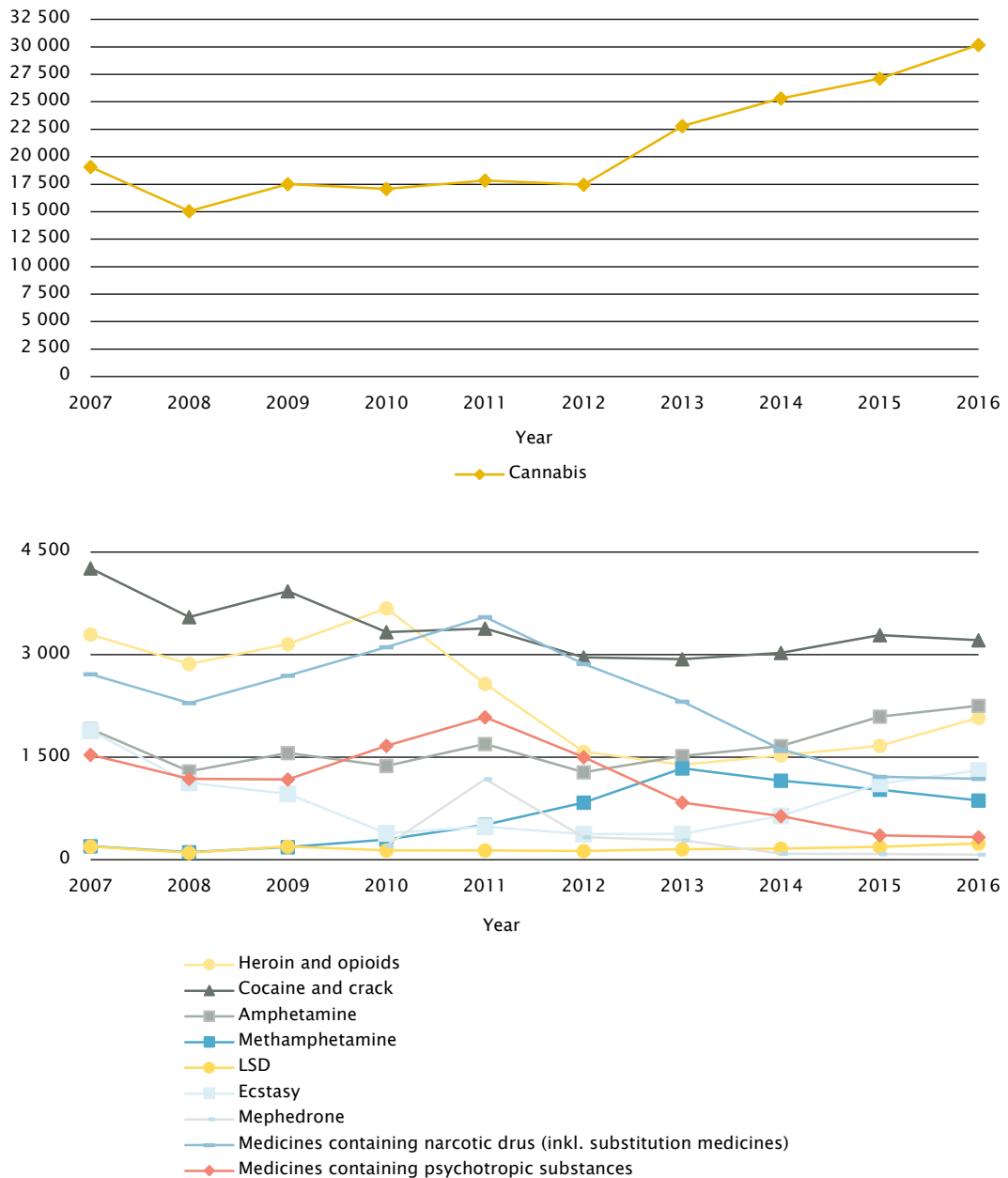
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Since 2008, mushrooms containing psilocin, psilotin or psilocybin have also been included here.

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Round figures.

Figure 7.4:
Development in crime reports relating to violations of the Narcotic Substances Act in Austria, by
type of drug; from 2007-16



As the figures are broken down by type of drug, multiple counts of individual reports cannot be ruled out.
Due to high number of reports relating to cannabis, the corresponding figures have been represented in a separate diagram.

Source: BMI/.BK; graphic representation: GÖG

Notable trends or important developments in the organisation, coordination and implementation of drug supply reduction activities

Besides the national measures to reduce drug supply in Austria described in section 7.2.3, another focus of activities concerns the deep web¹²⁹ and the darknet. In order to respond to the new challenge of darknet-based drug trafficking, in 2015 Austria took over the chair of the EU-cofunded project Joint investigation to combat drug trafficking via the virtual market (darknet) within and also into the EU. In addition, December 2016 saw the start of the project Joint investigation to fight trafficking in drugs and firearms, with the main focus on international airports within, and also into, the EU, together with the partner countries of Kosovo and the Czech Republic. We are finally seeing cooperation at the international level, e.g. with Interpol, Europol and the United Nations network that is worthy of mention (Stadler, personal communication; BMI 2017).

Data on crime reports and seizures relating to substitution medicines have been made available for the period from 2014 to 2016 (Mader, personal communication). According to the Federal Ministry of the Interior, the number of corresponding crime reports has decreased from 1 389 in 2014 to 1 056 in 2016. The majority of these concern illicit handling of narcotic drugs (SMG Section 27; in 2016: 987). A small proportion relate to felonies (SMG Section 28; in 2016: 69). Table 7.8 represents both the number of seizures of substitution medicines and the quantities confiscated from 2014 to 2016. Again, a decline with regard to both quantities and numbers has been apparent. These data confirm that even though every type of substitution medicine can be found on the black market, the measures taken to reduce this phenomenon seem to be effective (see Weigl et al. 2014). It should also be taken into account that only a small part of the total quantities prescribed have been detected on the black market (2013: 0.1%; see GÖG/ÖBIG 2013).

Table 7.8:
Seizures of substitution medicines in Austria, by quantity and number of seizures; 2014–16

Active ingredient	2014		2015		2016	
	Quantity (units)	Number of seizures	Quantity (units)	Number of seizures	Quantity (units)	Number of seizures
Codeine	112	16	221	14	141	14
Buprenorphine	511	80	742	95	488	69
Levomethadone	–	–	–	–	7	2
Methadone	578	13	74	14	71	16
Slow-release morphine	3 739	552	3 343	505	2 602	456
Total	4 940	661	4 380	628	3 309	557

Source: Mader, personal communication

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The deep web (also referred to as the 'hidden web' or the 'invisible web') is a part of the worldwide web whose contents you cannot find when using a standard search engine. It largely consists of specialised (technical) databases and websites. In short, its contents are not freely accessible and/or are not indexed, or prohibited from being indexed, by search engines.

7.4 New developments

In March 2015, Subdepartment 3.3/Drug-Related Crime of the Federal Criminal Agency set up a task force that focuses on illicit drug trafficking on the darknet. Since then, 697 persons have been reported in Austria. They had purchased on the darknet, imported – and mostly sold to others – 123 kg of narcotic drugs and 78 000 ecstasy pills. In 159 cases, evidence of commercial trafficking in large quantities was found. During 181 searches, 35 kg of narcotic drugs and 4 500 ecstasy pills were seized. The majority of drug orders had been placed in Upper Austria (almost 32%), followed by Vienna (21%), Styria (12.5%) and Lower Austria (10%; BMI 2017).

In August 2016, the darknet task force started Operation Porto. Investigations have shown that most of the drugs sold on the darknet are produced and sold in the Netherlands. The packages are then dispatched by mail, through intermediaries in Germany. As these packages are shipped to countries all over the world, parcels sent by mail have been checked and seized at international airports in Germany. So far, around 6 000 parcels with a total of 170 kg of narcotic drugs were detected in Germany (BMI 2017).

7.5 Additional information

In 2015 and 2016, interviews with drug users were conducted in the context of a KIRAS project (i.e. the VIDRO project) on virtual drug trafficking to survey their experience of drug purchases on the internet.

7.6 Sources and methodology

Sources

The data on production, smuggling, supply routes and seizures given here have been provided by the Federal Criminal Agency at the Federal Ministry of the Interior (BMI/.BK), which has also communicated the data on crime reports, prices and purity (see ST11, ST13, ST14 and ST16). Further information on ingredients and purity have been made available by *checkit!*¹³⁰ (see ST15), MDA basecamp¹³¹ and the Austrian Federal Office for Safety in Health Care/AGES Medicines and Medical

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checkit! is a cooperation project run jointly by the *Suchthilfe Wien* addiction services and the Clinical Institute of Medical and Chemical Laboratory Diagnoses of the Medical University of Vienna. Its services include lab analyses of psychoactive substances at (music) events (parties, raves, festivals, etc.).

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MDA basecamp is part of the Z6 drug support centre, and cooperates with the Innsbruck Department of Forensic Medicine

Devices Agency (BASG/AGES)¹³². The figures on drugs and alcohol in road traffic contexts have also been provided by the Federal Ministry of the Interior.

The Narcotic Substances Act (SMG) is an important basis for criminal prosecution activities (see also chapter 2 and chapter 11 in GÖG/ÖBIG 2011 and GÖG/ÖBIG 2008).

For the VIDRO project, a total of 18 guided face-to-face interviews with drug users were conducted from October 2015 to December 2016 to survey their experience of drug purchases on the internet. The respondents were recruited in various ways: through addiction support centres in Vienna, a pharmacy and a psychotherapist, acquaintances of the surveyors, as well as via an invitation to participate published on *checkit!*'s Facebook page.

Methodology

Schmutterer, Irene (2016). Face-to-Face-Interviews zu Erfahrungen mit dem Kauf von Drogen im Internet. Ergebnisbericht. Im Auftrag von VICESSE. Gesundheit Österreich Forschungs- und Planungs GmbH. Vienna

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BMI (2016b). JICDT – VM. Darknet Project.
http://www.bmi.gv.at/cms/BK/publikationen/files/27102016_Web_Darknet_25_10_16.pdf
[accessed 14 July 2017]

BMI (2017). Jahresbericht über die Suchtmittelkriminalität in Österreich 2016. Bundesministerium für Inneres/Bundeskriminalamt. Vienna.

Drogenarbeit Z6 (2017). Tätigkeitsbericht 2016. Innsbruck.

and *checkit!* to provide services such as mobile drug support and drug checking at music events, concerts and parties in Innsbruck and throughout the province of Tyrol.

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

EMCDDA (2013). European Monitoring Centre for Drugs and Drug Addiction. Drug squads: units specialized in drug law enforcement in Europe, EMCDDA Papers, Publications Office of the European Union. Luxembourg.

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

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Schmutterer, I. (2016). Face-to-Face-Interviews zu Erfahrungen mit dem Kauf von Drogen im Internet. Ergebnisbericht. Im Auftrag von VICESSE. Gesundheit Österreich Forschungs- und Planungs GmbH. Vienna

SHW (2017). *checkit!* Tätigkeitsbericht 2016. Suchthilfe Wien gGmbH. Vienna.

Weigl, M., Busch, M., Grabenhofer-Eggerth, A., Horvath, I., Klein, C., and Türscherl, E. (2014). Report on the Drug Situation 2014. Gesundheit Österreich GmbH/Geschäftsbereich ÖBIG. Vienna.

7.8 Referenced Federal Acts

BGBl. I 146/2011. Bundesgesetz über den Schutz vor Gesundheitsgefahren im Zusammenhang mit Neuen Psychoaktiven Substanzen (Neue-Psychoaktive-Substanzen-Gesetz, NPSG)

BGBl. 1960/159. Bundesgesetz vom 6. Juli 1960, mit dem Vorschriften über die Straßenpolizei erlassen werden (Straßenverkehrsordnung 1960 – StVO)

BGBl. I 1997/112. Bundesgesetz über Suchtgifte, psychotrope Stoffe und Drogenausgangsstoffe (Suchtmittelgesetz – SMG)

BGBl. I 1997/120. Führerscheingesetz (FSG)

7.9 Personal communications (alphabetical order)

Name	Institution or function
Christian Mader	Federal Ministry of the Interior
Thomas Schmid	Federal Ministry of the Interior
Karin Schranz	Federal Ministry of the Interior
Gerhard Stadler	Federal Ministry of the Interior

7.10 Annex

Table A7. 1:

Distribution of crime reports relating to violations of the Narcotic Substances Act, by first offenders and repeat offenders as well as total reports; 2007-16

Reports**	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total reports	24 166	20 043	22 729	23 853	25 892	23 797	28 227	30 250	32 907	36 235
First offenders	16 053	13 634	14 893	19 409	21 828	19 683	22 979	24 660	17 570	22 715
Repeat offenders	7 569	5 990	7 258	3 681	3 247	3 107	3 688	3 717	13 235*	10 741

* According to the BMI, the massive increase in 2015 as against 2014 results from a new nationwide comparison of all relevant data fields, which enables an improved, and more precise, acquisition of the corresponding data, but also leads to a break in the time series.

**All reports, not only reports relating to narcotic substances but also reports concerning psychotropic substances. Difference between sum of individual figures and total figure = unknown.

Source: BMI/.BK; graphic representation: GÖG

Table A7. 2:

Distribution of crime reports relating to violations of the Narcotic Substances Act (narcotic substances only) by province; 2007-16

Province	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Burgenland	1 008	871	953	716	801	687	844	773	855	895
Carinthia	1 408	1 153	1 372	1 522	1 422	1 165	1 460	1 961	1 607	1 646
Lower Austria	3 464	2 583	3 165	2 978	2 917	2 683	3 134	3 629	4 019	4 153
Upper Austria	3 786	3 245	3 908	3 660	3 590	3 547	4 446	5 009	5 104	6 006
Salzburg	1 116	1 015	1 096	1 099	1 431	1 145	1 350	1 502	1 755	2 106
Styria	1 929	1 372	1 669	1 607	1 878	1 879	2 465	3 266	3 246	3 363
Tyrol	2 454	1 982	2 555	2 692	3 095	2 570	3 929	3 502	3 917	3 987
Vorarlberg	1 153	976	1 027	1 143	1 092	1 392	1 251	1 385	1 304	1 498
Vienna	6 611	5 883	6 056	7 001	7 903	7 435	8 597	8 647	10 704	12 203
Total reports	22 929	19 080	21 801	22 418	24 129	22 503	27 476	29 674	32 511	35 857

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

Source: BMI/.BK; graphic representation: GÖG

Table A7. 3:

Distribution of crime reports relating to violations of the Narcotic Substances Act (psychotropic substances only) by province; 2010-16

Province	2010	2011	2012	2013	2014	2015	2016
Burgenland	19	30	14	3	7	3	2
Carinthia	25	44	29	36	44	33	12
Lower Austria	97	124	88	71	43	45	27
Upper Austria	180	249	229	98	86	32	49
Salzburg	31	31	22	23	5	8	7
Styria	41	49	54	26	14	10	10
Tyrol	99	80	75	58	52	51	34
Vorarlberg	39	61	25	20	28	9	29
Vienna	904	1 095	758	406	287	187	178
Total reports	1 435	1 763	1 294	741	566	378	348

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

Source: BMI/.BK; graphic representation: GÖG

Table A7. 4:

Distribution of crime reports to the public prosecutors relating to violations of the New Psychoactive Substances Act, by province; 2012-16

Province	2012	2013	2014	2015	2016
Burgenland	5	4	3	0	2
Carinthia	3	5	5	0	7
Lower Austria	25	32	25	16	16
Upper Austria	10	9	8	11	13
Salzburg	9	3	5	0	4
Styria	15	35	15	11	13
Tyrol	12	19	40	6	4
Vorarlberg	2	6	7	2	9
Vienna	12	15	5	2	10
Total reports	93	128	113	48	78

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

Source: BMI/.BK; graphic representation: GÖG

Table A7. 5:

Distribution of crime reports relating to violations of the Narcotic Substances Act, by narcotic drug/substance; 2007–16

Narcotic drug/substance	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Cannabis	19 063	15 063	17 513	17 066	17 836	17 461	22 798	25 309	27 127	30 184
Heroin and opioids	3 294	2 865	3 157	3 677	2 575	1 582	1 390	1 529	1 666	2 077
Cocaine and crack	4 263	3 551	3 930	3 332	3 383	2 963	2 936	3 026	3 287	3 211
Amphetamine	1 914	1 296	1 562	1 375	1 696	1 283	1 517	1 663	2 097	2 253
Methamphetamine	198	109	187	294	510	837	1 337	1 159	1 026	869
LSD	196	101	193	137	138	129	155	163	189	238
Ecstasy	1 889	1 127	966	388	485	375	378	642	1 115	1 307
Mephedrone	–	–	–	209	1 179	331	285	89	82	75
Medicines containing narcotic drugs (incl. substitution medicines)	2 714	2 294	2 693	3 113	3 552	2 864	2 317	1 616	1 213	1 186
Other narcotic drugs*	323	263	363	185	160	143	164	260	232	381
Psychotropic substances	20	13	16	37	58	35	59	62	46	37
Psychotropic medicines	1 535	1 185	1 174	1 666	2 086	1 502	837	637	359	330
Precursor substances	2	12	1	3	4	8	18	15	13	8

– No data available.

As the figures are broken down by type of drug, multiple counts of individual reports cannot be ruled out. The sum total therefore differs from the total number of crime reports.

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

Source: BMI/.BK; graphic representation: GÖG

Table A7. 6:

Distribution of crime reports relating to violations of the Narcotic Substances Act, by narcotic drug/substance and province; in 2016

Narcotic drug/substance	B	C	LA	UA	S	St	T	Vb	V	Total
Cannabis	825	1 325	3 641	5 045	1 828	3 083	3 747	1 288	9 402	30 184
Heroin and opioids	23	196	208	345	43	25	15	130	1 092	2 077
Cocaine and crack	30	258	231	302	182	131	367	195	1 515	3 211
Amphetamine	87	64	280	742	229	245	223	87	296	2 253
Methamphetamine	62	17	160	266	32	23	45	21	243	869
LSD	18	11	61	44	10	12	34	12	36	238
Ecstasy	48	93	125	241	112	225	131	68	264	1 307
Mephedrone	2	8	3	14	2	38	2	0	6	75
Medicines containing narcotic drugs (incl. substitution medicines)	14	56	94	298	77	50	43	39	515	1 186
Other narcotic drugs*	14	25	65	73	22	57	31	18	76	381
Psychotropic substances	0	0	5	12	3	2	3	8	4	37
Medicines containing psychotropic substances	2	13	22	41	4	8	35	24	181	330
Precursor substances	0	0	4	3	0	0	0	0	1	8

As the figures are broken down by type of drug, multiple counts of individual reports cannot be ruled out. The sum total therefore differs from the total number of crime reports.

* Including mushrooms containing psilocin, psilotin or psilocybin.

Source: BMI/.BK; graphic representation: GÖG

Table A7. 7:

Number of seizures of narcotic drugs/substances in Austria; 2007-16

Narcotic drug/substance	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Cannabis (resin, herbal, concentrates)	5 732	5 050	5 733	6 195	6 750	7 137	10 139	11 914	13 879	16 697
Cannabis plants	-	-	-	-	-	-	-	-	-	508
Heroin	765	673	901	1 048	640	393	346	428	605	677
Cocaine	1 087	936	984	946	970	912	992	1 078	1 190	1 315
Amphetamine	319	262	347	352	383	348	496	613	784	828
Methamphetamine	61	37	53	114	162	259	363	317	304	334
LSD	39	20	39	43	41	47	39	61	69	90
Ecstasy	250	181	131	63	90	113	119	212	357	455
Mephedrone				73	125	36	54	11	12	8
Medicines containing narcotic drugs (incl. substitution medicines)	1 234	1 015	1 121	1 456	1 712	1 435	1 129	742	704	655
Other narcotic drugs*	92	58	79	72	67	65	88	120	127	176
Psychotropic substances	10	1	2	13	23	22	30	26	18	21
Medicines containing psychotropic substances	1 019	843	697	993	1 268	888	495	417	242	251
Precursor substances	1	12	0	1	0	8	9	16	9	5
Substances under the NPSG**							424	220	256	

- No data available.

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

** NPSG: New Psychoactive Substances Act; only data for the period from 2013 to 2015 have been made available.

Source: BMI/.BK; graphic representation: GÖG

Table A7. 8:

Seizures of narcotic drugs/substances in Austria by quantity; 2007–16

Narcotic drug/substance	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Cannabis (resin, herbal, concentrates)	1 276.0	873.6	1 139.3	1 292.3	915.6	1 158.6	1 757.8	1 708.5	1 138.8	1 082.7
Cannabis plants (no. of plants)	-	-	-	-	-	-	-	-	-	24 166
Heroin (kg)	117.0	104.0	189.6	96	64.9	222.1	80.2	56.2	69.5	68.9
Cocaine (kg)	78.1	78.38	53.2	241	139	64.6	24.7	31.0	119.6	86.4
Amphetamine (kg)	17.5	12.9	63.9	22.0	13.4	32.1	21.4	15.9	66.6	87.6
Methamphetamine (kg)	1.9	0.1	1.1	1.4	2.4	3.2	7.6	4.7	2.9	4.8
LSD (no. of trips)	1 058	225.50	1 581	533.5	1 588	276	618	778	1 848	1 865
Ecstasy (no. of pills)	66 167	45 335	5 847.5	7 275	45 780	8 998	5 768	5 001	10 148	29 485
Mephedrone (kg)	-	-	-	2.9	14.2	2.4	4.0	1.0	0.2	0.02
Medicines containing narcotic drugs (units) incl. substitution medicines	10 376	7 180	8 233.5	11 630.5	12 504	11 039.5	8 196	19 041.5	7 343	4 820
Other narcotic drugs (kg)*	3.6	2.9	5.3	5.5	0.5	1.1	2.2	2.1	3.6	4.8
Psychotropic substances (kg)	0.20	0.00	0.01	2.6	4.3	2.9	0.6	0.5	15.4	0.18
Medicines containing psychotropic substances (units)	26 289	24 675	36 624.5	28 178	157 910	18 042	8 423	163 287.5	3 697	4 325
Precursor substances***	0.17	22.16	0	1	0	2.8	149.7	135.1	2 223.2	6.65
Substances under the NPSG** (kg)							31.6	10.0	23.0	

- No data available.

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

** NPSG: New Psychoactive Substances Act; reliable data are only available for the period from 2013 to 2015.

*** Precursor substances have been listed in kg up to and including 2015, and since 2016, in litres.

Source: BMI/.BK; graphic representation: GÖG

Table A7. 9:

Ingredients of samples bought as 'ecstasy' (pills) and analysed by *checkit!* at parties and clubbing venues, percentages; 2007–16

Ingredients	Percentage of samples bought as 'ecstasy pills'									
	2007 (n=117)	2008 (n=146)	2009 (n=105)	2010 (n=76)	2011 (n=135)	2012 (n=145)	2013 (n=108)	2014 (n=219)	2015 (n=285)	2016 (n=328)
MDMA	60.7	61.6	15.2	21.1	29.6	56.6	63.0	81.3	82.1	89.0
MDMA + MDE	0.0	0.0	0.0	0.0	0.0	2.1	0.0	0.5	0.4	0.0
MDMA + MDA	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.5	0.7	0.3
MDE and/or MDA	0.0	1.4	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
MDMA + caffeine	0.9	0.7	1.0	0.0	5.9	2.1	0.9	6.7	6.7	3.7
MDMA + amphetamine	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.0	0.4	0.3
MDMA + various combinations*	6.0	7.5	1.9	5.3	18.5	6.2	12.0	4.7	2.1	0.9
PMA/PMMA, PMA/PMMA + various combinations*	0.0	0.0	1.0	0.0	0.0	9.7	1.9	0.0	0.0	0.0
Amphetamine	0.0	0.7	1.0	1.3	0.0	0.0	0.0	0.5	0.0	0.0
Methamphetamine	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Caffeine	1.7	0.0	0.0	6.6	0.7	0.0	0.9	0.0	1.1	0.3
Piperazine/piperazine + various combinations*	16.2	17.8	52.4	47.4	19.3	–3	–3	–3	–3	0.3
Various combinations*	14.5	10.3	25.7	11.8	3.0	9.7	5.6	4.1	4.9	3.7
<i>New psychoactive substances</i> ¹ / NPS ² + various combinations*	–	–	0.0	6.6	23.0	13.8	13.9	1.5	1.8	0.9

* Various combinations: one or more additional substances.

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

² *New psychoactive substances*.

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

Source: Suchthilfe Wien gGmbH; graphic representation: GÖG

Table A7. 10:

Ingredients of samples bought as 'ecstasy' or 'MDMA' (in powder or crystalline form or as capsules) and analysed by *checkit!* at parties and clubbing venues, percentages; 2007–16

Ingredients	Samples bought as 'ecstasy' or 'MDMA' in powder or crystalline form or as capsules (percentages)									
	2007 (n=27)	2008 (n=31)	2009 (n=25)	2010 (n=91)	2011 (n=163)	2012 (n=222)	2013 (n=290)	2014 (n=224)	2015 (n=152)	2016 (n=166)
MDMA	81.5	87.1	69.6	51.6	82.2	80.2	78.3	82.6	85.5	84.3
MDMA + MDE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.7	0.0
MDMA + MDA	0.0	0.0	0.0	0.0	0.0	2.7	0.0	0.0	0.0	0.0
MDE and/or MDA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
MDMA + caffeine	0.0	0.0	0.0	0.0	0.6	0.0	1.4	0.0	1.3	0.6
MDMA + amphetamine	0.0	3.2	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.0
MDMA + various combinations*	11.1	0.0	4.3	7.7	5.5	1.4	1.0	1.8	2.6	1.8
PMA/PMMA, PMA/PMMA + various combinations*	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Amphetamine	0.0	0.0	0.0	0.0	0.0	0.9	0.0	0.0	0.7	0.6
Methamphetamine	0.0	0.0	0.0	1.1	0.0	0.0	0.3	0.0	0.0	0.6
Caffeine	0.0	0.0	0.0	1.1	1.2	0.0	0.3	0.0	0.0	0.0
Piperazine/piperazine + various combinations*	0.0	3.2	21.7	0.0	1.2	–3	–3	–3	–3	–3
Various combinations*	7.4	6.5	4.3	3.3	1.2	5.0	2.4	4.0	2.0	3.0
<i>New psychoactive substances</i> ¹ /NPS ² + various combinations*	–	–	8.7	35.2	8.0	9.9	16.2	8.0	6.6	9.0

* Various combinations: one or more additional substances.

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

² *New psychoactive substances*.

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

Source: Suchthilfe Wien gGmbH; graphic representation: GÖG

Table A7. 11:

Ingredients of samples bought as speed and analysed by *checkit!* at parties and clubbing venues; 2007–16

Ingredients	Percentage of samples bought as speed									
	2007 (n=129)	2008 (n=99)	2009 (n=113)	2010 (n=124)	2011 (n=203)	2012 (n=273)	2013 (n=321)	2014 (n=219)	2015 (n=260)	2016 (n=289)
Amphetamine	22.5	15.2	9.7	14.5	5.4	7.0	17.8	35.2	34.2	25.3
Amphetamine + caffeine	10.1	27.3	50.4	61.3	55.7	55.7	56.7	38.8	50.8	59.5
Amphetamine + methamphetamine	0.0	2.0	0.0	0.0	0.5	0.4	0.0	0.0	0.0	0.0
Amphetamine + various combinations*	31.8	34.3	15.0	10.5	18.2	24.9	19.3	19.6	10.4	10.4
Methamphetamine	10.1	1.0	0.9	1.6	0.5	2.2	0.9	0.0	0.4	0.0
Caffeine	1.6	3.0	8.8	1.6	7.9	0.4	0.6	0.0	0.0	0.7
MDMA	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.4	1.2	0.7
Various combinations*	23.3	14.1	14.2	7.3	5.4	5.5	2.5	2.7	2.3	2.1
Piperazine/piperazine + various combinations*	0.8	2.0	0.9	0.8	1.0	– ³	– ³	– ³	– ³	0.3
<i>New psychoactive substances</i> ¹ /NPS ² + various combinations*	–	–	0.0	2.4	5.4	4.0	2.2	2.3	0.8	1.0

* Various combinations: one or more additional substances.

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

² *New psychoactive substances*.

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

Prison

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8 Prison

8.1 Summary

National profile

In Austria, the Federal Government (i.e. the Directorate-General of Prisons and Detention Measures of Department II of the Ministry of Justice) is in charge of matters concerning penal imprisonment and non-punitive detention. Austria has 27 prisons with 12 affiliated institutions, which could – by May 2017 – house 8 738 prisoners, and are almost fully occupied.

No information on illicit substance use during imprisonment has been made available. General health care in prison is subject to the principle of equivalence of care and equal treatment of diseases, according to which inmates must have access to the same medical treatment as is normal and usual outside prison. Treatment is delivered by both prison doctors and external providers. Quality assurance is based on various general circulars, e.g. the substitution guidelines, which regulate opioid substitution treatment during imprisonment. By 1 April 2017, almost 10% of inmates (872 persons) were in opioid substitution treatment, which is a slight increase compared to the reference date of the previous year (1 April 2016: 836 persons). Neither needle and syringe exchange programmes nor systematic hepatitis B (HBV) vaccinations for all seronegative prisoners are available in Austrian prisons. With regard to basic care services responding to injecting drug use among inmates, the Addiction Prevention Strategy of the Ministry of Health indicates that it is necessary to make sterile syringes available to prisoners.

New developments

In the prisons, particular attention is increasingly being paid to infectious diseases. The inmates are tested for HIV, as well as TB, HBV and HCV. In addition, HCV genotype testing is performed, and the treatment of HCV infections with the new directly acting antivirals is being intensified in the prisons.

8.2 National profile

8.2.1 Organization

Overview of the organisation of prisons in Austria

In Austria, the Federal Government is in charge of matters concerning penal imprisonment and detention in the context of measures other than punishment or for preventive reasons ('non-

punitive detention'). The Federal Ministry of Justice, as the highest administrative and law enforcement authority, is responsible for strategic and operative planning and control, and represents the highest management level of prisons and non-punitive detention centres. Until 30 June 2015, their operative management was the task of the Prisons Directorate, as the subordinate administrative authority. As of 1 July 2015, it has been replaced by the Directorate-General of Prisons and Detention Measures (Department II) at the BMJ. This department consists of four divisions: Division II 3 is in charge of law enforcement and care services in prison, as well as medical supervision services and the competence centre for non-punitive detention in accordance with Criminal Code Section 21, para. 2. It is thus comparable to the former Division VD 2 of the Prisons Directorate.

Austria's system of prisons and detention centres consists of 27 prisons (one exclusively for women and one exclusively for young people) with 12 affiliated institutions, as well as the juvenile court representatives¹³³. Austria's prisons can house 8 738 persons. By May 2017, the total number of inmates was 8 991 persons, and 8 286 of these were inmates of prisons. This prison population consists of persons in pre-trial detention, penal prisoners, as well as persons detained for non-punitive purposes ('non-punitive detainees'; see also Table A8. 1, reference date of 1 April 2017). The remaining 705 persons were detained in special departments of psychiatric hospitals, or were living in electronically monitored house arrest¹³⁴. Table 8.1 provides a list of the Austrian prisons, including the number of places and the specific characteristics of the individual institutions, e.g. the age groups and gender of inmates, as well as the duration of imprisonment for which the respective prisons are designed. The prisons of Favoriten (Vienna) and the women's prison at Schwarzaau (Lower Austria) specialise in addiction treatment.

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Since 2015 the juvenile court representatives system has been introduced gradually. The tasks that the juvenile court representatives can take over on behalf of the courts and the public prosecutors are defined in Section 48 of the Juvenile Court Act (JGG; BGBl. 599/1988 as amended). They primarily comprise six areas: investigations into the situation of young people in the context of criminal proceedings; crisis intervention; assistance in decisions for or against detention; participation in extra-judicial compensation procedures or in organising community service; defence in district court proceedings; and services for pre-trial detainees and penal prisoners (BMJ 2017).

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https://www.justiz.gv.at/web2013/home/strafvollzug/statistik/verteilung_des_Insassenstandes~2c94848542ec49810144457e2e6f3de9.de.html (accessed 1 June 2017).

Table 8.1:
Prisons in Austria; date of reference: 1 August 2016

Name of prison (province)	Number of places	Further information
Justizanstalt Eisenstadt (B)	190	Male adults and young people; pre-trial detention and penal imprisonment for up to 18 months; prison leave scheme.
Justizanstalt Klagenfurt (C) Rottenstein (affiliated institution) Grafenstein (affiliated institution)	378	Men, women, young people; Pre-trial detention and penal imprisonment for up to 18 months; imprisonment under eased conditions and prison leave scheme.
Justizanstalt für Jugendliche Gerasdorf (LA)	122	Male young people and young adults.
Justizanstalt Göllersdorf (LA)	165	Non-punitive detainees under StGB Section 21, para .1 (offenders suffering from mental disorders lacking criminal capacity) and penal prisoners.
Justizanstalt Hirtenberg (LA) Münchendorf (affiliated institution)	421	Male inmates; term of imprisonment from 18 months to a maximum of 6 years; prison leave scheme.
Justizanstalt Korneuburg (LA)	269	Men and women; pre-trial detention and penal imprisonment for up to 18 months.
Justizanstalt Krems (LA)	162	Men, women, young people; pre-trial detention and penal imprisonment for up to 18 months.
Justizanstalt Schwarzbau (LA)	196	Women and female young people; offenders suffering from mental disorders but not lacking criminal capacity, and in need of addiction treatment (referral under StGB Section 21, para. 2 and Section 22); penal imprisonment from 18 months to life; kindergarten for up to 23 children.
Justizanstalt Sonnberg (LA)	350	Male adults; term of imprisonment from 18 months to 10 years. 2 units with prison leave scheme.
Justizanstalt St. Pölten (LA) Landesnervenklinikum Mostviertel (psychiatric institution)	245	Male adults and young people; pre-trial detention and penal imprisonment for up to 18 months; prison leave scheme.
Justizanstalt Stein (LA) Mautern (affiliated institution) Oberfucha (affiliated institution) Department of Landesnervenklinikum Krems/Donau (psychiatric institution)	787	Male adults and non-punitive detainees under StGB Section 21, para. 2 and Section 22 (offenders suffering from mental disorders but not lacking criminal capacity, and in need of addiction treatment); imprisonment from 18 months to life; high-security prison and imprisonment under eased conditions; focus on opioid substitution treatment.
Justizanstalt Wiener Neustadt (LA)	211	Men, women, young people; pre-trial detention and penal imprisonment for up to 18 months, prison leave scheme.
Justizanstalt Garsten (UA)	367	Male penal prisoners, non-punitive detainees under StGB Section 21, para. 2 (offenders suffering from mental disorders but not lacking criminal capacity) and pre-trial detainees.
Justizanstalt Linz (UA) Asten (affiliated institution) Therapeutisches Zentrum Asten (treatment centre)	531	Men, women, young people, non-punitive detainees; pre-trial detention and penal imprisonment for up to 18 months; male non-punitive detainees under StGB Section 21, paras. 1 and 2.
Justizanstalt Ried im Innkreis (UA)	144	Men, women, young people; pre-trial detention and penal imprisonment for up to 18 months; prison leave scheme.

Name of prison (province)	Number of places	Further information
Justizanstalt Suben (UA)	289	Male penal prisoners; imprisonment for up to 18 months; prison leave scheme, penal imprisonment for older inmates.
Justizanstalt Wels (UA)	156	Men, women, young people; non-punitive detainees under StPO Section 429, para. 4; pre-trial detention and penal imprisonment for up to 18 months; prison leave scheme.
Justizanstalt Salzburg (S)	227	Men, women, young people; pre-trial detention and penal imprisonment for up to 18 months.
Justizanstalt Graz-Jakomini (St)	538	Men, women, young people; pre-trial detention and penal imprisonment for up to 18 months.
Justizanstalt Graz-Karlau (St) Lankowitz (affiliated institution)	522	Male adults, non-punitive detainees under StGB Section 21, para. 2; imprisonment for over 18 months; very high security standard; imprisonment under eased conditions.
Justizanstalt Leoben (St)	205	Men, women, young people; pre-trial detention and penal imprisonment for up to 18 months.
Justizanstalt Innsbruck (T)	495	Male and female inmates and young people; pre-trial detention and penal imprisonment.
Justizanstalt Feldkirch (Vb)	160	Men, women, young people; pre-trial detention and penal imprisonment for up to 18 months.
Justizanstalt Wien-Favoriten (V) Münchendorf (affiliated institution)	113	Men and women; special institution for offenders in need of addiction treatment ⇒ treatment of inmates addicted to narcotic substances or alcohol.
Justizanstalt Wien-Josefstadt (V)	1057	Men, women, young people; pre-trial detention and penal imprisonment for up to 18 months; large proportion of pre-trial detainees.
Justizanstalt Wien-Mittersteig (V) Floridsdorf (affiliated institution)	150	Special institution for non-punitive detention of offenders suffering from mental disorders but not lacking criminal capacity (under StGB Section 21, para. 2).
Justizanstalt Wien-Simmering (V)	452	Male adults; penal imprisonment from 3 months to approx. 5 years.

Source: BMJ 2016a; graphic representation: GÖG

Table 8.2 below provides an overview of the number of inmates¹³⁵ in Austrian prisons on six selected reference days. It becomes apparent that the proportion of female prisoners out of the total number of inmates is around 6%. Pre-trial detainees account for approximately one in five of the total number of inmates, and the percentage of young people was approximately 2% up to 2010. The temporary decrease in their proportion, to approximately 1% in 2014, has been attributed to the effects of the interdisciplinary round table aimed at avoiding and shortening the pre-trial detention of young people, which was started in summer 2013 and subsequently continued (BMJ 2013a; BMJ 2015b). At present, the proportion of young people has again seen a rise (2017: 1.6%).

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The number of inmates comprises all inmates under the administration of prisons, i.e. it also includes persons imprisoned or detained in the context of commitment to a hospital or persons in electronically monitored house arrest (i.e. wearing an ankle monitor).

Table 8.2:

Number of inmates in Austrian prisons and similar institutions by 1 December 2008, 2009, 2010 and 2014, and by 1 April 2016 and 2017

Inmates	2008	2009	2010	2014	2016	2017
Men	7 766	8 186	8 251	8 363	3 344	8 493
Women	482	522	562	541	523	513
Total	8 248	8 708	8 813	8 904	8 867	9 006
of those: young people	184	172	193	88	133	145
of those: pre-trial detainees	1 785	1 994	1 909	1 807	1 729	1 880

Pre-trial detainees (with a few exceptions) are detained in criminal court prisons at the location of the court of first instance (Hofinger, Pilgram undated).

Source: Moser-Riebinger, Mika, personal communication: graphic representation: GÖG

Information on social characteristics of inmates (such as level of education and occupational situation) has been provided in the 2011 report on the drug situation (GÖG/ÖBIG 2011). In addition, the security report by the Federal Ministry of Justice (BMJ 2017) lists this type of data, which are collected in the 'social workers module' of the integrated prison administration system (IVV). However, the corresponding data entries are still incomplete to a high degree – in spite of considerable improvements in recent years – and conclusive statements on all imprisoned persons are thus impossible. Whenever necessary, the analyses given are therefore restricted to selected subgroups or institutions where social workers use the IVV more intensively.

The available 2016 data on housing¹³⁶ reveal that before their imprisonment, the majority of inmates had been tenants or subtenants, or had shared a flat/house with others (71%); and 12% had been homeless. The proportion of those living in public institutions or federal accommodation, i.e. who did not have a home in a strict sense, was eight per cent; and also roughly eight per cent indicated that they were home owners. More women than men said they had been tenants, whereas a larger proportion of men indicated that they had been housemates/flatmates.

With regard to education, data on approximately half of inmates with Austrian nationality can be provided. If all inmates (including non-Austrian nationals) are taken into account, education data exist for only 36% of inmates. Approximately two out of three inmates with Austrian nationality indicate completion of compulsory school as their highest educational level (completion of general secondary school: 34%; general secondary school including pre-vocational year: 19%; primary school: 5%; special-needs school: 5%). One in four (25%) has completed vocational school, and approximately 10% have completed upper secondary school or further educational levels. In 2012, the proportion of persons all over Austria who had completed upper secondary school and/or university as their highest educational level was around 30%, and 19% had completed compulsory school. If the parameter of education among Austrians is studied only for those three prisons in which the highest educational level of four out of five inmates has been entered, i.e. Favoriten

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In the IVV system, information on the housing situation before imprisonment is available for only 63% of inmates.

(Vienna), Feldkirch (Vorarlberg) and Sonnberg (Lower Austria), then again, completion solely of compulsory school is the highest level of education of nearly two out of three prisoners.

8.2.2 Drug use and related problems among prisoners

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

The results of the PRIDE survey (Weltzien et al. undated), which focuses on the prevention of infectious diseases in prison, will be described below.

8.2.3 Drug-related health responses in prisons

Since the end of 2015, Austria's national Addiction Prevention Strategy has been in place, which underlines that the principle of health in all policies (HiAP) also applies to addiction policy. In addition, it states that services need to be provided in the context of the health and social care system to support addicted people, whose disease often takes a chronic course, in line with their needs; and that the preservation of human health, harm reduction and treatment shall be given priority over security interventions and law enforcement (see chapter 2). The Addiction Prevention Strategy also points out that the basic care services for persons in prison should, in addition to health care and addiction treatment, include harm reduction (particularly giving injecting drug users in prison access to sterile syringes and condoms as well as lubricants; BMG 2015). The Ministry of Justice has issued a guideline that defines standards for the advice, care and treatment of addicted persons in pre-trial detention, in penal imprisonment and in non-punitive detention in Austria (BMJ 2015a).

The Execution of Sentence Act (BGBl. 1969/144, StVG), various general circulars, as well as the European Prison Rules (EPR), provide the legal basis for general health care in prison. Its funding comes from public budgets, through the Federal Ministry of Justice. The prisoners do not have health insurance (see also chapter 2; BMJ 2016b).

Structure of drug-related prison health responses

In order to ensure the necessary cooperation of all stakeholders in the health and social care sector, cooperation models – mostly at the regional level – have been established between the prison administrations and the relevant institutions and service providers. In addition, links to the individual provincial governments and district governors' offices have been established. Health

care for addicted prisoners is provided through health and treatment services, which are often delivered in cooperation with external organisations, e.g. *Dialog* (see GÖG/ÖBIG 2011).

Types of drug-related health responses available in Austrian prisons

Detailed information on drug-related health responses in prison is given in GÖG/ÖBIG 2011. In the prisons, a variety of treatment services are available, and include maintenance treatment, detoxification, assistance with regard to abstinence-oriented goals if desired, as well as the prevention, diagnosis and treatment of HIV, hepatitis C and other infectious diseases. Upon commencing a prison sentence, prisoners receive care packages with condoms and leaflets on HIV, AIDS and hepatitis. Prison inmates should have easy, unobserved access to condoms and personal lubricants as a measure aimed at harm reduction (see BMJ 1998b and 1998c), however, according to a European survey on the prevention of infectious diseases in prison (Weltzien et al. undated; see section 8.4), this applies to only around half of Austrian prisons. This means that the relevant national guidelines (usually communicated in general circulars) and international guidelines are not implemented in all Austrian prisons. Antiretroviral (ARV) therapy for HIV infections is offered in all 27 prisons, and testing for infectious diseases is available in two out of three institutions. Furthermore, information on post-exposure prophylaxis is available in less than half of prisons. Systematic hepatitis B vaccinations for all seronegative prisoners, syringe exchange programmes and prevention measures relating to the transmission of diseases due to tattooing or piercing are not available in Austrian prisons. The above study recommends awareness-raising with regard to harm reduction interventions, as well as training in this field. It also reveals that only a small number of non-governmental organisations (NGOs) have been active within prisons in Austria, and compared to other countries, only few NGOs provide services in the context of harm reduction. This could be one of the reasons for the absence of a network between prisons and NGOs. However, the study underlines that the general guidelines described below (BMJ 2015a) will contribute to raising the awareness among prison staff that addiction is a disease and that distinctions must be made between different types of drug tests (prison-related v. treatment-oriented testing).

In order to assess the state of health of new prisoners and to initiate treatment whenever necessary, all inmates are medically examined shortly after commencing a prison sentence. This examination, in accordance with the general guidelines (BMJ 2015a), includes the collection of addiction-related/diagnostically relevant data by medical staff ('addiction screening I'). It is no longer the attending doctor's decision as to what data on the duration of prior drug misuse are surveyed: now a standard question to this effect is part of a checklist and must be asked (see BMJ 2015a). For each addicted inmate, imprisonment goals must be defined, which also include an individual treatment plan. Supervisory measures for prison-related security purposes ('drug tests') taken by the prison management must be distinguished from tests in the context of medical, treatment-related monitoring (blood or saliva tests, urinalyses), which are performed by the appropriate specialists. Unlike the tests carried out for prison-related security reasons, the results of medical drug tests are subject to doctor-patient confidentiality and are thus not documented in the inmate penalty module of the integrated prison administration system. Prisoners must be prepared for release in a structured way, and must be provided with adequate doses of substitution medicine and/or valid prescriptions. If the inmate concerned agrees, an addiction support service and/or the doctor in charge is contacted in the course of preparing for release (BMJ 2015a).

The guidelines also include the option that addiction support centres cooperate with the psycho-social service at the prison to make psychotherapy available to addicted inmates at an early stage. Particularly in the context of preparation for release, this contributes to a structured transition to treatment/therapy outside prison. For instance, the *Dialog* association cooperates with the prison of Simmering (Vienna) in this regard, and similar cooperation has been established in Styria between the *b.a.s* service and the prisons of Graz-Karlau and Graz-Jakomini, as well as between the Drug Advice Centre of the Province of Styria and the prison of Graz-Jakomini (Verein Dialog 2017, Horvath et al. 2017).

Since 1999, the *Dialog* association has offered a variety of social work services and medical treatment to inmates of the two Viennese police detention centres¹³⁷. In 2016, staff of the *Dialog* association provided services to a total of 2 145 clients (2015: 1 738 clients) at the detention centres, including interventions specifically addressing women or men (Verein Dialog 2017). In Styria, staff of *Kontaktladen* and *streetwork* visit drug users in prison (2016: 159 visits in the context of individual case support). Their services include psychosocial support as well as planning ahead for the time after release (Caritas Diözese Graz-Seckau 2017). The *Suchthilfe Salzburg* addiction services also offer liaison services (Schabus-Eder, personal communication).

The prisons do not offer pre-release emergency services such as naloxone programmes or training to prevent overdoses.

The number of persons undergoing (or wishing to undergo) drug-related treatment other than opioid substitution treatment and who do not (wish to) receive OST is not known. The ratio between such measures offered and actual demand is therefore likewise unknown. Approximately 16% of inmates are assumed to be receiving some form of drug treatment. Information on drug-free zones in prison is provided in the 2011 report on the drug situation (GÖG/ÖBIG 2011).

The extent of substitution treatment in prison

Opioid substitution treatment can either be started or continued during imprisonment (BMJ 2015a). By 1 April 2017, a total of 872 prison inmates, or 9.7% of inmates, received opioid substitution treatment (Table A8. 2). This represents a slight increase compared to 836 persons recorded on the reference date of 1 April 2016. Opioid substitution treatment is available in all prisons in Austria. The highest proportions are accounted for by the prison of Favoriten (Vienna), where almost 39% of inmates are undergoing substitution treatment. However, Favoriten is a special prison for offenders in need of addiction treatment. The Viennese prisons of Simmering and Josefstadt rank second (approximately 14% each), followed by Krems-Stein (Lower Austria), with around 13% OST prisoners. On the reference date, around 11% of the inmates of the prisons of

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Austria has a total of 18 police detention centres, i.e. prisons administered by the Federal Ministry of the Interior. In contrast to prison inmates, the detainees do not serve penal prison sentences. Police detention centres primarily house persons detained pending deportation or administrative law offenders. In sum, more people are detained there than in the regular prisons, and the average periods of detention tend to be rather short (Hofinger, Pilgram undated; Verein Dialog 2015).

Feldkirch, Hirtenberg, Suben and Wiener Neustadt were in opioid substitution treatment. The lowest proportions of OST patients are accounted for by the prisons of Göllersdorf and Leoben (approximately 2.4% each), Krems (4%) as well as Eisenstadt (4.7%). In Vienna's Mittersteig prison (special institution for non-punitive detention of offenders suffering from mental disorders but not lacking criminal capacity), two inmates were in opioid substitution treatment, as was one inmate of the Gerasdorf prison for young people (Mika, personal communication).

The substitution medicines most frequently administered in prison are methadone (38.4% of opioid substitution treatments), Substitol (18.6%), Suboxone (15.4%), L-polamidone (11.2%), as well as Subutex/Bupensan (approx. 10.1%; Mika, personal communication; see Table A8. 2). Methadone is thus used considerably more often in prison than outside prison (see chapter 5).

More detailed information on drug-related health interventions during imprisonment is provided in the selected issues chapter on drug-related health policies and services in prison (chapter 11) of the 2011 report on the drug situation (GÖG/ÖBIG 2011).

8.2.4 Quality assurance of drug-related health responses in prison

The majority of guidelines mentioned in T1.3 have been published in the form of general circulars. For instance, since April 2015, the general guidelines for advice, care and treatment of addicted pre-trial detainees in Austria, as well as penal prisoners and detainees in non-punitive detention, have been implemented. They are based on the current legislation as amended and on state-of-the-art research (BMJ 2015a; see also GÖG/ÖBIG 2013). These general guidelines must be implemented in all Austrian prisons; they include checklists for medical and social care services (to enhance professional responses by the experts involved) and constitute a step towards harmonised procedures and quality assurance. The general guidelines endorse the view of addiction or dependence as a disease, which means that those suffering from addiction are entitled to adequate advice, care and treatment both in prison and outside prison, in accordance with the principle of equivalence of care and equal treatment of diseases¹³⁸. For instance, addicted patients must not be discriminated against on grounds of their disease with regard to eased conditions of imprisonment, occupation, training and leisure activities. In prison, as well as outside prison, the former paradigm of abstinence is to be replaced by the paradigm of acceptance, not least due to the possibility of substitution treatment. After relapses¹³⁹ of addicted patients, which addiction medicine describes as part of the disease, their subsequent treatment must not be punitive but must

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In accordance with the principle of equivalence of care and equal treatment of diseases, medical treatment in prison must be equivalent to the treatment that is normal and usual outside prison.

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This relates to addiction treatment in the strict sense, irrespective of any responses undertaken for legal reasons by the prison authorities.

primarily be oriented towards a medically appropriate course of action. Most of the standards included in the general guidelines were already defined in 2014, as minimum standards for responses to addiction among prison inmates and detainees in non-punitive detention, in accordance with Criminal Code Section 22 and Prisons Act Section 68a¹⁴⁰ (BMJ 2014). In line with these standards, which also distinguish between the individual stages of imprisonment (admission, imprisonment stage, preparation for release, release), each prison must hire and maintain a multi-professional treatment team of specialists (doctors, psychiatrists, psychologists, social workers and teachers). Data relevant for addiction/diagnosis ('addiction screening I') must be gathered soon after admission. In order to ensure the continuity of treatment upon commencing imprisonment, the inmates' prior substitution treatment is kept up (see also 8.2.3).

Based on a general circular issued by the BMJ, substitution treatment in prison must correspond to the substitution guidelines for prisons (BMJ 2005a), which include a section on specific aspects (indication, supervision etc.) of opioid substitution treatment during penal imprisonment. The guidelines propose the exclusive use of substitution medicines with an action duration of at least 24 hours in order to enable administration only once a day (methadone, buprenorphine and slow-release morphine). From a scientific point of view, and on grounds of cost, the prescription of methadone is recommended. In the case of intolerance to methadone, a change to another substitution medicine can be considered. If patients have already started treatment with another medicine, this substance should continue to be administered. Other general circulars stipulate the publication of information booklets on hepatitis, HIV/AIDS in prison (BMJ 2013b, BMJ 1998a, BMJ 1998b, BMJ 1998c) and on (further) training schemes for inmates (BMJ 2012). In 1999, guidelines and recommendations for post-exposure prophylaxis in the case of workplace-related exposure to HIV were issued (BMJ 1999). The booklet on ways out of addiction published in 2005, and in a revised form in 2009, addresses prison staff and provides an overview of the treatment of addicted persons both during and after imprisonment (BMJ 2005b, BMJ 2009). According to Ms Winterleitner, since 2013 obligatory screening tests for HCV have been carried out for all new prisoners. All pre-trial detainees belonging to a risk group are tested (Winterleitner, personal communication).

A guideline on opioid substitution treatment initiated by the BMGF explicitly refers to the specific treatment situation of prisoners (see chapter 5; ÖGABS et al. 2017).

8.3 New developments

Since 2016, prisons, in cooperation with the Austrian Federal Office for Health and Food Safety (AGES), have surveyed the prevalence of infectious diseases in prisons, with the focus on TB, as well as on the drug-related infectious diseases of HIV, HCV and HBV. During the reporting period, the prisons have begun to use the new direct-acting antiviral agents for treating HCV, and in

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The acts cited regulate the addiction treatment of penal prisoners and their possible referral to specialised institutions for offenders in need of addiction treatment.

addition to HCV screening, genotype testing has been intensified. The results of the survey have been scheduled for publication late in 2017 (Winterleitner, personal communication).

Many of the legal proposals made by the round table on the pre-trial detention of young people, the proposals coming from reform initiatives and practitioners, and academic input have been incorporated in the amendment to the Juvenile Court Act, which entered into force at the beginning of 2016 (BGBl. I 2015/154) and is regarded as the implementation (to a great extent) of the corresponding items of the current Government Programme (BMJ 2016). Since 2015 the juvenile court representatives system has been gradually introduced. With regard to quality assurance, uniform federal standards have been defined, and a specific registry has been established in cooperation with the family court assistants. In the reporting period, the juvenile court representatives investigated a total of 3 479 cases, and in 3 124 cases, recommendations for necessary measures were made; in 131 cases, a directive was issued recommending that the person should undergo 'drug treatment' (BMJ 2017).

The aforementioned guideline on quality standards for opioid substitution treatment, which was drawn up by national experts on behalf of the BMGF (see chapter 5), also mentions the treatment of imprisoned OST patients, and refers to the BMJ guideline on responses to addicted prisoners (BMJ 2015a). It also points out that the treatment situation in prison is often difficult, due, for instance, to the high prevalence of personality disorders among inmates, limited medical and therapeutic resources and problems in the patient-doctor relationship. It also stresses the need for qualified (further) training for the staff, and the importance of close links with external providers of addiction services, which have already been established in several cases (ÖGABS et al. 2017).

In its report to the two houses of the Austrian Parliament on preventive human rights monitoring, the Austrian Ombudsman Board emphasises the need for expertise with regard to addicted young people in prison – particularly *'the delivery of opioid substitution treatment, as well as induction and stabilisation of underage prisoners requires the expertise of a medical specialist in child and youth psychiatry'* (p. 114). On a positive note, the report mentions the training programme on the imprisonment of young people, which addresses prison staff and also includes the subjects of psychiatric diseases and addiction problems among young people (Volksanwaltschaft 2017).

At present, new psychoactive substances play an insignificant role in prison (Winterleitner, personal communication).

A problem that exists throughout Austria is that (addicted) persons released from prison do not immediately get health insurance coverage. This is particularly difficult for patients needing opioid substitution treatment. For Vienna, a procedure is being developed that aims at the provision of health insurance immediately after release from prison (SDW 2017).

For further changes in the legal framework please consult chapter 2.

8.4 Sources and methodology

Sources

The information presented in this chapter is primarily based on data collected by the Federal Ministry of Justice (Division of Law Enforcement and Care Services in Prison of the Directorate-General of Prisons and Detention Measures). Other information has been retrieved from academic publications, general circulars, national legislation, publications by the BMJ as well as the annual reports of drug support services.

Methodology

The study PRIDE Europe – an inventory of infection prevention services in prison, whose results have been presented in 8.2.3, was conducted from 2013 to 2014 in the context of the project CARE – Quality and Continuity of Care for Drug Users in Prisons, which was coordinated by Frankfurt University of Applied Sciences and co-funded by the EU Drug Prevention and Information Programme (Weltzien et al. undated). The CARE project was aimed at collecting and communicating data and information on drug use and risks associated with drug use in prison. It also covers the issues of harm reduction, prevention of overdoses and reintegration after release from prison. The survey was conducted in Austria, Belgium, Denmark and Italy. Its goal was to obtain data on risk behaviour with regard to infections and other drug-related health risks in prison and to document to what extent the services available in prison correspond to existing (inter)national guidelines. In the questionnaires, the availability of prevention measures to avoid infections was surveyed for 10 subcategories in all prisons (e.g. substitution treatment, syringe exchange, availability of condoms/personal lubricants). The survey was carried out from July 2013 to January 2014: the questionnaire was sent to the prison managers, who were asked to present them to the prisons' medical departments. Adherence to (inter)national guidelines and availability of harm reduction interventions was assessed on the basis of a scoring system. All 27 Austrian prisons took part in the survey, and 19 returned fully completed questionnaires.

The data given in 8.2.2 relate to the research project *Senior Drug Dependents and Care Structures* carried out by Eisenbach-Stangl and Spirig (2010), which had been supported by the European Union. The aim of the project was to gain more insight into the situation of older women and men addicted to drugs, and to provide a basis for devising care services during old age. The project was carried out from 2008 to 2010, in four countries: Austria, Germany, Poland and Scotland. The Austrian project was implemented in the form of active cooperation between the *European Centre for Social Welfare Policy and Research* and the *Schweizer Haus Hadersdorf* treatment centre. The project consists of five loosely connected substudies. For the purpose of this report, the second substudy is relevant. In the context of this substudy, qualitative interviews were conducted, for instance, with 19 older addicted patients (in accordance with the definition 'opioid users aged 35 years or older') at the prison of Favoriten (Vienna) and the Schweizer Haus Hadersdorf inpatient treatment centre.

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StGB BGBl. 60/1974 v. 23. Jänner 1974 über die mit gerichtlicher Strafe bedrohten Handlungen (Strafgesetzbuch – StGB)

StVG BGBl. 144/1969 v. 26. März 1969 über den Vollzug der Freiheitsstrafen und der mit Freiheitsentziehung verbundenen vorbeugenden Maßnahmen (Strafvollzugsgesetz – StVG)

8.7 Personal communications (alphabetical order)

Name	Institution or function
Claudia Mika	Federal Ministry of Justice
Andrea Moser-Riebniger	Federal Ministry of Justice
Margit Winterleitner	Federal Ministry of Justice
Franz Schabus-Eder	Addiction Coordinator of the Province of Salzburg

8.8 Annex

Table A8. 1:

Austrian prisons – number of penal prisoners and inmates detained in the context of other types of detention; by 1 April 2017

Type of detention	Male				Female				Total	
	Adults	Young adults	Young people	Total	Adults	Young adults	Young people	Total	Total	Percentage
Penal imprisonment	5 324	252	57	5 633	293	4	2	299	5 932	65.87 %
Pre-trial detention	1 587	138	53	1 778	93	6	3	102	1 880	20.87 %
Non-punitive detention	738	21	5	764	71	4	2	77	841	9.34 %
Other type of detention*	269	28	21	318	32	1	2	35	353	3.92 %
Total	7 918	439	136	8 493	489	15	9	513	9 006	100 00%

* For instance, penal imprisonment for fiscal law offenders, detention pending deportation or coercive detention for contempt.

Source: BMJ; graphic representation: GÖG

Table A8. 2:
Substitution treatment in prisons; by 1 April 2017

Prison incl. affiliated institution(s)	Total substitution patients	No. of patients taking:									
		Methadone	L-polamidone	Substitol	Mundidol	Mundidol Substitol	(Subutex) Bupensan	Suboxone	Compensan	Codidol	Other substances
Eisenstadt	9	1	0	2	0	0	6	0	0	0	0
Feldkirch	18	8	0	1	0	1	7	0	1	0	0
Garsten	34	10	11	4	0	0	7	2	0	0	0
Gerasdorf	1	1	0	0	0	0	0	0	0	0	0
Göllersdorf	4	0	0	2	0	0	2	0	0	0	0
Graz/Jakomini	42	9	5	22	1	0	2	0	2	0	1
Graz/Karlau	57	18	12	8	1	0	6	10	0	2	0
Hirtenberg	49	17	3	12	0	0	1	16	0	0	0
Innsbruck	52	7	5	10	0	0	22	0	6	2	0
Klagenfurt	32	12	5	0	0	0	0	15	0	0	0
Korneuburg	15	7	1	2	0	0	0	0	0	5	0
Krems	7	4	1	0	0	0	0	2	0	0	0
Leoben	7	3	0	1	0	0	1	2	0	0	0
Linz	30	1	4	18	0	0	7	0	0	0	0
Ried	11	5	2	2	0	0	0	2	0	0	0
Salzburg	18	1	1	7	1	0	3	0	4	1	0
Schwarzau	17	5	6	3	0	0	3	0	0	0	0
Sonnberg	30	19	0	3	0	0	0	8	0	0	0
St. Pölten	16	9	0	3	0	0	0	2	1	0	1
Stein	98	46	18	8	0	0	0	26	0	3	0
Suben	32	11	3	3	0	0	3	5	1	6	0
Wels	16	2	6	6	0	0	1	1	0	0	0
Vienna/Favoriten	44	23	14	0	0	0	7	0	0	0	0
Vienna/Josefstadt	148	102	0	10	0	0	0	34	0	0	2
Vienna/Mittersteig	2	2	0	0	0	0	0	0	0	0	0
Vienna/Simmering	57	9	0	26	0	0	0	9	0	0	13
Wiener Neustadt	23	3	1	9	0	0	10	0	0	0	0
Total (as reported by prisons)	872	335	98	162	3	1	88	123	15	19	17
Distribution (percentages)*	9.7	38.4	11.2	18.6	0.3	0.1	10.1	15.4	1.7	2.2	1.9

* Total inmates: 9006 persons.

Source: BMJ; graphic representation: GÖG