



EMCDDA PAPERS

Drug policy profile: Austria

Contents: Introduction (p. 2) | Drug control development and external influence (to 1970) (p. 3) | New issues and the birth of the Austrian approach (1971–85) (p. 5) | New challenges, structures and responses (1985–97) (p. 7) | Policy adjustments (1998–2012) (p. 9) | Conclusions (p. 14) | References (p. 16)

Abstract: This paper describes the development and main characteristics of drug policy in Austria. It provides readers – from researchers to policy makers – with an insight into how illicit drugs have been controlled and drug-related problems have been responded to. The report traces the development of Austrian drug laws from the time of the Austro-Hungarian Empire through to the present day. Austria’s drug policy has several distinctive and innovative features, including the early creation of and lasting support for the principle of ‘treatment instead of punishment’. Drug problems emerged in several phases in Austria. Prior to the late 1960s there were low levels of illicit synthetic opioid use, while cannabis use emerged among adolescents in the early 1970s. Heroin use increased at the end of that decade and had a significant impact on drug treatment provision from the 1980s onwards in the context of HIV/AIDS and injecting drug use. Like in other EU Member States, new psychoactive substances have emerged in Austria, triggering a new legal response. This report explores the response to these issues

through four periods of policy development. The profile shows that federalism is associated with diversity within a national policy, as suggested by either drug strategies or wider addiction strategies in the provinces or variations in opioid substitution treatment practices.

Keywords drug policy drug laws
drug treatment Austria
drug problems

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Introduction

The EMCDDA's drug policy profiles aim to describe some of the main characteristics of national drug policies in Europe and beyond. In contrast to other approaches, we do not attempt to assess these policies, but instead to outline their development and main features. Our objective is to help readers — from researchers to policymakers — gain a better understanding of the way in which countries control drugs and respond to drug-related security, social and health problems.

National drug policies are the outcome of the interaction of multiple factors, such as political and administrative structures, the role and influence of stakeholders, financial resources, the drug situation, other public policies (e.g. health, security) and international agreements. There is no simple model for how to combine these factors and assess their respective weight and interrelations. However, this should not prevent analysts from exploring the significant changes in these factors that may have shaped drug policy in the short and long term.

The EMCDDA's drug policy profiles use a historical perspective to identify such drug policy changes. While some of these changes may have occurred in parallel in many countries because they were facing the same issues (e.g. the adoption of new UN conventions, HIV/AIDS epidemics, diffusion of new drugs), the policy profiles show that each country has its specific drug policy timeline and events.

This profile is the first one to examine a country with a federal structure: Austria. The country's drug policy has features that

are distinctive and innovative from a European perspective. The policy profile considers, whenever available, drug or addiction strategies, the legal context within which they operate, and the public funds spent, or committed, to resource them. It also describes the main developments of drug-related interventions, the political bodies and mechanisms set up to coordinate the response to the multi-faceted problem and, when existing, the systems of evaluation that may help to improve future policy. Social and epidemiological developments are also mentioned whenever relevant.

The profile puts this information in context by outlining the size, wealth and economic situation of the country as a whole, as well as the historical development of the current policy. One note of caution for the reader is that the availability of information and analysis in the area of demand reduction is, as with most national and international drug policy studies, much greater than in the area of supply reduction.

What is a drug policy?

To prevent both a too broad or too restrictive approach we will use an adaptation of Kilpatrick's definition of public policies (www.musc.edu/vawprevention/policy/definition.shtml): 'A system of laws, regulatory measures, courses of action and funding priorities concerning (illicit) psychoactive drugs and promulgated by a governmental entity or its representatives.'

Austria in figures

	Year	Austria	EU (27 countries)
Population	2012	8 443 018	503 663 601 (P)
Population by age	15–24	12.1 %	11.7 %
	25–49	36.3 %	35.4 %
	50–64	19.4 %	19.5 %
GDP per capita in PPS (1)	2011	129	100
Total expenditure on social protection (% of GDP) (2)	2010	30.4 %	29.4 % (P)
Unemployment rate (3)	2012	4.3 %	10.5 %
Unemployment rate of population aged under 25 years	2012	8.7 %	22.8 %
Prison population rate (per 100 000 of national population) (4)	2011	104.3	
At risk of poverty rate (5)	2011	12.6 %	16.9 %
Political system	Federal republic		

(P) Eurostat provisional value.

(1) Gross domestic product (GDP) is a measure of economic activity. It is defined as the value of all goods and services produced less the value of any goods or services used in their creation. The volume index of GDP per capita in purchasing power standards (PPS) is expressed in relation to the European Union (EU-27) average set to equal 100. If the index of a country is higher than 100, this country's level of GDP per head is higher than the EU average and vice versa.

(2) Expenditure on social protection includes benefits, which consist of transfers in cash or in kind to households and individuals to relieve them of the burden of a defined set of risks or needs.

(3) Unemployment rate represents unemployed persons as a percentage of the labour force. Unemployed persons comprise persons aged 15 to 74 who are: (a) without work during the reference week; (b) currently available for work; (c) actively seeking work.

(4) Situation in penal institutions on 1 September 2010.

(5) Share of persons aged 0+ with an equivalent disposable income below the 'at risk of poverty' threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers).

Source: EMCDDA country overview — Austria (www.emcdda.europa.eu/publications/country-overviews/at)

Policy timeline: key dates

International and EU developments	Year	National developments
	1951	Narcotic Drugs Act (NDA) enters into force
UN Single Convention on Narcotic Drugs	1961	
UN Convention on Psychotropic Substances	1971	Amendment to Narcotic Drugs Act Advisory Board for Combating the Misuse of Alcohol and Other Addictive Substances
	1972	First long-term residential treatment facility at the Anton Proksch Institute in Vienna
	1975	Central Office for Combating Drug-Related Crime
	1979	Narcotic Drugs Regulation
	1980	Amendment to Narcotic Drugs Act Vorarlberg issues first provincial drug concept
	1985	Amendment to Narcotic Drugs Act Austrian Aids Service Organisation
	1987	Regulation on Opioid Substitution Treatment
UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances	1988	
European Plan to Combat Drugs	1990	
Report on the European Plan to Combat Drugs	1992	
EU Plan to Combat Drugs 1995–99	1995	Austria becomes a member of the European Union Provincial Drug Coordinators Conference
UN General Assembly Special Session on the World Drug Problem	1997	Federal Drug Coordination and Federal Drug Forum
	1998	Narcotic Substances Act (NSA)
EU Drugs Strategy 2000–04 EU Action Plan on Drugs 2000–04	2000	Working Group for Addiction Prevention
	2001	Amendment to Narcotic Substances Act
	2002	All nine provinces have issued Drug Strategies
EU Drugs Strategy 2005–12 EU Drugs Action Plan 2005–08	2005	
	2008	Amendment to Narcotic Substances Act
EU Drugs Action Plan 2009–12	2009	
	2012	New Psychoactive Substances Act
EU Drugs Strategy 2013–20 EU Drugs Action Plan 2013–16	2013	

Drug control development and external influence (to 1970)

Available information suggests that in the nineteenth century there was a relatively tolerant approach towards drug use in Austria, with no significant attempts at creating drugs legislation. Drug addiction was considered an illness but was not thought to be a major social problem. The first legislation related to substance use was the Poison Regulation (*Giftverordnung*) issued by the Austro-Hungarian Empire in 1876. It regulated the commercial distribution of poisons, including drugs ⁽¹⁾ and harmful chemical preparations (Eisenbach-Stangl and Burian, 1998). At this time the medical use of opiates was relatively common among war veterans (Pilgram, 1992), particularly after the war against the Italian *Risorgimento* in 1859 and the German war in 1866. Towards the end of the century studies on the medical use of cocaine and heroin were popular in the academic field (see the box ‘Vienna and the belle époque’).

Representatives from the Austro-Hungarian Empire attended the Shanghai Opium Commission’s conference in 1909 together with 12 other states, and participated in the 1912 International Opium Conference in The Hague. However, it did not ratify the Opium Convention because of internal political tensions that led to the First World War (Pilgram, 1992). In 1916, during the war, an Incapacity Law (*Entmündigungsordnung*) was enacted as a first element of a criminal law reform that had already been debated for over 20 years. The Incapacity Law made provision for the civil rights of alcohol and drug abusers to be restricted to that of adolescents, but also permitted judicial authorities to assess and regulate coercive treatment within psychiatry. It was eventually replaced in 1984 by the Law on Trustees (Eisenbach-Stangl, 2012).

After the First World War the St. Germain-en-Laye peace treaty required Austria to adopt new drug legislation. In 1920 the Austrian Republic signed the 1912 International Opium Convention, and one year later it adopted a regulation (*Verordnung*) to control the production and distribution of raw opium, semi-synthetic opioids and cocaine. This was the first piece of legislation to refer to specific substances (Pilgram, 1992). In 1928 Austria signed the revised 1925 International Opium Convention of Geneva and passed a corresponding Poison Act (*Giftgesetz*). The Act regulated the distribution and possession of poisons and drugs. Pharmacies and, to a smaller extent, scientific studies became the only legitimate recipients for the production and distribution of drugs, and the only ones allowed to store them. The illicit distribution or possession for circulation of drugs, now also including

(1) The term drug (*Droge*) initially referred to arsis, quicksilver, hydrocyanic acid and other chemical substances.

cannabis, became a crime for the first time, punishable by one week to six months of imprisonment (Pilgram, 1992). When the Act was adopted in Parliament, mention was made of about 2 000 cocaine users known to the police. This number may, however, have decreased thereafter as a rapid change in the economic, social and political situation in the early 1930s led to the dissolution of some wealthy and bohemian circles in which drugs, notably cocaine, were used (Pilgram, 1992). This and other factors meant that the Poison Act was rarely enforced.

As a result of Austria's annexation by Germany in 1938, German law was applied from 1 January 1939 until the end of the Second World War. The Opium Act (*Opiumgesetz*), issued by the German Reich in 1929, was the main drug legislation. The Reich generally encouraged abstinence from substance use, although it provided amphetamines to soldiers at the battlefronts (Pieper, 2002).

The second Austrian Republic was established initially under the auspices of the victorious allies in 1945. One year later the Narcotic Drugs Act (NDA) (*Suchtgiftgesetz*), reflecting the international drug conventions of that time, replaced the Poison Act. It introduced stricter penalties for the production, import, export and circulation of drugs, with periods of imprisonment of one to five years, in some cases rising to 10 years, alongside a fine of up to ATS (Austrian Schillings) 25 000 (Eisenbach-Stangl and Burian, 1998; Pilgram, 1992). This law, the first to focus exclusively on illicit drugs, provided the legal framework for the next 50 years. It defined drug trafficking as a crime against public health (*Verbrechen gegen die Volksgesundheit*). Possession for personal use became a crime with the first amendment of the NDA in 1948/49, with possible imprisonment of one week to six months (Pilgram, 1992). Austria also re-signed the 1925 Opium Convention and other relevant international conventions. Austrian sovereignty

was fully re-established in 1955 under the obligation of 'everlasting neutrality'.

Neither illicit drug use nor the content of the Narcotic Drugs Act were prominent political issues until the late 1960s (Pilgram, 1992). Data show that between 1948 and 1968 only 744 sentences were passed under the Act, most of which related to doctors prescribing controlled substances for either their own use or for drug users. War veterans were among the groups most affected by drug addiction, because of their use of prescription drugs due to mental or physical illnesses (Grassberger, 1969). The most commonly used drugs were heptadon^(?), morphine, or morphine combined with other substances.

In 1968 the Federal Ministry for the Interior (*Bundesministerium für Inneres*) organised a drug conference attended by police officers and psychiatrists. This was mainly to discuss developments occurring in other parts of the world, notably in the USA (Eisenbach-Stangl and Burian, 1998), as there were no reports of a significant market for illicit substances or significant drug dealing at that time in Austria. This was illustrated by a study on drug law offenders conducted in the late 1960s which showed that only a minority had used cannabis or other illicit substances (Grassberger, 1969; Eisenbach-Stangl and Burian, 1998). The first representative survey among students, conducted in 1971, also found a low lifetime prevalence of 3 % for the use of any illicit drugs.

During the 1960s treatment was only available in closed psychiatric wards, and the number of drug-dependent patients was probably low: in 1971 some 3 % of all psychiatric patients were treated for drug addiction, although the type of substances, illicit or prescribed drugs, that they were treated for is not known (Eisenbach-Stangl and Burian, 1998). Other health-related responses were either rare or non-existent.

(?) Methadone hydrochloride, a derivative of methadone. It is only available in Austria. See: www.drugs.com/international/heptadon.html

Vienna and the *belle époque*

In the second half of the nineteenth century Vienna was the capital of one of Europe's biggest and most multicultural empires. It was a centre of music, literature, arts, architecture and sciences. The *fin de siècle* was characterised by a strong belief in the progress of humankind and in the freedom of arts. Many popular figures, especially artists, identified themselves with drugs and escapism.

Various forms of drug use were reported in society and science. The use of opiates, for example, was limited to medicinal purposes and was regarded as a cure for a variety of diseases. A change occurred from the mid nineteenth century onwards when the use of opiates, especially morphine, became more common. In the late nineteenth century morphine was believed to cause addiction, while cocaine and heroin were used for medical purposes and marketed as non-addictive morphine substitutes.

In the academic field, studies on the medical use of drugs were popular towards the turn of the century. Medical research on cannabis was conducted by Schroff and Fränkel, and research on cocaine was conducted by Freud, Koller and Schroff. Many publications on the phenomenon of 'morphinism' – the non-medical use of morphine – were published by Eder, Löbel, Dulchek, Levinstein and Leidesdorf (Springer, 2009).

The *belle époque* ended with the outbreak of the First World War. After the war the phenomenon of 'cocainism' — the non-medical use of cocaine — was reported among specific groups in Vienna. New studies on drugs were conducted during the 1920s, including research on cocaine by Bonvici and Hartmann, on mescaline by Pötzl and Adler and on morphine by Neutra. Although addiction in its modern sense was not defined before the 1930s, Freud introduced initial theoretical ideas about the concept during this period (Springer, 2009).

New issues and the birth of the Austrian approach (1971–85)

The drug phenomenon in Austria underwent quantitative and qualitative change in the late 1960s and early 1970s. This was reflected in the number of drug law offences, which increased rapidly to reach 607 cases in 1971 (Pilgram, 1992). While most of these offences still occurred within a medical context, young cannabis users appeared as a new group of offenders from 1966 onwards, with numbers increasing rapidly in the early 1970s. A survey conducted in Salzburg in 1972 found that about 15 % of 17-year-olds had used cannabis (Eisenbach-Stangl and Burian, 1998).

This increased in the use of cannabis and some other illicit substances was different from previous drugs issues in Austria. It occurred among adolescents and young adults, transcended social classes, had an international dimension and was a backdrop to the 1968 students' movements and calls for social change (Pilgram, 1992; Eisenbach-Stangl and Burian, 1998). This led to the first public debate on drugs in the country. The NDA, adopted shortly after the Second World War and only rarely applied until the late 1960s, was criticised for inflicting unnecessary criminal penalties on a population of mainly young students, often from middle- and high-income families. Some professionals working with adolescents, mainly teachers, probation assistants and social workers, called for the decriminalisation of the possession of drugs for personal

use (Eisenbach-Stangl and Burian, 1998), while government officials requested increased attention to the drugs situation to prevent levels of use increasing to those being observed internationally at that time.

The outcome of this public debate was an approach that is still at the core of Austria's drug policy today: 'treatment instead of punishment'. Its first application came in 1971 with the second amendment to the NDA. Penalties were removed for offenders possessing less than a threshold quantity, provided they consented to a medical examination by health authorities and, if required, were willing to undergo treatment or monitoring (Eisenbach-Stangl and Burian, 1998). The threshold quantity was defined as a 'weekly ration', although what quantity this represented was left to judicial interpretation. The probationary suspension of criminal proceedings provided another part of the move towards the de facto decriminalisation of minor offences in the NDA. In addition, the principle of 'privileged situation' was introduced, allowing for punishment to be reduced for individuals whose responsibility was regarded as limited because of their addiction. Treatment regimens within prison were also introduced for dependent drug users. At the same time, the amendment increased penalties for drug trafficking (Reitox National Focal Point, 1996), a trend that continued with two further amendments to the NDA in 1974 and 1978, when maximum fines increased tenfold (Fehervary, 1989; Eisenbach-Stangl and Burian, 1998).

One of the consequences of the 1971 amendment was the development of specialised drug treatment services in Austria (Eisenbach-Stangl and Burian, 1998). In 1972 a long-term treatment centre opened as a department of the Anton Proksch Institute in Vienna, followed by a specialised institute for drug-dependent offenders (*Sonderanstalt Favoriten für entwöhnungsbedürftige Rechtsbrecher*) in the same year (Fehervary, 1989). The first private drug treatment centre opened in Tyrol in 1975. However, treatment services remained limited in number, and focused on abstinence-oriented long-term residential care, with most patients referred through the NDA (Eisenbach-Stangl and Burian, 1998) ⁽³⁾. Rehabilitation of drug patients remained primarily the responsibility of psychiatric facilities (Eisenbach-Stangl, 2001b).

Drug research developed from 1971 on through the Ludwig Boltzmann Institute for Addiction Research, established in association with the Ministry of Health and the Anton Proksch Institute. The Institute was the main Austrian research institution on drug issues until 2009, when the Ludwig Boltzmann Society closed most of its 200 establishments ⁽⁴⁾ (Anton Proksch Institute, 2014). Primary prevention measures were introduced in the 1970s, though in a mostly uncoordinated way. In 1980 the Federal Ministry for the Interior started a prevention campaign for students with its 'drug suitcase' (a display case of illicit substances), which police officers showed to pupils during presentations they gave at schools. An amendment to the drug law in 1980 (see below) gave the provinces responsibility for developing drug prevention. The city and province of Vienna developed new approaches to support marginalised and dependent drug users, including a transitional housing project in 1978 and the first street work project one year later (Eisenbach-Stangl and Burian, 1998; Reitox National Focal Point, 1996), as a first step towards harm reduction responses.

The growing importance of drug issues in Austria was acknowledged when the remit of the Advisory Board on Alcohol Issues, which had existed since the 1950s, was extended to include other substances in 1971. The new Advisory Board for Combating the Misuse of Alcohol and Other Addictive Substances (*Beirat zur Bekämpfung des Mißbrauchs von Alkohol und anderen Suchtmitteln*) was located within the Federal Ministry of Social Affairs, which was also in charge of health issues. As the Advisory Board dealt with a social issue its composition reflected the social partnership approach that was central to policymaking in Austria, with the participation of interest groups, and labour and employer unions. Until its dissolution in the early 1990s

the Advisory Board's work was mainly focused on illicit substances (Eisenbach-Stangl et al, 2002).

Increased coordination efforts were made in the area of supply reduction. The Federal Ministry for the Interior was tasked in the early 1970s with coordinating measures in this area, primarily through the Central Unit for Illicit Substances (*Zentrales Suchtgiftreferat*). This unit was transformed into a Central Office for Combating Drug-Related Crime (*Zentralstelle für die Bekämpfung der Suchtgiftkriminalität*) in 1975, and special 'drug training' was made available to all police officers. That same year the Ministry started to publish annual reports on drug law offences (*Suchtgiftstatistik*), which were the main source of data on the drug situation in Austria at the time. A conference on illicit substances (*Suchtgift Enquete*) was organised by the Ministry in 1979. It focused on combating illicit substance use and contributed to the ongoing public debate on this issue in the late 1970s (Eisenbach-Stangl and Burian, 1998).

At the end the 1970s the Austrian State scaled up its drug control measures. The country signed the 1961 Single Convention on Narcotic Drugs and its 1972 Protocol (United Nations, 2012) in 1978, and a year later a Narcotic Drugs Regulation (*Suchtgiftverordnung*) was adopted, bringing Austrian drug law in line with that Convention (Pilgram, 1992) ⁽⁵⁾. In 1980 a new amendment to the NDA was adopted. It was made as a response to several issues related to the implementation of the 1971 amendment, including the difficulty in determining what a 'weekly ration' was and what control procedures should be applied during the probationary suspension of criminal proceedings or penalties. The amendment was also a response to recent increases in drug-law offences, the emergence of a more violent drug scene and pressure from politicians (Pilgram, 1992).

The new amendment introduced a stricter but more structured approach based on the concept of 'treatment instead of punishment': it extended the probationary period from one to two years and introduced a compulsory medical examination for all offenders. It also introduced the concept of 'approved treatment institutions' and the mandatory reporting of drug users to the Federal Ministry of Health in order to enhance cooperation between health and criminal prosecution authorities (Eisenbach-Stangl and Burian, 1998). The threshold quantity for personal possession was reduced, with the 'weekly ration' being replaced by the term 'small amount' (Pilgram, 1992). Once again, this amount was not defined but was instead left to judicial interpretation ⁽⁶⁾. The number of

⁽³⁾ During the 1970s the 'closed' treatment sector for drug-dependent offenders had more beds than the 'open' sector for users entering treatment voluntarily. This changed progressively during the 1980s (Eisenbach-Stangl and Burian, 1998).

⁽⁴⁾ The Institute became the Department for Addiction Research and Documentation (SucFoDok) of the Anton Proksch Institute.

⁽⁵⁾ In 1979 the International Narcotics Control Board and other UN organisations moved to Vienna, which became the new administrative centre for international drug control.

⁽⁶⁾ A decree of the Ministry of Justice of 1981 defined the 'small amount' as being 10 % of the threshold for large amounts (*Grenzmenge*). A 'large amount' was, however, not precisely defined, so a formula was introduced to calculate this upper threshold. This approach was rapidly criticised, as the large amount could be less than the daily consumption of a dependent user (Uhl, 1984).

sentences under the NDA doubled from 931 in 1978 to 1 803 in 1981 (Fehervary, 1989).

The definition of 'approved treatment institutions' and improved modalities for treatment funding (Pilgram, 1992) contributed to the extension of specialised services. Residential drug treatment centres were the first to expand, both in size and in numbers, while specialised outpatient services developed more slowly. Most institutions still had a very large proportion of their patients referred through the NDA, while detoxification and abstinence-based treatment remained the main treatment modalities (Eisenbach-Stangl and Burian, 1998). From the mid-1980s onwards the focus progressively moved towards harm reduction oriented measures and away from the primary reliance on inpatient facilities and abstinence-oriented programmes established since the 1970s (Eisenbach-Stangl, 2001b). The first short-term treatment centres opened at that time.

The first national survey on drug use was conducted in 1984, covering the adult population between the ages of 15 and 40. It reported lifetime prevalence rates for cannabis use of 14.6 %, for cocaine 2.5 %, for heroin 2 % and for LSD 3.6 % (Springer et al., 1987). Heroin had progressively replaced opium and morphine on the illicit market in the late 1970s, and this change triggered further debates between supply and demand reduction representatives during the 1980s⁽⁷⁾ (Eisenbach-Stangl and Burian, 1998; Wiener Zeitschrift für Suchtforschung, 1982; Marinell et al., 1983). Police officers were calling for increased supply reduction interventions, while therapists were campaigning for the treatment system to be reformed.

A new amendment to the NDA in 1985 provided some answers. The principle 'treatment instead of punishment' and the 'privileged situation' were extended (Reitox National Focal Point, 1996): addiction was defined as an extenuating cause in punishment, and a suspension of charges for small-scale dealers was introduced (Eisenbach-Stangl and Burian, 1998). Additionally, the Advisory Board provided a precise definition of 'large amounts', and thereby also indirectly quantified 'small amounts' that were used as thresholds for personal possession offences (Fehervary, 1989; Reitox National Focal Point, 1996). At the same time, the maximum penalty for organised trafficking was increased from 10 to 20 years' imprisonment, and fines were increased from ATS 250 000 (EUR 18 168) to ATS 2 000 000 (EUR 145 348) (Pilgram, 1992).

New challenges, structures and responses (1985–97)

The first cases of human immunodeficiency virus (HIV)/ acquired immune deficiency syndrome (AIDS) were diagnosed in Austria, and the first related death recorded, in 1983. This led to the establishment of the Austrian AIDS service organisation *Österreichische AIDS Hilfe* in 1985, followed by the opening of branches in all provinces. Because health policy is mainly the responsibility of the provincial governments as part of a decentralised public health system, a federal AIDS decree was passed in 1986 but no national HIV/AIDS strategy was issued (AIDS Hilfe Wien, 2014).

Throughout the 1980s the phenomenon of drug use became more visible in Austria, as illustrated by the emergence of an open drug scene at the *Karlsplatz* in Vienna. While around 5 000 heroin users were known to the police in the early 1980s, this figure rose to between 8 000 and 10 000 a decade later (Reitox National Focal Point, 1996)⁽⁸⁾. The fall of the Iron Curtain in 1989, and later the wars in the former Yugoslavia, triggered major socio-political changes in Europe, some of which had an impact on the Austrian drugs situation. This included the increased availability of cheaper and much purer heroin on the Austrian market (Reitox National Focal Point, 1997), a trend associated with a rapid increase in HIV infections and other drug-related harms in the early 1990s. The number of drug-related deaths tripled from 82 in 1989 to 250 in 1994, after which they decreased. The number of newly diagnosed HIV cases among injecting drug users (IDUs) peaked in 1993 with 59 cases, while the annual number of reports for violations of the NDA rose from 4 474 in 1989 to 10 915 in 1993, with the number of convictions doubling from 1 252 to 2 683 (Reitox National Focal Point, 1996).

Increasing drug problems triggered a critical discussion about the state of the treatment system, and a debate about the introduction of opioid substitution treatment (OST)⁽⁹⁾ took place following its rapid development in some of Austria's neighbouring countries (Eisenbach-Stangl, 2013). OST was authorised in 1987 following a decree issued by the Federal Ministry of Health. With the official introduction of OST, drug treatment became part of the public health system (Eisenbach-Stangl and Burian, 1998) and, generally, drug users could obtain of this type of treatment through the Austrian public health insurance system (Burian, 1991; Reitox National Focal Point, 1996). Methadone was initially the only

⁽⁷⁾ Illustrated by the 1982 Narcotic Substances Congress of the Renner Institute and the 1984 Congress for Combating Substance Misuse of the Federal Ministry for the Interior.

⁽⁸⁾ For a short period in the mid-1980s heroin was displaced in Eastern Austria by 'O-tea', a preparation made of poppy capsules that were available in flower shops (Eisenbach-Stangl and Burian, 1998; Franke, 1988).

⁽⁹⁾ In the 1970s a few medical doctors had prescribed codeine and morphine to heroin users, but some were prosecuted until a 1980 expertise declared substitution treatment to be in accordance with medical science. In the late 1970s the Medical Faculty of the University of Vienna provided methadone substitution treatment to pregnant drug users (Eisenbach-Stangl, 2013).

substance prescribed, but clinical trials with slow-release morphine started in 1993 and its prescription for opioid substitution purposes was authorised in 1998, followed shortly afterwards by buprenorphine (Springer et al., 2008). The substitution decree was amended in 1991 to lower thresholds and the same year a decree of the Ministry of Justice widened the application of OST within prisons (Eisenbach-Stangl, 2013). The total number of clients undergoing substitution treatment increased during the decade from 1 188 in 1990 to 4 232 in 1999.

Significant steps towards the development of harm reduction interventions were taken with the introduction of needle and syringe exchange programmes (NSP) and low-threshold facilities in the early 1990s (Eisenbach-Stangl, 2000). The Association for Social Projects in Vienna (*Verein Wiener Sozialprojekte*) was established in 1990, followed in the same year by the low-threshold service *Ganslwirt, Ex & Hopp and H.I.O.B. Do it yourself* in Vorarlberg and *Mentlvilla* in Tyrol were established in the following two years. *Fix und Fertig*, a social reintegration project, and the hospital liaison service *CONTACT* began in Vienna in 1993, and the harm reduction centre *KOMFÜDRO* in Tyrol was set up in 1995. In general, a number of specialised services were made available in most

provinces at this time, though Vienna and the Western provinces had higher levels of service provision.

To respond to increasing drug trafficking, intensified supply reduction measures were taken by extending the rights of police (e.g. bugging operations (*Lauschangriff*)) and involving regular police units in drug-related investigations (Eisenbach-Stangl, 2012). In addition, legislation on money laundering was adopted in 1993, and membership of a 'criminal organisation' was used in the definition of an offence under the criminal law in the same year (Reitox National Focal Point, 1996). Registered drug law offences increased in the 1990s, also influenced by the growing number of police officers deployed to combat illicit drugs (Eisenbach-Stangl, 2003b).

Significant changes in the organisation and coordination of drug policy took place in the 1990s with the establishment of a new public administration specifically tasked with the design and implementation of drug policy (Eisenbach-Stangl, 2013). Drug coordinators and coordination bureaux were established in all provinces by the mid-1990s and an inter-provincial coordinating body, the Provincial Drug Coordinators Conference, became operational in 1995 (Reitox National Focal Point, 1996). The nine provinces also started to issue drug policies and addiction

Drug policy developments in the provinces

Austria is a federal republic with nine provinces (*Bundesländer*) (Burgenland, Carinthia, Lower Austria, Upper Austria, Salzburg, Styria, Tyrol, Vienna and Vorarlberg). Each province has its own government and parliament. Regional authorities play a central role in the healthcare system, while the federal government is responsible for justice, interior and crime investigation issues. While the Narcotic Substances Act (NSA) provides the legal framework for drug control, the implementation of specific strategies is the responsibility of the regional governments. The scope and approach of provincial drug policies differs but they all share some basic principles, such as the 'balanced approach' between health policy measures to achieve drug demand reduction, and law enforcement measures to reduce drug supply. The principle of 'treatment instead of punishment' is also implemented throughout Austria.

Currently, all nine provinces have drug strategies and addiction prevention units. Vorarlberg, one of the smallest

provinces in terms of population, was the first to issue a drug strategy in 1980 and to open a prevention unit in 1993. This is in part due to its proximity to Switzerland (Haller et al., 2002), where some cantons had started developing innovative drug policies and interventions during the 1980s. The other provinces issued their drug strategies and drug plans throughout the 1990s and early 2000s. Two out of nine provincial strategies (Salzburg and Vorarlberg) focus primarily on illicit substances. The strategies and plans of the other provinces focus on a more comprehensive understanding of addiction, also covering licit drugs and other behavioural addictions (Reitox National Focal Point, 2005 and 2012) ⁽¹⁰⁾.

Drug coordinators and coordination bureaux were established in all provinces at about the same time (Reitox National Focal Point, 1996), although they do not always perform the same tasks (see the box 'Drug policy coordination').

⁽¹⁰⁾ The following nine strategies are currently in force: Vienna Drug and Addiction Strategy 2013; Vorarlberg Drug Strategy 2002; Tyrol Addiction Strategy 2012; Styria Addiction Strategy 2012; Salzburg Drug Strategy 1999; Upper Austria Addiction Strategy 2004; Lower Austria Addiction Strategy 2011; Carinthia Addiction Plan 2006; Burgenland Addiction Strategy 2002.

plans during this period, such as, for example, Vienna in 1991 and Tyrol in 1993 (Reitox National Focal Point, 2000) (see the box 'Drug policy developments in the provinces'). Addiction prevention units were set up in all provinces following a call for more coordinated prevention measures in the 1980s and early 1990s (Uhl and Springer, 2002), and a Working Group for Addiction Prevention was established as another inter-provincial cooperation body. This contributed to the spread of new approaches in prevention and health promotion in Austria. At the federal level, the Federal Drug Coordination and the Federal Drug Forum were established in 1997 (see the box 'Drug policy coordination', p. 12).

Policy adjustments (1998–2012)

In 1998 a new Narcotic Substances Act (NSA) (*Suchtmittelgesetz*) entered into force and replaced the Narcotic Drugs Act (NDA). It reinforced the guiding principle of 'treatment instead of punishment' by introducing special regulations for minor cannabis offences, and extending the number of health-related measures and the deferment of charges for some offences committed to finance drug use (Reitox National Focal Point, 2004). This contributed to a rapid increase in the number of cases of 'alternatives to punishment' in the early 2000s. In 2007 an amendment to the NSA continued this pattern by turning some optional deferments into mandatory ones (see the box 'The Austrian drug control law').

The Austrian drug treatment system also expanded and became more diversified, with an increasing number of specialised units providing inpatient and, especially, outpatient treatment services. In 1998, opioid substitution treatment was introduced into the Narcotic Substances Act through its Section 8. One year later, the thresholds for accessing opioid substitution treatment were reduced and dispensing practices were widened. This contributed to a rapid increase in the number of patients from 4 232 in 1999 to 16 782 in 2011.

Slow-release morphine became the most widely prescribed substitution medication in 2003 and was also found on the illicit market in Vienna, replacing heroin, a phenomenon similar to that occurring in other countries where methadone or buprenorphine are diverted from treatment (Eisenbach-Stangl, 2013; Springer and Uhl, 2010). This development triggered a debate between authorities and professionals regarding the regulation of OST. One outcome was the 2006 Oral Substitution Further Training Regulation (*Weiterbildungsverordnung orale Substitution*), which made special training compulsory for prescribing physicians (Reitox National Focal Point, 2005) and created a Committee on the Quality and Safety of Substitution Treatment (Reitox National

Focal Point, 2006). Slow-release morphine is still the most commonly prescribed substitution drug in Austria (55 %), followed by methadone (21 %) and buprenorphine (18 %) (Reitox National Focal Point, 2012) ⁽¹¹⁾. However, large regional differences exist: while slow-release morphine is prescribed in 61 % of OSTs in Vienna, Vorarlberg reports a share of only 16 % (Reitox National Focal Point, 2012). The framework for OST provision also varies between provinces, with general practitioners licensed to initiate OST in some provinces (e.g. Vienna, Tyrol and Lower Austria), while in other regions it can only be provided by specialised centres and practitioners.

More harm reduction interventions and services have been put in place throughout Austria since the end of the 1990s. Responding to an increased level of synthetic drugs use, the research project *Check it!*, a substance-testing on-site laboratory, was started in Vienna in 1997 (Reitox National Focal Point, 1998). A similar project, *MDA basecamp*, providing on-site drug counselling, started in Tyrol in 2001. Following an increase in the number of hepatitis infections among IDUs, increased testing and vaccination was made available in Innsbruck and Vienna, while the 'Hepatitis folder' (a preventative information guide) was introduced in Vorarlberg, Vienna and Tyrol. Additional low-threshold services were made available in Salzburg and Graz, and social reintegration projects started in Vorarlberg and Tyrol (Reitox National Focal Point, 1999). In 1999 the Viennese counselling centre *DIALOG*, which offers a wide variety of drug-related counselling and prevention services, started an innovative social reintegration project in cooperation with the public employment service (Reitox National Focal Point, 2000).

Over the period, evaluation and research aimed at improving the delivery of existing programmes and services became a popular issue in the field of prevention and treatment (Reitox National Focal Point, 2000–12). For example, following the creation of addiction prevention units and the Working Group for Addiction Prevention in the early 1990s, a study on addiction prevention in Austria was conducted in 1998. This led to a review of the provision of prevention services and related practices in Austria (*Professionelle Suchtprävention in Österreich*) in 2002 (Uhl and Springer, 2002).

At the end of the 1990s increased levels of organised crime were reported in Austria and a new series of supply reduction measures were put in place. In 1998 an amendment of the penal code provided regulations against bribery and corruption. That same year, Austria ratified the Europol Convention and signed the OECD Anti-Bribery Convention in 1999 (Reitox National Focal Point, 1998; Winslow, 2014).

⁽¹¹⁾ An amendment to the NSA introduced in 2008 identified methadone and buprenorphine as substitution substances of 'first choice', with slow-release morphine used only in specific justifiable situations.

The Austrian drug control law

The Narcotic Substances Act (NSA) (*Suchtmittelgesetz*) of 1998 distinguishes between possession of drugs for personal use (health measures) and for drug trafficking (criminal penalties and repression) (Reitox National Focal Point, 1997 and 2000; Litzka, 2000). The guiding principle of ‘treatment instead of punishment’ was emphasised by including substitution treatment and withdrawal into the range of statutory health-related measures.

Generally, penalties for drug law offences depend on the quantity rather than the type of substance involved. However, separate rules apply for narcotic drugs and psychotropic substances and threshold quantities⁽¹²⁾ for each substance are defined in separate regulations (*Suchtgift-Grenzmengenverordnung and Psychotropen-Grenzmengenverordnung*).

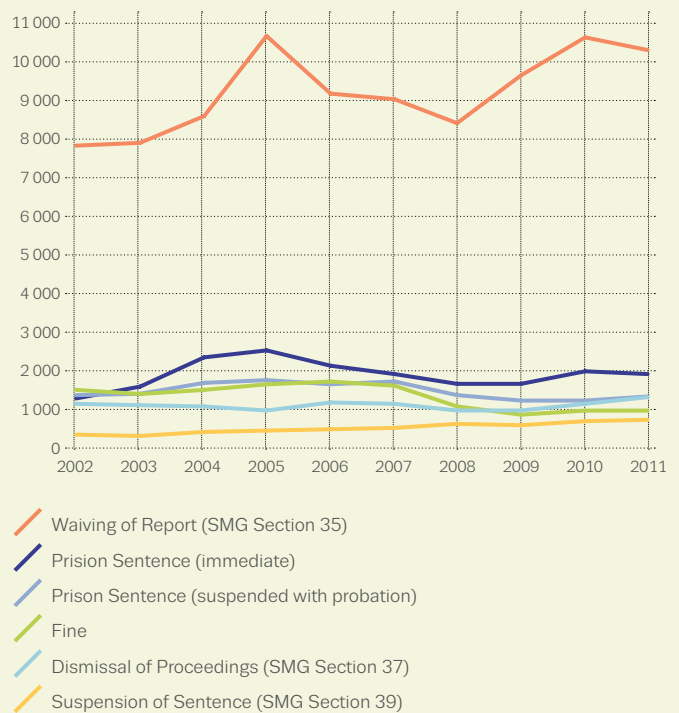
Simple possession may be punished by up to six months in prison or a fine, while those convicted of possession for personal use of more than the threshold quantity may receive up to three years’ imprisonment for narcotic drugs or up to two years for psychotropic substances. Prior to 2008 prosecution for personal possession of a ‘small quantity’ could be suspended following a health report from the local authority, though this report was not required for minor cannabis offences. Under the 2007 amendment to the NSA, the imprecise ‘small quantity’ criterion was deleted, allowing suspension of prosecution for any personal use offence up to the threshold quantity, the health report is no longer required in cases involving cannabis, psychotropic substances or mushrooms, and lower penalty ranges were introduced for drug-dependent offenders.

From 2008 the maximum prison penalty for a drug supply offence involving less than the threshold quantity was raised from six months to one year, following the European Framework Decision 2004/757. A supply offence involving more than the threshold quantity could lead to five years’ imprisonment, and supply of at least 25 times the threshold quantity would lead to a prison sentence of 1–15 years. A

mid-level supply offence was also introduced, setting a minimum penalty (range 1–10 years) when the offence involved at least 15 times the threshold quantity.

The graph below illustrates the number of alternatives to punishment and sentences given in Austria⁽¹³⁾. The most common approach is the waiving of the report by the prosecutor, with more than 10 000 cases a year, while the courts’ probationary dismissal of proceedings and suspension of sentences amount to over 2 000 cases together. Among the more than 4 000 sentences given by the courts, immediate prison sentences represent the largest share (46 %), followed by suspended prison sentences (31 %) and fines (23 %). Prison sentences are mainly linked with drug trafficking, which is generally punished with imprisonment (EMCDDA, 2009).

Trends in alternatives to prosecution/punishment and court sentences for drug law offences in Austria



Source: Reitox National Focal Point, 2013.

⁽¹²⁾ MDMA 30 g, cocaine 15 g, heroin 3 g, cannabis (THC) 20 g, morphine 10 g, methadone 10 g, codeine 30 g, LSD 0.01 g, amphetamine 10 g, etc.

⁽¹³⁾ The statistics on alternatives to punishment are provided by the Ministry of Health, while the data on sentences come from the criminal court statistics. The data include all cases where the drug law offence has been the leading offence (the one with the highest range of punishment) and, therefore, do not cover all drug-law offences. For drug trafficking offences, alternatives to punishment are only provided to dependent drug users.

In 2002 a registry for drug precursors (*Meldestelle für Vorläuferstoffe*) was established within the Federal Criminal Intelligence Office (*Bundeskriminalamt*) (Federal Ministry of the Interior/Criminal Intelligence Service Austria, 2003). Austria was also increasingly affected by international drug trafficking after becoming a transit point on the Balkan Route. This led to increased Austrian involvement in international cooperation to target drug trafficking through the Balkan countries. As part of the Agis programme, the project Drug Policing Balkan Advances 2009–12 was started in 2009 and a twinning project with Croatia, ‘Strengthening the capacities of the Ministry of the Interior to combat narcotic drug trafficking and drug abuse’, was initiated one year later (Federal Ministry of the Interior/Criminal Intelligence Service Austria, 2011; United States Department of State, Bureau for International Narcotics and Law Enforcement Affairs, 2010). The need for increased collaboration with countries in the Balkans was again stressed by the Federal Ministry of the Interior in 2012 (National Reitox Focal Point, 2013).

In 2007 ‘protection areas’ (*Schutzzonen*) were set up around specific schools and retirement homes, where police can place an exclusion order on known drug dealers for a period of 30 days. A further measure against public nuisance was adopted in selected parts of Vienna city centre, where closed circuit television was installed to assist in the prevention of open drug scenes (Reitox National Focal Point, 2005; INCSR Country Report, 2010). Rebuilding work on the *Karlsplatz* and the reorganisation of some harm reduction services also led to the dispersal of open drug scenes.

The use of new psychoactive substances was first reported in the late 2000s in Eastern Austria and in Vorarlberg. In a first step, in 2009 Austria classified Spice products⁽¹⁴⁾ under non-criminal medicines legislation. In 2011, following an increase in the number and availability of new substances, Austria became one of the first European countries to issue a new law specifically targeting them — the Act on New Psychoactive Substances (*Neues-Psychoaktive-Substanzen-Gesetz*) (Reitox National Focal Point, 2011) (see the box ‘The Act on New Psychoactive Substances’).

The Act on New Psychoactive Substances

The use and increased availability of new psychoactive substances has been reported in some parts of Austria, as in several countries in the EU, in recent years. In 2009, in order to stop the open marketing and distribution of Spice products in Austria, while avoiding criminalising users, Austria classified them under non-criminal medicines legislation, reinforced by import bans (Regulation on Incense Blends with Cannabinomimetic Ingredients). While only having a regulatory fine as a maximum penalty, this law proved effective (EMCDDA, 2011a).

Responding to the continuing increase in the availability of various new psychoactive substances, the Act on New Psychoactive Substances (ANPS) (*Neues-Psychoaktive-Substanzen-Gesetz*) was issued in 2011 and entered into force on 1 January 2012 (Reitox National Focal Point, 2011). The ANPS aims to minimise the circulation of new psychoactive substances and the health hazards resulting from the use of these substances by adopting supply control measures (Reitox National Focal Point, 2012). It defines a ‘new psychoactive substance’ as a substance or preparation that has the ability to have psychoactive effects

when applied in a human body and that is not subject to the Single Convention on Narcotic Drugs 1961 or the Convention on Psychotropic Substances 1971. Psychoactive effects are defined as stimulation or depression of the central nervous system associated with hallucinations or disturbances in motor functions, thinking, behaviour, perception or mood.

The Minister for Health must name the substances in a regulation, but under the condition that they are likely to be abused by certain sections of society with a possible threat to public health⁽¹⁵⁾. Unauthorised supply is a crime if the supplier intends to benefit, and intends that the product will be used for its psychoactive effects; maximum penalties for supply are two years’ imprisonment, rising significantly if supply results in serious injury or death. Under the new law, seizure of any amount of substance is possible even if no offence has been committed unless the person who has the power to dispose of the substance credibly shows a legal purpose and guarantees that the substance will not be used to have psychoactive effects in a human body⁽¹⁶⁾.

⁽¹⁴⁾ Herbal mixtures containing in some cases synthetic cannabinoid receptor agonists intended to mimic the effects of the THC of cannabis.

⁽¹⁵⁾ This can be done for individual substances but also for classes of chemical substances (generic approach).

⁽¹⁶⁾ EMCDDA Drugnet 78 — Drugslex.

While a broad discussion about the possible adoption of a national drug strategy took place in the mid-2000s, no federal level drug strategy and action plans was adopted (Reitox National Focal Point, 2005; Pietsch, 2005) and Austria remains one of the few EU Member State without a top-level national drug strategy or action plan. However, a new process was recently launched aimed at developing a national addiction prevention strategy with a focus on children and young people (Reitox National Focal Point, 2012; Uhl et al., 2013). Preparatory work included a Delphi study conducted with a sample of almost 100 experts, which showed a strong commitment to 'treatment instead of punishment', harm reduction and substitution treatment. Meanwhile, the Federal Ministry of the Interior published its own anti-drugs strategy in 2012. The document addressed not only law enforcement practices and strategies but also some interventions in the health area, including opioid substitution treatment, with a suggestion that it may be replaced by other approaches that are more effective in achieving abstinence⁽¹⁷⁾. This led to a wide debate about the benefits and shortcomings of substitution treatment, both among professionals and in the media (Reitox National Focal Point, 2013).

Drug policy coordination

Responsibility for overall drug policy coordination in Austria rests with the Federal Ministry of Health. It is responsible for the operational coordination of the federal drug policy, including the other ministries and the nine provinces. The Federal Ministry of Health chairs the Federal Drug Coordination, which has a permanent member from the Ministry of Health, the Ministry of the Interior and the Ministry of Justice, and ad hoc participants from other Ministries.

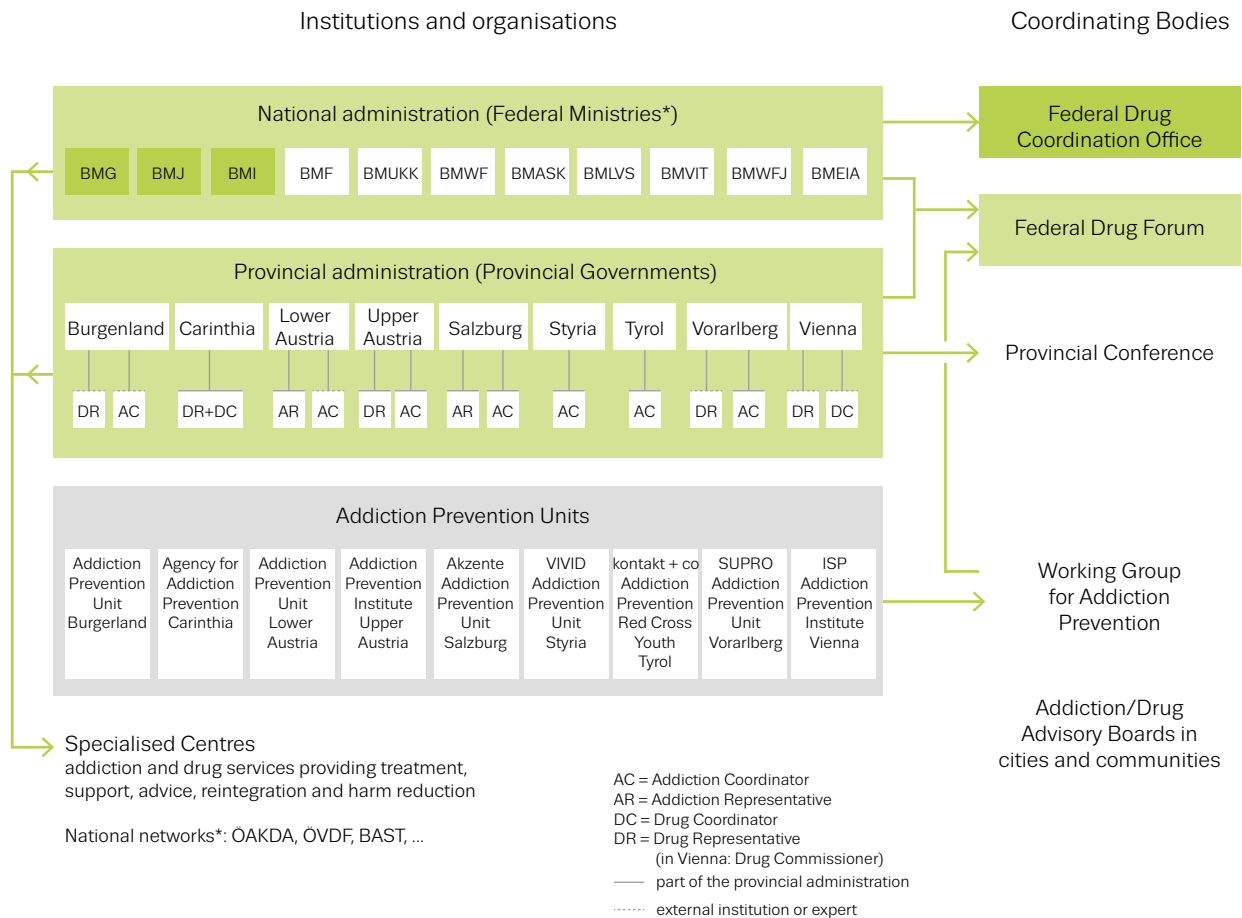
The Federal Drug Forum (*Bundesdrogenforum*), chaired by the Ministry of Health, includes representatives from the Federal Ministries, the Provincial Governments, the associations of cities and municipalities and the Austrian National Focal Point (*Gesundheit Österreich GmbH*) in the EMCDDA's Reitox network. Individual experts and scientists also participate on invitation.

The Provincial Drug Coordinators Conference allows cooperation and coordination between Austria's nine provinces. It draws up joint positions and statements.

Each of Austria's nine provinces nominates representatives who are referred to as Addiction Coordinators, Addiction Representatives, Drug Coordinators or Drug Representatives. They are responsible for coordinating actions in the drugs area and the actions of federal authorities' direct partners. In addition, there are both Provincial Drug or Addiction Coordination Offices, and Provincial Addiction Prevention Units in all Austrian provinces.

⁽¹⁷⁾ Shortly before, in 2011, the Ministry of Justice restricted the cost coverage of inpatient treatment as a health measure to six months.

Drug policy coordination in Austria



Source: Reproduced from GÖG/ÖBIG, 2013.

Alcohol and tobacco policies

At the Federal level, alcohol and tobacco policies are the responsibility of the Ministry of Health in Austria. It has established a special unit for alcohol and tobacco issues and behavioural addictions. The unit includes an ombudsman for the protection of non-smokers. Both alcohol and tobacco policy are subject to federal and provincial legislation and administration (Pietsch, 2005).

The federal level provides the legal framework for alcohol policy (Federal Ministry of Health, 2013a). Most alcoholic beverages are regulated by corresponding decrees for production, importation and taxation. Additional alcohol-related legislation can be found in youth protection and road traffic acts. Austria's per capita annual alcohol consumption for adults over the age of 15 was 12.2 l in 2011, placing it second highest out of 40 OECD countries, the average being 9.1 (OECD, 2014). An Alcohol Forum that brings together all major alcohol policy stakeholders in Austria was established in 2007. It has four working groups and elaborates recommendations for national policy.

The Austrian Tobacco Act (*Tabakgesetz*) was issued in 1995 and has been amended several times (Federal Ministry of Health, 2013b). A 2004 amendment brought Austrian tobacco law in line with the European Strategy for Tobacco Control and the World Health Organization Framework Convention on Tobacco Control (World Health Organization, 2013). It banned smoking in public places (offices, public transport, shopping malls, etc.) and in schools and other institutions for young people. The ban was extended to hospitality venues in 2008, although there are still rules for exceptions, notably for bars and restaurants. Austria has also launched various media campaigns targeting school-aged children and their parents, and addiction prevention units have developed tobacco-related programmes at the provincial level. Only the province of Styria has adopted a tobacco prevention strategy. In 2009 some 23.2 % of the Austrian population were daily smokers; this is slightly above the OECD average of 22.1 % (OECD, 2012). Scoring 32/100, Austria ranked 30th and last on the tobacco control scale in Europe (Joossens and Raw, 2011).

Conclusions

Austria provides a first insight into the drug policies of federal countries. The profile shows that federalism is associated with diversity within a national policy, as suggested by either drug strategies or wider addiction strategies in the provinces or variations in opioid substitution treatment practices. This diversity may be linked to the distribution of powers in federal countries and to the increased proximity between decision-makers and the social problems they address, but also to cultural differences, ruling parties or variances in drug problems between provinces. Whatever the reason for this diversity, federalism provides a laboratory within which different policy models can be compared and can influence each other⁽¹⁸⁾. It can also be favourable to the development of innovations. For instance, while it does not come as a surprise that Vienna, like Frankfurt and Zürich in neighbouring federal countries, was once a centre of innovation for drug-related measures, this policy profile has also shown that other provinces, such as Vorarlberg or Tyrol, have been early adopters of new approaches and interventions.

This leads to another characteristic of federalism: a greater need for coordination, related to issues such as the clarification of responsibilities of the federal and the provincial levels or cooperation among provinces. In Austria there are at least four drug coordination and cooperation bodies at the national level⁽¹⁹⁾ and additional ones within each province. While this may be demanding and complicated, it may also provide a vector for more regular and sustained knowledge and information exchanges. This 'soft' coordination can also be pragmatic in its contents, focusing more on practical issues and compromises than on ideological debates and conflicts. This may have reduced Austria's need for other currently widespread coordination tools in Europe, such as a national drug strategy and action plan.

One of the most noticeable elements of Austrian drug policy is the concept of 'treatment instead of punishment'. Not only was this health-oriented approach adopted in the early 1970s when public health was much less influential than it is today, but it has also remained in place for more than 40 years with only limited changes overall. This is quite an unusual instance of drug policy longevity in the European context.

The Austrian approach shares some features with the Portuguese decriminalisation scheme, as it aims to provide drug users, and particularly dependent drug users, with treatment (EMCDDA, 2011b). However, the approach differs from the Portuguese as health-related measures in Austria are

a conditional alternative to criminal prosecution and punishment. While drug users are identified primarily as in need of help, if they do not accept medical assessment and, if needed, treatment⁽²⁰⁾, or undergo other measures, they remain under the threat of criminal prosecution and punishment. This approach, with a strong incentive to undergo health-related measures, was a key driver for the development of the Austrian drug treatment system in its early days. Currently about one in three clients entering specialist drug treatment in Austria is referred by the police, the prosecutor or the courts. This is among the highest rates in Europe⁽²¹⁾.

The Austrian approach may be seen as a historical compromise between health and law enforcement objectives⁽²²⁾. The changes in the design and implementation of 'treatment instead of punishment' over time have reflected some of the challenges of maintaining this compromise and finding the correct balance between the two main elements of drug policies. Some reforms put more emphasis on health aspects, others on criminal justice issues. The enlargement of 'alternative to punishment' for drug users was often associated with an extension of police resources and increased penalties to fight drug trafficking. The overall approach has, however, remained the same and the compromise behind the 1971 amendment of the NDA still remains today. This underlines the flexibility of the Austrian approach, which has survived political changes but has also adapted to fluctuations in the drug situation, from cannabis use by students in the early 1970s to ageing opioid users today. The fact that the implementation of 'treatment instead of punishment' is regularly discussed⁽²³⁾ and amended is probably another indicator of this flexibility.

Another interesting feature of Austrian drug policy is the development of opioid substitution treatment. The country was not an early adopter of this type of treatment, at least in terms of its widespread availability, but today it has almost 17 000 patients in OST. The relative delay in the introduction of OST may be linked to the development in the 1970s and 1980s, in the framework of 'treatment instead of punishment', of abstinence-oriented inpatient treatment facilities as the main drug treatment providers. The HIV/AIDS epidemic and rising drug problems in the 1990s have led to a paradigm change where OST became progressively the treatment of first choice for heroin users. Today the majority of patients undergoing this type of treatment receive slow-release morphine, a substitution medication that is not prescribed as widely in any other European country. The popularity of slow-release morphine in Austria, and particularly in Vienna,

⁽¹⁸⁾ The downside may be that citizens' access to services might differ, depending on where they live.

⁽¹⁹⁾ The Federal Drug Coordination Office, the Federal Drug Forum, the Provincial Conference and the Working Group for Addiction Prevention (National Reitox Focal Point, 1999).

⁽²⁰⁾ The choice of the type of treatment is usually made by the offender.

⁽²¹⁾ See TDI-16 parts II and IV in the 2012 Statistical bulletin of the EMCDDA (www.emcdda.europa.eu/stats13#display:/stats13/tidtab16b).

⁽²²⁾ Jurists played a key role in developing this approach.

⁽²³⁾ The topic was, for instance, on the agenda of the Federal Drug Forum in 2012–13 (Reitox National Focal Point, 2013).

seems to be linked to many factors, ranging from marketing practices to patients' preferences and prescribers' perceptions of its effectiveness (Eisenbach-Stangl, 2013; Springer et al., 2008). Recent analysis of Austrian data has shown that the prescription of this substance was associated with higher treatment retention rates than methadone and buprenorphine, and that diversion into the black market remained limited (GÖG/ÖBIG, 2013). As with other substitution medications, the wide prescription of slow-release morphine in Austria will probably continue to create debates about its merits and shortcomings in the future ⁽²⁴⁾.

The Austrian profile also gives an insight into how drug policy is sometimes shaped by external factors. In the first half of the twentieth century the development of the Austrian drug control system was largely imposed through the peace treaties following the two world wars. Towards the end of the century, the fall of the Iron Curtain, the wars in the former Yugoslavia and Austria's accession to the European Union significantly modified its geo-political position, from a country

on the border of 'Western' Europe to one located near the centre of the new 'post-communist' Europe. This has also meant increased availability and trafficking of drugs, due to the emerging drug markets in neighbouring countries and the use of new routes to smuggle drugs towards and through Europe. These changes have been a challenge for the country, both in health and law enforcement terms, and have, for instance, led Austria to take a leading role in supply reduction cooperation with Balkan countries.

Today Austria's drug policy seems to be consolidated, its drug situation is not exceptional within the European context (see the box 'Austria's current drug situation') and services are diverse, professional and generally widely available. The country's drug policy approach might be described as a balance between demand and supply reduction measures. An integrative approach towards addictions has already been realised in most provinces, and the other provinces and the federal level might follow this approach soon.

Austria's current drug situation

Austria's current drug situation is characterised by levels of drug use among the general population that are below European averages. For example, last year cannabis use among young adults aged 15–34 was 6.6 % in 2008, about half the current European average of 12.4 %. The Austrian figure for last year cocaine use among young adults aged 15–34 was 1.2 % in 2008 compared to an estimated current average of 2.1 % for the EU and Norway. In terms of trends, general population surveys show a decline regarding both cannabis and cocaine use in Austria between 2004 and 2008. Austria has not participated in the latest round of the ESPAD survey among school-aged children aged 15–16, but similar data from another international survey (HBSC) indicate that lifetime cannabis use has remained stable among school-aged children at 14 % between 2002 and 2009/10.

Figures for problem drug use and drug-related harms for Austria are somewhat closer to or above European averages. The most recent (2011) estimate of the number of problem drug users (mostly opioid users) in Austria had a

central value of 30 306, which represents 5.3 cases per thousand population aged 15–64, slightly higher than the estimated European average of 4.2 cases per thousand for problem opioid users only. The latest figure for the number of drug-induced deaths (overdoses) in Austria was 201 cases in 2011 and represents about 23.9 cases per million population, compared to an European average of about 13 cases per million. The number of newly diagnosed HIV cases among injecting drug users in 2011 was 36 ⁽²⁵⁾. This represents 4.3 cases per million population, slightly above the European average of 3 cases per million.

Every year Austrian law enforcement bodies confiscate large quantities of cannabis products. In 2011 seizures amounted to about 700 kg with, as in previous years, the vast majority being herbal cannabis (621 kg). Other drugs seized in 2011 included 65 kg of heroin, 139 kg of cocaine, 13 kg of amphetamines and almost 46 000 ecstasy tablets.

See the EMCDDA *Statistical bulletin* for additional data and methodological notes.

⁽²⁴⁾ A recent systematic review found that, because of the low number and varied quality of studies on slow-release morphine in opioid substitution treatment, it is unfortunately still not possible to draw conclusions on its effectiveness (Ferri et al., 2013).

⁽²⁵⁾ Data is based on the Austrian HIV-cohort study (AHIVCOS), which covers about 85 % of all HIV-infected persons receiving ART and about 50 % of those not receiving it (see Reitox National Focal Point, 2013).

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Online resources

- | AIDS Service Organisation Vienna (AIDS Hilfe Wien): www.aids.at/uber-uns/geschichte-der-aids-hilfe-wien/
- | Anton Proksch Institute: www.api.or.at/typo3/index.php
- | Crime and Society/Comparative Criminology: www-rohan.sdsu.edu/faculty/rwinslow/europe/austria.html
- | Drug coordination, Vienna, Austrian drug policy (Drogenkoordination, Wien, Österreichische Drogenpolitik): drogenhilfe.at/drogenpolitik/oesterreichische-drogenpolitik/
- | EMCDDA country overview, Austria: www.emcdda.europa.eu/publications/country-overviews/at
- | EMCDDA Statistical bulletin: www.emcdda.europa.eu/stats13
- | Federal Ministry of Health (Bundesministerium für Gesundheit): bmg.gv.at/home/Schwerpunkte/Drogen_Sucht/Drogen/Berichte_zur_Drogensituation
- | Federal Ministry of Health (tobacco): bmg.gv.at/home/Schwerpunkte/Drogen_Sucht/Tabak_Nichtrauchen/Das_oesterreichische_Tabakgesetz
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