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for Drugs and Drug Addiction



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### **Workbook Treatment**

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## 0 Summary (T0)

The German treatment system for people with drug-related problems or their relatives is very differentiated. The core of the addiction support system is provided by (in addition to family doctors) the approximately 1,431 addiction counselling and treatment centres, the 300 psychiatric outpatient institutes, the roughly 550 facilities for integration support and the about 80 (all-day) outpatient and 242 inpatient therapy facilities. Facilities which exclusively or primarily treat users of illicit drugs are in the minority. There is a host of self-help organisations working in parallel or sometimes in cooperation with professional support services in the area of addiction. Governance and coordination occurs at *Laender*, regional or municipal level. Health insurance providers and pension insurance providers establish the essential guideline conditions and are responsible for paying the treatment costs (Rehabilitation: pension insurance; detoxification: health insurance).

Counselling, motivational support and outpatient treatment are mostly offered in the outpatient counselling centres. They are often the first port of call for clients with addiction problems, to the extent that they are not treated by primary care – usually by general practitioners in their own practice. Counselling is free of charge, the outpatient treatment facilities are financed by the communes and Bundesländer, as well as by significant self-funding (e.g. donations and church tax, etc.). It continues to be the case that one third of clients who seek outpatient treatment do so due to a dependence on or harmful use of opioids. In contrast, almost half of the outpatient clients are cannabis users. In cases of persons in addiction specific treatment for the first time, this trend is again reinforced, such that 63% are seeking treatment for harmful cannabis use. Stimulants are in third place amongst all persons being treated and second place in cases of persons receiving treatment for the first time, ahead of opioids.

Inpatient treatment is a fundamental element of the treatment and rehabilitation forms for drug dependent persons. In recent years we have seen increased flexibility in the structure of treatments offered and this has enabled clients to combine outpatient and inpatient rehabilitation (combination treatment) or to make use of other, needs specific treatment services, including day care and outpatient treatment options. The proportion of cannabis and stimulant users among clients in inpatient treatment continues to grow. The proportion of those who seek inpatient treatment due to opiate use, however, is continuing to fall.

The second major pillar of addict care is provided by the addiction psychiatry facilities within the specialist psychiatric clinics and the addiction psychiatry departments of general hospitals and university clinics.

From 2002, when reporting became obligatory, the number of substitution patients reported continuously increased until 2010. Since then, the number has remained largely stable and was at 77,200 persons on 1 July 2015. A total of 2,613 doctors providing substitution treatment reported patients to the substitution register in 2015. This number of doctors actually performing substitution treatment is slightly lower than in previous years, returning to the lev-

el of 2004. The nationwide average number of registered substitution patients for every doctor providing the treatment is 29, however this number varies considerably between the individual *Laender* (Hamburg: 40.7; Brandenburg: 6.5). In an inpatient setting, substitution treatment is available in around 10% of clinics with medical rehabilitation for drug addicts. The supply of care in rural areas in particular, as well as the treatment of long term substitution patients are causes for concern. In 2015, of the total of 1,226 drug-related deaths in the whole of Germany, 34 people with monovalent poisoning died from opiate substitution drugs. In the case of polydrug poisoning by opiate substitution drugs used in connection with other substances, 174 persons were recorded.

New developments in the treatment system can be seen most readily in the discussion regarding the treatment of persons dependent on methamphetamine. In previous years, the relevance of the treatment of persons dependent on methamphetamine in Germany increased due to rising regional consumption and the demand for specific treatment options. The reaction has been in the form of the provision of specific information both for practitioners (among other things, the new S-3 treatment guidelines, "Methamphetamine related Disorders" or the DHS tool) and for users (e.g. the internet portal <https://breaking-meth.de>).

Moreover, cooperation between the original addiction support system and other areas of support is being accelerated, as for example with psychiatry. Psychiatry is of essential importance in the treatment of people with addiction disorders, as are cooperation and consultation with other institutions which are possibly involved in the treatment of the people affected or which resume their work after inpatient treatment. In the context of the current migration and refugee issue, questions are also being asked in the context of the national addiction support landscape about the prevalence of use of addictive substances and the need of support by refugees, as well as suitable treatment options for persons with migration backgrounds. To this end, various events are being held. The available studies on the utilisation of addiction support by people with migration background show the differing needs and usage behaviour.

In addition, internet based treatment is a topic in the addiction support arena. Until now only a few evaluated services could be found (e.g. Quit the shit<sup>1</sup>). At the forefront of internet service for addiction support, is the information on use, substances, effects and support services.

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<sup>1</sup> [www.quit-the-shit.net](http://www.quit-the-shit.net) [accessed: 24 Aug. 2016].

# 1 National profile (T1)

## 1.1 Policies and coordination (T1.1)

### 1.1.1 Main treatment priorities in the national drug strategy (T1.1.1)

The National Strategy on Drug and Addiction Policy, announced by the Federal Government Commissioner on Narcotic Drugs (Drogenbeauftragte der Bundesregierung) in 2012, places a particular focus on addiction prevention and early intervention but also stresses the necessity of counselling and treatment services in Germany (Die Drogenbeauftragte der Bundesregierung 2012a).

In the current Drug and Addiction Report, the Drugs Commissioner named crystal meth as a focus of her work in the current legislative period (Die Drogenbeauftragte der Bundesregierung, 2016). In cooperation with the German Medical Association (Bundesärztekammer, BÄK), the German Agency for Quality in Medicine (Ärztliche Zentrum für Qualität in der Medizin, ÄZQ) and an expert group, practice orientated recommendations for action regarding the treatment of methamphetamine related disorders were approved in January 2016 and came into effect in September 2016 (Die Drogenbeauftragte der Bundesregierung et al. 2016).

### 1.1.2 Governance and coordination of drug treatment implementation (T1.1.2)

The German counselling and treatment system for people with drug-related problems or their relatives is very differentiated. Planning and governance of treatment in the various segments of the medical and/or social support system at a national level would not be compatible with the federal structure of Germany. Instead, governance and coordination occurs at *Laender*, regional or municipal level. The Federal Ministries, e.g. the German Federal Ministry of Health (Bundesministerium für Gesundheit, BMG) fulfil a cross-departmental and cross-institutional coordinating role at a federal government level. They have influence on the preparation and amendment of federal statutes (e.g. social welfare legislation which also has an impact on treatment). Other than that, the BMG, just like the Federal Drugs Commissioner, can only issue recommendations to the *Laender* and responsible institutions.

The health insurance providers and pension insurance providers in Germany play an important role in the governance and coordination of the treatment of persons with addiction disorders. They are intrinsically involved in the establishment of framework guidelines for the staffing and equipping of treatment facilities (structural requirements), for the referral to suitable further treatment and aftercare institutions as well as to other participating organisations, such as e.g. job centres. Health insurance providers and pension insurance providers also bear the costs of treatment; the health insurance providers are responsible for the costs of detoxification, the pension insurance providers are responsible for rehabilitation.

Detailed information can be found in Chapter 1 of the REITOX Report 2014 on drug policy, case law and strategies (Pfeiffer-Gerschel et al. 2014).

### **1.1.3 Further aspects of drug treatment governance (T1.1.3)**

In 2015 the DHS presented a comprehensive description of the addiction support and treatment system (DHS 2015). Furthermore, the DHS issued an inventory of addiction support in the regional treatment association which forms the basis for local support (DHS 2010a). In section 1.4.1 the outpatient and inpatient treatment system is described in detail.

Further information on treatment in detention can be found in the Prison workbook.

## **1.2 Organisation and provision of drug treatment (T1.2)**

In Germany, there is a sophisticated, nationwide support system available to addicts. They can use this support free of charge, however in some cases approval for costs is required from the social funding agencies defined in the German Codes of Social Law (Leune 2014). Family doctors play a special role as they are often the first point of contact for addicts and at-risk persons. The core of the addiction support system is provided by (in addition to family doctors, for whom no detailed data regarding addiction treatment is available) the approximately 1,300 addiction counselling and treatment centres, the around 300 psychiatric outpatient institutes, the roughly 800 facilities for integration support and the about 500 (all-day) outpatient and 320 inpatient therapy facilities. The psychiatric clinics also have an important significance. The majority of the support facilities are funded by free, charitable bodies. Public and commercial organisation are also active, in particular in the area of inpatient treatment.

## **Outpatient network**

### **1.2.1 Outpatient treatment system – facilities and services (T1.2.1)**

Counselling, motivational support and outpatient treatment are mostly offered in the outpatient counselling centres. They are often the first port of call for clients with addiction problems, to the extent that they are not treated by primary care.

Table 1 Network of outpatient addiction support (total number of units)\*

German term (description)	Number of facilities	EMCDDA term
Counselling and/or treatment facility, specialist outpatient clinic or outpatient department	1,431	Specialised drug treatment centres
Low-threshold facilities (emergency overnight accommodation, consumption room, street work, etc.)	226	Low-threshold agencies
Substitution doctors	2,613**/8,416***	General/ Mental health care
External services for counselling/treatment in prison	64	Prisons
Psychiatric outpatient institutes**** (whole day) outpatient rehabilitation	300	Other outpatient units
Outpatient assisted living	81	Other outpatient units
Employment projects/ qualification measures	476	Other outpatient units
Self-help groups****	91	Other outpatient units
	8,700	Other outpatient units

\* Facilities which exclusively or primarily treat users of illicit drugs are in the minority. In the vast majority of cases, alcohol problems are treated (as well).

\*\* In 2015, 2,613 doctors reported data to the substitution register (BOPST 2016).

\*\*\* The number of doctors qualified to administer addiction therapy reported by the medical associations is higher than the number of doctors actually performing substitution treatment. In 2012 8,416 doctors qualified to treat addiction were registered (BOPST 2013). This number has no longer been updated.

\*\*\*\* There is no new available information. This data stems from Pfeiffer-Gerschel et al. 2013. BOPST 2016; IFT 2016.

Low-threshold support and counselling are, for the most part, funded from public resources. However, a relevant portion of the costs of outpatient facilities is borne by the providers themselves. With the exception of therapeutic treatment, outpatient addiction support is, for the most part, voluntarily funded by the *Laender* and municipalities on the basis of community services of general interest. This is anchored under constitutional law in the Social State Principle (Sozialstaatsprinzip) as per Art. 20 (1) German Constitution (Bürkle & Harter 2011). The legal basis for the funding of outpatient services, which is only partially secured, leads time and again to financing problems. Generally counselling is free.

### 1.2.2 Further aspects of outpatient treatment provision (T1.2.2)

With regard to the availability of individual treatment and support services, there are differences to be found between the *Laender*. In rural regions especially (particularly in the eastern *Laender*), there are difficulties in providing region-wide care to patients (who wish to receive substitution treatment). All in all, the situation with regard to services available has not changed significantly in recent years.

### 1.2.3 Outpatient treatment system (T1.2.3)

Table 2 Number of places available in outpatient addiction support\*

German term/description	Number of places	EMCDDA term
Counselling and/or treatment facility, specialist outpatient clinic or outpatient department	>500,000	Specialised drug treatment centres
Low-threshold facilities (emergency overnight accommodation, consumption room, street work, etc.)	300	Low-threshold agencies
Substitution doctors	77,200**	General/ Mental health care
External services for counselling/treatment in prison	n/a	Prisons
Psychiatric outpatient institutes	91,800	Other outpatient units
(whole day) outpatient rehabilitation	>1,000	Other outpatient units
Outpatient assisted living	>12,000	Other outpatient units
Employment projects/ qualification measures	>4,800	Other outpatient units
self-help groups	n/a	Other outpatient units

\*Apart from the substitution doctors/patients, there is no new available information for this table. This data stems from Pfeiffer-Gerschel et al. 2013.

\*\*Number of patients in substitution treatment (BOPST 2016).

Data on the characteristics of the patients as well as on the features of individual facilities can be found in sections 1.3 and 1.4.

### 1.2.4 Further information on the utilisation of outpatient treatment systems (T1.2.4)

No additional information is available on this subtopic.

### 1.2.5 Further aspects of outpatient drug treatment provision and utilization (T1.2.5)

No additional information is available on this subtopic.

## Inpatient network

### 1.2.6 Inpatient treatment system – facilities and services (T1.2.6)

Inpatient treatment is a fundamental element of the treatment and rehabilitation forms for drug dependent persons. In Germany, there are around 320 facilities with over 13,200 places which offer inpatient rehabilitation measures for people with substance related disorders (incl. alcohol problems). Of those, 4,000 places are available for drug addicts. The aims of rehabilitation are the achievement and maintenance of abstinence, remedying and relieving

physical and psychological disorders and as enduring as possible a reintegration into work, into an occupation and into society.

Table 3 Network of inpatient addiction support (total number of units)\*

German term / description	Number of facilities	EMCDDA term
Specialist hospital departments	218	Hospital-based residential drug treatment
Inpatient rehabilitation facilities	242**	Residential drug treatment (non-hospital based)
Therapeutic communities	n/a***	Therapeutic Communities
Psychiatric clinics	300	Other inpatient units
Withdrawal with motivational elements	190	Other inpatient units
Transition facilities	97	Other inpatient units
Social therapy inpatient facilities	371	Other inpatient units
Social therapy day care facilities	73	Other inpatient units

\* Facilities which exclusively or primarily treat users of illicit drugs are in the minority. In the vast majority of cases, alcohol problems are treated (as well). Apart from inpatient rehabilitation facilities, transition facilities, social therapy inpatient facilities and social therapy day care facilities, there is no new available information for this table. This data stems from Pfeiffer-Gerschel et al. 2013.

\*\* Inpatient rehabilitation facilities which treat users of illicit drugs.

\*\*\* In Germany, there is no statistical data on therapeutic communities within the meaning of the term as understood on an EU level. In Germany, there are only isolated facilities which work according to that concept. It is even more difficult to identify numbers of clients or places as some clients remain in a facility their whole life (e. g. Synanon, [www.synanon.de](http://www.synanon.de) [accessed 4 April 2016]). The problem was already addressed in the REITOX Report 2012. Pfeiffer-Gerschel et al. 2012. IFT 2016.

Data on the characteristics of the patients as well as the features of individual facilities can be found in sections 1.3 and 1.4.

### 1.2.7 Further aspects of inpatient drug treatment provision (T1.2.7)

In recent years we have seen increased flexibility in the structure of treatments offered and this has enabled clients to combine outpatient and inpatient rehabilitation (combination treatment) or to make use of other, needs specific treatment services, including day care and outpatient treatment options.

In the integration and after-care phase, a multi-faceted range of services is offered comprising occupational support, housing projects and services for living in the community which are specifically geared to the needs of the addicted persons. All these fields of work are staffed with specialists who, for the most part, have received supplementary training specific to the field.

Acute treatments for drug-related problems and withdrawal treatments are normally performed in hospitals. The costs for this withdrawal phase are in general borne by the statutory health insurance providers.

The costs of withdrawal treatment are in general borne by the statutory pension insurance providers (c.f. section 1.1.2).

The Federal Association for inpatient addiction support (Bundesverband für stationäre Suchtkrankenhilfe, BUSS) carried out an analysis on the capacity utilisation of alcohol and drug facilities by its members in 2015 and determined a decrease in the financial situation of the facilities. Around one third of the drug facilities in the year 2014 had an unchanged utilisation rate of 70 to 90 percent. The proportion of drugs facilities with an occupancy rate of over 90% has decreased by four percent. Altogether, the analysis of the overall sample reveals a decrease in occupancy from 2014 to 2015. The causes of this decrease mentioned by drugs facilities were fewer approvals participants/patients (2015: 16%, 2014: 27%), fewer applications (2015: 20%, 2014: 21%) as well as other causes (2015: 55%, 2014: 42%). More than half of all 127 facilities (alcohol facilities are also included) report not being able to cover their costs (Otto & Koch 2016).

### **Treatments: Psychiatry**

The addiction psychiatry facilities within the specialist psychiatric clinics and the addiction psychiatry departments of the general hospitals and university clinics represent, alongside facilities for counselling and rehabilitation, the second major pillar of addict care in Germany. These facilities perform qualified withdrawal treatments. A not insignificant proportion also performs emergency treatments, crisis intervention and complex treatments in the case of comorbidity. Detailed diagnosis and reintegration planning is also performed. A multi-professional team treats all types of addiction disorder on an inpatient, day care or outpatient basis. This ensures a coordinated medical, psychosocial and psychotherapeutical care.

According to an extrapolation of the data, approximately 300,000 inpatient addiction treatments took place in psychiatric clinics in 2010. In addition, there were around 300,000 quarterly treatments that were carried out in psychiatric outpatient departments of the clinics. This shows that 31% of inpatient and 14% of outpatient psychiatric cases involve addiction patients. By comparison, only 150,000 treatments were performed in facilities for internal medicine as a result of alcohol or drug addictions, according to the health reporting by the German Federal Government. Most persons were primarily alcohol-dependent (approx. 70%). Disorders related to opioid consumption or consumption of multiple substances were the reason for inpatient treatment in approximately 10 to 13% of cases (DGPPN/Bundessuchtausschuss der psychiatrischen Krankenhäuser 2011, cited according to Die Drogenbeauftragte der Bundesregierung 2012b).

At the local and regional level, psychiatric-psychotherapeutic facilities work closely with the psychosocial counselling facilities and with rehabilitation facilities. (c.f. section 3.1).

### 1.2.8 Inpatient drug treatment system (T1.2.8)

Table 4 Number of places available in inpatient addiction support \*

German term (description)	Number of places	EMCDDA term
Specialist hospital departments	>7,500	Hospital-based residential drug treatment
Inpatient rehabilitation facilities	13,200** (>4,000)***	Residential drug treatment (non-hospital based)
Therapeutic communities	n/a	Therapeutic communities
Psychiatric clinics	>220,000	Other inpatient units
Withdrawal with motivational elements	>2,000	Other inpatient units
Transition facilities	>1,200	Other inpatient units
Social therapy inpatient facilities	>10,700	Other inpatient units
Social therapy day care facilities	>1,200	Other inpatient units

\* Facilities which exclusively or primarily treat users of illicit drugs are in the minority. In the vast majority of cases, alcohol problems are treated (as well).

\*\* in relation to all 320 inpatient rehabilitation facilities which also treat alcohol users.

\*\*\* related to drug addicts

There is no new available information for this table. This data stems from Pfeiffer-Gerschel et al. 2013.

One must bear in mind, when looking at the information concerning the facilities, that those which exclusively or primarily treat users of illicit drugs are in the minority. In the vast majority of cases, alcohol problems are treated (as well).

Data on the characteristics of the patients as well as on the features of individual facilities can be found in sections 1.3 and 1.4.

### 1.2.9 Further aspects of inpatient drug treatment utilisation (T1.2.9)

Based on DSHS data, Hildebrand and colleagues (Hildebrand et al. 2009) reported estimates of percentages of relevant persons reached by outpatient and inpatient addiction support facilities. According to these estimates, the specialised addiction support system is able to reach between 45% and 60% of the estimated persons with harmful use of or dependence on opioids but only between approximately 4% and 8% of respective cannabis users.

### 1.2.10 Further aspects of inpatient drug treatment provision and utilisation (T1.2.10)

No additional information is available on this subtopic.

### **1.3 Key data (T1.3)**

#### **1.3.1 Summary table of key treatment related data and proportion of treatment demands by primary drug (T1.3.1)**

##### **Outpatient treatment**

In 2015 data from a total of 344,885 therapies (not including one-off contacts) carried out in 858 outpatient facilities was collected within the framework of the DSHS. For the following remarks, however, only those clients who were primarily treated for illicit substance use (including sedatives/hypnotics and volatile solvents) were taken into account (patients treated primarily for alcohol-induced disorders accounted for 43.5% of all recorded cases in 2015 by themselves). For 2015, the DSHS contains data on the main diagnoses from a total of 71,955 treatments from 858 facilities that were started or completed in outpatient psychosocial addiction support counselling centres due to problems with illicit drugs. If one looks only at the data from the DSHS pertaining to illicit substances, now only 33.4% of cases today (2014: 35.3%; 2013: 37.6%; 2012: 41.1%; 2011: 44.9%) concerned clients who had sought treatment or counselling primarily due to dependence on or harmful use of opioids. More than a third of the cases (41.2%; 2014: 40.2%; 2013: 38.7%; 2012: 36.5%) concerned clients primarily with cannabis problems (Braun et al. 2016b).

Amongst persons who received addiction specific treatment for the first time, cannabis was again in first place (59.8%; 2014: 60.8%; 2013: 59.5%; 2012: 58.4% of all clients). By a considerable margin, the second largest group is, as in the previous year, first-time clients with the main diagnosis stimulants (19%; 2014: 19.1%; 2013: 18.7%; 2012: 16.6%) followed by first-time clients with opioid related disorders (13%; 2014: 11.9%; 2013: 12.7%; 2012: 15.0%). The proportions of first-time clients with cocaine related disorders (5%; 2014: 5.1%; 2013: 5.5%; 2012: 6.0%), as well as of all other substance groups, have remained practically unchanged in size since last year (Table 5) (Braun et al. 2016b).

Table 5 Main diagnosis in outpatient therapy (DSHS ambulant, 2015)

Main diagnosis harmful use of/dependence on (ICD10: F1x.1/F1x.2x)	All persons treated (%)			Persons treated for the first time (%)		
	Males	Females	Total	Males	Females	Total
Opioids	32.4	36.9	33.4	12.0	14.4	12.5
Cannabinoids	44.0	30.7	41.2	63.3	46.4	59.8
Sedatives/Hypnotics	1.1	5.3	2.0	1.0	4.9	1.8
Cocaine	6.3	3.7	5.8	5.9	3.7	5.5
Stimulants	14.2	21.4	15.8	16.3	28.8	18.9
Hallucinogens	1.6	0.1	0.2	0.2	0.1	0.2
Volatile substances	0.0	0.1	0.1	0.0	0.2	0.1
Multiple/other substances	1.7	1.7	1.7	1.3	1.5	1.3
<b>Total (Number)</b>	<b>56,576</b>	<b>15,303</b>	<b>71,955</b>	<b>18,643</b>	<b>4,779</b>	<b>23,435</b>

Braun et al. 2016a; Braun et al. 2016b.

Additional addiction diagnoses in addition to the main diagnosis are relatively common. Out of the clients with primary opioid-related problems in 2015, around one in five clients (20.5%) also displayed an alcohol-related disorder (dependence or harmful use) or a disorder in connection with the use of cocaine (17.6%) (Braun et al. 2016a).

Data on socio-demographic information in an outpatient setting can be found in section 1.3.4.

### Inpatient treatment

In general, inpatient treatment in Germany is carried out under drug-free conditions. Since documentation standards are determined by the respective source of funding and not by the type of treatment, all inpatient treatments carried out for persons with main diagnoses F11-F16 or F18-F19 are presented in the following with a differentiation by acute hospital treatment (Statistical Report on Hospital Diagnoses, Krankenhausdiagnosestatistik and rehabilitation therapy (Statistical Report of the German Statutory Pension Insurance Scheme, Statistik der Deutschen Rentenversicherung). Furthermore, there is data from the DSHS which provides data for a section of specialist clinics and facilities in accordance with the German Core Data Set on Documentation in the area of Addict Support (Deutscher Kerndatensatz zur Dokumentation im Bereich der Suchtkrankenhilfe, KDS; see also section 6.2.1).

Out of the total of 48,841 inpatient treatments of substance-related disorders in 212 facilities, documented in the DSHS in 2015, 11,738 were related to illicit substances (including sedatives/hypnotics and volatile solvents) (Braun et al. 2016c). Of the treatments with primary drug problems in the scope of the DSHS, the proportion of those with a main diagnosis based on dependence or harmful use of cannabis (33%; 2014: 30.7%; 2013: 28.3%) continued to rise whilst the proportion of treatments based on opioids (22%; 2014: 27.0%; 2013: 27.1%) continued to fall. Treatments based on cannabis thus remain the largest single group in the inpatient setting (without main diagnosis alcohol). The proportion of treatments based

on stimulants use (23%) continued to rise (2014: 20%; 2013: 18.3%) and in 2015 overtook those who sought treatment primarily due to opioid use (22%).

Table 6 Inpatients broken down by addiction diagnosis

Main diagnosis	Hospital	DRV	DSHS			
	2014 (%)	2014 (%)	2014 (%)	2015 (%)		
	Total	Total	Total	Total	Males	Females
Opioids	32	22	25	22	22	24
Cannabinoids	14	24	31	33	36	25
Sedatives or Hypnotics	9	2	3	3	1	9
Cocaine	2	5	7	7	7	4
Stimulants incl. caffeine	8	14	20	23	22	27
Hallucinogens	1	0	0	0	0	0
Volatile substances	0	0	0	0	0	0
Multiple substance use & use of other psychotropic substances	34	32	13	12	12	11
<b>Total (Number)</b>	<b>106,315</b>	<b>12,091</b>	<b>10,972</b>	<b>11,738</b>	<b>9,245</b>	<b>2,493</b>

Braun et al. 2016c; Destatis 2015b; DRV 2015.

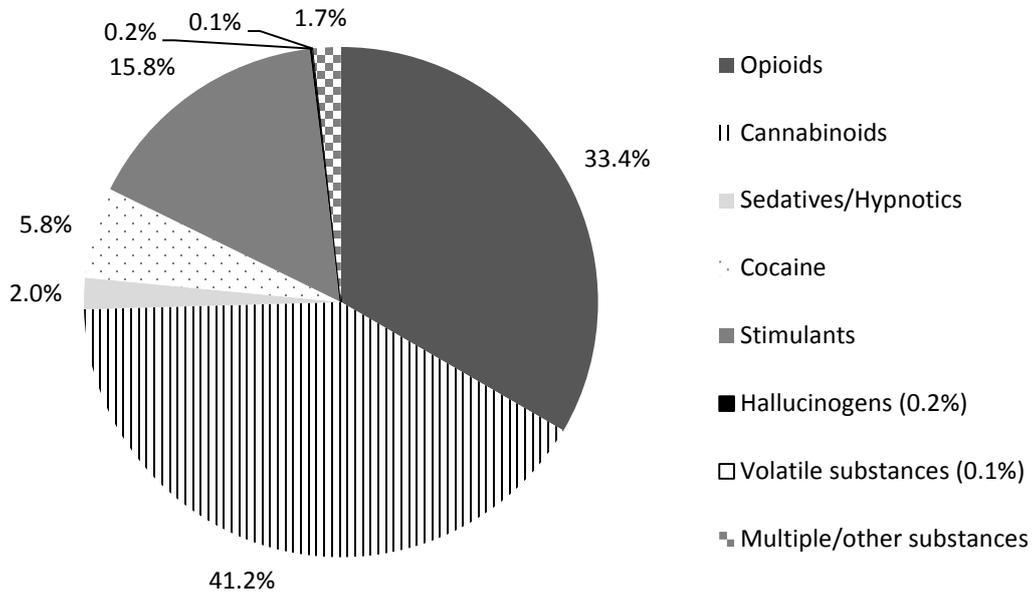
Table 7 Summary – patients in treatment

	Number of patients
<b>All patients in treatment</b>	According to the DSHS 2015 with main diagnosis illicit drugs: 71,955 outpatient 11,738 inpatient
<b>All patients in opiate substitution treatment</b>	77,200
<b>Total</b>	Not specified*

\* The available data sets cannot be seen as adding to one another, rather they overlap in part with the same groups of persons within outpatient and/or inpatient care. Therefore, it is impossible to derive overall estimates from the routine data, in particular when one takes into account family doctors.

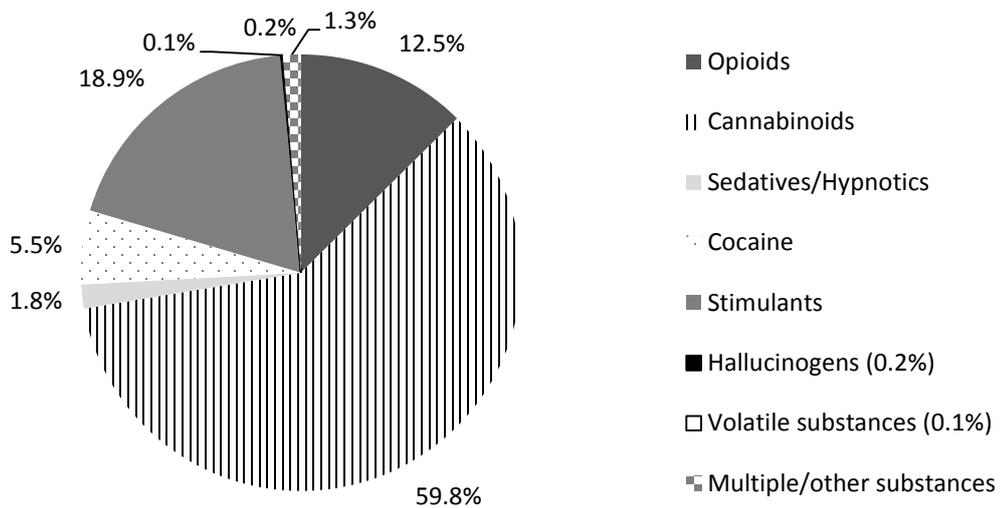
BOPST 2016; Braun et al. 2016b; Braun et al. 2016c.

**1.3.2 Distribution of primary drug in the total population in treatment (T1.3.2)**



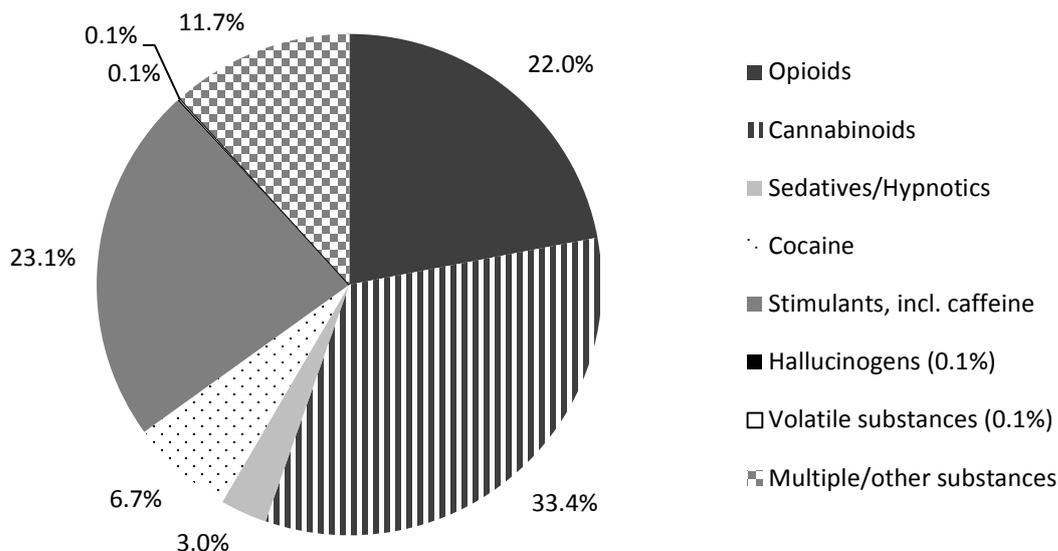
Braun et al. 2016d.

**Figure 1** Proportion of all patients treated by main diagnosis (outpatient)



Braun et al. 2016d.

**Figure 2** Proportion of all first-time patients treated by main diagnosis (outpatient)



Braun et al. 2016c.

Figure 3 Proportion of all patients treated by main diagnosis (inpatient)

### 1.3.3 Further methodological comments on the key treatment-related data (T1.3.3)

The German Statutory Pension Insurance Scheme provides comprehensive statistics of their medical rehabilitation services, the type, duration and results of the service as well as an overview of the income and expenses and the number of beds in their own facilities (DRV 2015).

In total 11,479 people (9,221 males, 2,258 females) who have utilised the services of the statutory pension insurance providers received the diagnosis "Mental and behavioural disorders due to medicinal drugs / illicit drugs". Of those, 1,170 were foreigners. On average 94 days of care were utilised. The average age at the end of the treatment was 33.1 years old and is the lowest age in comparison to other rehabilitation services which are used (for the purposes of comparison, alcohol rehabilitation: 46.0 years old) (DRV 2014).

### 1.3.4 Characteristics of clients in treatment (T1.3.4)

#### Outpatient network

Table 8 gives an overview of the socio-demographic data of patients treated in outpatient addiction support.

Table 8 Socio-demographic data by main diagnosis (DSHS ambulant, 2015)

Characteristics	Main diagnosis			
	Opioids	Cannabinoids	Cocaine	Stimulants
Age when starting treatment in years*	38.1	24.6	33.9	28.7
Age of first drug use in years*	21.4	15.4	21.8	18.8
Gender (ratio males)	76.4%	84.1%	86.3%	71.1%
Living alone	53.3%	62.4%	45.6%	54.2%
Employment status				
Unemployed	60.6%	33.3%	41.1%	49.2%
in school/education	1.7%	33.5%	4.0%	10.3%
Homeless	3.5%	0.8%	2.0%	1.7%

\*Mean value.

Braun et al. 2016b.

In an explorative study, Schneider (2016) analysed the patterns of use and negative impacts of 194 cannabis users who were being cared for or treated in outpatient counselling facilities. The main question was how the "typical", highly impacted, cannabis clientel was distinguished. The results support the assumption that cannabis users who seek out a counselling facility are exhibit intensive patterns of use and suffer from many varied problems. In addition to addiction specific problems there is a higher need for social and legal support. Almost half of these cannabis users already have already come to the attention of judicial authorities. The multi-layered need for counselling was also apparent from the type of counselling requested: the most frequent counselling objective was stated as "Support in social and legal matters". The absolute majority report having already experienced manifest effects of consumption. Symptoms such as panic, fear of persecution etc. are also often experienced. These symptoms correlate strongly with the negative effects in the social environment. In this context, there are differences with respect to age and user habits between "urban" and "rural" areas (ebd.).

## Inpatient treatment

Table 9 gives an overview of the socio-demographic data of patients treated in inpatient addiction support.

Table 9 Socio-demographic data by main drug (DSHS stationär, 2015)

Characteristics	Main diagnosis			
	Opioids	Cannabinoids	Cocaine	Stimulants
Age in years when starting treatment* <sup>1)</sup>	36.0	27.5	33.3	29.2
Age in years of first drug use* <sup>2)</sup>	20.7	15.8	21.0	18.7
Gender (ratio males) <sup>3)</sup>	77.2%	83.8%	87.2%	74.7%
Living alone <sup>4)</sup>	56.3%	64.0%	55.0%	60.5%
Employment status <sup>5)</sup>				
Unemployed	71.5%	64.9%	62.4%	68.1%
pupil/in training/education	1.2%	7.3%	2.0%	3.1%
Homeless	3.5%	2.8%	3.2%	3.2%

\*Mean value.

1) Details on all those treated in outpatient, inpatient and low-threshold treatment as well as in external counselling in prisons can be found in TDI Table 11.1.1.

2) Details on all those treated in outpatient, inpatient and low-threshold treatment as well as in external counselling in prisons can be found in TDI Table 10.1.1.

3) Details on all those treated in outpatient, inpatient and low-threshold treatment as well as in external counselling in prisons can be found in TDI Table 14.1.1.

4) Details on all those treated in outpatient, inpatient and low-threshold treatment as well as in external counselling in prisons can be found in TDI Table 18.1.1.

5) Details on all those treated in outpatient, inpatient and low-threshold treatment as well as in external counselling in prisons can be found in TDI Table 16.1.1.

Braun et al. 2016c.

Since 2011, in addition to the standard analyses of the DSHS, information on selected treatment groups has been compiled, in annually changing special analyses, and presented over a few pages in the form of brief reports. Of note here is the report on clients/patients in different living situations in outpatient and inpatient addiction treatment (Künzel et al. 2014). In that report, client and patient groups with different living situations were studied in respect of their characteristics prior to the start, during and at the end of the support/treatment.

### **1.3.5 Further top level treatment-related statistics (T1.3.5)**

- Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS) 2014
- Statistical Report on Rehabilitation from the German Pension Insurance Scheme 2013
- Statistical Report on Hospital Diagnoses (Krankenhausdiagnosestatistik)
- Regional monitoring systems, such as COMBASS in Hesse (HLS 2015) or BADO in Hamburg (Martens & Neumann-Runde 2014)

Further information on consumption can be found in the Drugs workbook.

### **1.4 Treatment services and facilities (T1.4)**

In 2015 the DHS carried out a comprehensive analysis of the German care system. Accordingly, the interventions in the support system are categorised into the following areas (DHS 2015):

- Prevention and early intervention
- Acute treatment
- Counselling and care
- Educational support (SGB VIII)
- Addiction counselling at work
- Activity, qualification, employment support
- Addiction treatment
- Integration support
- Justice
- Support for persons requiring nursing care
- Self-help

The outpatient and inpatient treatment services and their responsibilities and legal bases are listed below.

#### **1.4.1 Outpatient drug treatment services (T1.4.1)**

##### **Counselling and/or treatment facilities, specialist outpatient clinics or outpatient departments**

The central task of these facilities is the counselling and care of persons with dependency disorders. The specialists encourage affected persons to accept help, they create support plans and refer patients to further services (social, occupational, medical rehabilitation). Ad-

diction support and treatment facilities also often assume the psychosocial support for substitution patients, they support self-help projects and are specialist facilities for prevention. The legal basis for this is the German Public Health Service Act (Gesetz über den öffentlichen Gesundheitsdienst, ÖGDG). The facilities will be planned and financed by the municipalities and *Laender*.

### **Low-threshold facilities (including consumption rooms, street work or drop-in centres etc.)**

Low-threshold facilities are services which help patients into the support system. In this area, there is a contact service as the basis for further help, including through consumption rooms, street work or drop-in centres with socio-pedagogical support. The services are financed by voluntary state services and projects planned by the municipalities and also in part by the *Laender*. For further information see Section 1.2.1 as well as the workbook Harms and Harm Reduction.

### **Practice-based doctors**

Practice based doctors are generally the first point of contact for people with an addiction problem. It is their responsibility, in the scope of the diagnosis and treatment of an illness, to address a dependence problem and its consequences. Patients are advised and are encouraged to use and referred to suitable support services. Across Germany, there are 120,700 practice-based doctors (BÄK 2016) with around 20% patients with addiction disorders<sup>2</sup>. The legal basis of this is the German Code of Social Law, Volume 5. The outpatient medical treatment is planned by the associations of SHI-accredited doctors. Information on substitution can be found in section 1.4.7.

### **External services for counselling/treatment in prisons**

Prisons cooperate with outpatient addiction support facilities at a local level. Social workers advise and help by, amongst other things, referring people to external services and arranging any substitution and support measures. Either regular consultations are offered or services are provided as required. The advisers are not employees of the correctional institution and are thus bound by confidentiality obligations. For example the Duesseldorf prison (Justizvollzugsanstalt, JVA, Duesseldorf) offers an abstinence orientated department for prisoners dependent on drugs (Justizvollzugsanstalt Düsseldorf 2016).

### **Psychiatric outpatient institutes**

Outpatient institutes are generally in psychiatric hospitals and sometimes also in psychiatric departments of general hospitals. They are characterised by the multi-professional composition of their team of staff. Their legal basis is the German Code of Social Law, Volume 5 (Sozialgesetzbuch V, SGB V). The service is planned by the health insurance providers.

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<sup>2</sup> Estimates of the DHS.

### **Outpatient medical rehabilitation**

Services in a variety of facilities are available to perform rehabilitation treatment in an outpatient rehabilitative setting: Counselling and treatment facilities, specialist outpatient clinics, whole-day outpatient facilities (also: day-care facilities, day clinics, daily rehabilitation). The legal basis is the German Code of Social Law, Volume 6 (SGB VI), as well as SGB V. The pension insurance providers are in charge of the planning and quality assurance.

### **Outpatient assisted living**

Outpatient assisted living enables dependent persons, who have difficulty coping with everyday life, to continue to live in their own, or shared, accommodation. They are assisted by outpatient addiction support services, which offer intensive therapy.

### **Employment projects / qualification measures**

The integration effect produced by gainful employment and its stabilising function are achieved in employment and qualification projects provided by the addiction support system. A job can provide the basis for a successful integration and stabilisation of the persons suffering from dependence diseases. Legal basis is SGB II, SGB III, SGB VI and SGB XII. The employment agencies, the German pension insurance scheme and the social welfare providers control the planning.

## **1.4.2 Further information on available outpatient treatment services (T1.4.2)**

### **Outpatient psychotherapeutic treatment.**

Psychotherapy can be performed by practice based, licenced psychological psychotherapists, according to the German Psychotherapy Act. Specialist doctors for psychiatry and psychotherapy, specialist doctors for psychotherapeutic medicine and doctors with the additional designation "psychotherapy" are also qualified to carry this out. In total there are 16,479 practice based psychological psychotherapists (including child psychotherapists and youth psychotherapists) as well as around 10,000 practice based specialist doctors for psychotherapy (Leune 2014). The legal basis is SGB V. Planning occurs through the psychotherapist chambers.

Further information on special services in the area of outpatient treatment can be found in the German Centre for Addiction Issues reports (DHS 2010a; DHS 2015).

## **1.4.3 Inpatient drug treatment services (T1.4.3)**

### **Qualified withdrawal facilities / specialist hospital departments**

A "qualified" withdrawal treatment complements withdrawal (detoxification) with motivational and psychosocial services. It takes place in special departments of specialist hospitals or special facilities where the psychophysical peculiarities of withdrawal from alcohol and psychotropic substances are taken into account appropriately. The legal basis is the SGB V. The *Laender* control planning.

### **Inpatient facilities for medical rehabilitation**

Medical rehabilitation is performed in specialist clinics and includes group therapy, individual therapy, family work in the form of couple and family sessions or seminars as well as non-verbal forms of therapy (design and music therapy). This is complemented by work and occupational therapy, sports and exercise therapy and other indicated treatment services. Social counselling and preparation for the subsequent support services (e.g. "after-care") are always a part of withdrawal treatment. The spectrum of medical rehabilitation also includes employment related services. Medical rehabilitation is time constrained. The treatment time of the individual forms of treatment is set individually. The legal basis is SGB VI and the SGB V. Planning and quality assurance are provided by the pension insurance providers and statutory health insurance providers.

### **Therapeutic communities (TCs)**

There are only a few therapeutic communities left in Germany as in the original meaning of the term. However, numerous specialist clinics within the medical addiction rehabilitation system work according to the principles of the TCs. Specialist clinics for medical rehabilitation which integrate the principle of TCs into their concept, generally have between 25 and 50 treatment places and thus number amongst the smaller rehabilitation facilities. Further information can be found in the Selected Issue Chapter "Inpatient Treatment of Drug Addicts in Germany" of the REITOX Report 2012 (Pfeiffer-Gerschel et al. 2012).

### **Treatment in prisons**

Information on this can be found in section 1.4.1.

### **Psychiatric clinics**

The services offered range from "qualified" withdrawal treatment to treatments for addicts with psychiatric additional disorders. In Germany there are over 220,000 places in over 300 facilities available to "addict patients" (Leune 2014). The legal basis is the SGB V. The *Laender* control planning.

### **Withdrawal with motivational elements**

See above, Qualified withdrawal facilities / specialist hospital departments. Also conducted in psychiatric clinics or general hospitals.

### **Transition facilities**

Inpatient medical rehabilitation can, in so far as this is required, include a so-called transition phase. These are also performed in the inpatient setting. The legal basis is SGB VI, as well as SGB V. The pension insurance providers control the planning and quality assurance.

### **Day-care (i.e. whole day outpatient) facilities within the social therapy system**

These include, for example, day-care centres under Sec. 53 et seqq. / Sec. 67 et seqq. SGB XII but also whole-day outpatient assisted living.

### **Inpatient social therapy facility**

This type of facility is residential or transitional accommodation according to the criteria of SGB XII, Sec. 53 et seqq. or Sec. 67 et seqq. as well as of Sec. 35a German Child and Youth Services Act (Gesetz zur Neuordnung des Kinder- und Jugendhilferechts, KJHG).

#### **1.4.4 Further information on available inpatient treatment services (T1.4.4)**

Further information on special services in the area of inpatient treatment can be found in the DHS reports (DHS 2015).

#### **1.4.5 Treatment outcomes and recovery from problem drug use (T1.4.5)**

The 2014 rehabilitation statistics report of the DRV shows the following data on treatment success from treatment outcomes of the total of 12,833 (2013: 13,151) services for persons with the diagnosis "mental and behavioural disorders due to medicines/drugs": For 3,595 persons, the treatment outcome is described as unchanged (28%), for 8,570 it was improved (67%), for 72 clients the outcome worsened (0.6%) and for 596 no conclusion was possible (4.6%) (DRV 2015). The values for treatment outcomes largely correspond to the levels in the previous year.

On the basis of data from 8 clinics, the Association of Addiction Professionals (Fachverband Sucht, FVS) performed a catamnesis for patients discharged from specialist drug rehabilitation clinics in 2013 and thus investigated the effectiveness of inpatient abstinence based drug rehabilitation (Fischer et al. 2016). The DGSS (Deutsche Gesellschaft für Suchtforschung und Suchttherapie, German Society for Addiction Research and Addiction Treatment) offers two possibilities to estimate the abstinence success of patients. According to a generous estimate, the proportion of "constantly abstinent" patients lies at 78.2% of all 1,535 Patients. A more conservative estimate puts this number down to 24.9%. The true value for treatment success will be found between those two extremes.

The BUSS presents an annual evaluation of basis and catamnesis data from the member facilities. The basis evaluation from 2014 covers 2,979 cases from 23 facilities for drug addicts (in total 18,623 cases in 105 facilities). At 29 years old, drug addicts in this evaluation were young in comparison to alcohol institutions or day clinics (44.6 and 44.5 years old respectively). In specialist drug clinics the proportion of women is 17%, of people who live alone is 62.1% and of unemployed people is 55.7%. Ordinary treatment in drug specialist clinics lasts, at the most, 137.8 days (=20 weeks, in alcohol facilities 91.6 days or 13 weeks). Just over half of rehabilitation patients end the drug treatment on schedule. In inpatient facilities which treat persons dependent on alcohol and medicinal drugs and in day clinics the proportion is over 84% (Otto & Koch 2015).

The BUSS catamnesis data for the indication drugs from 2013 was collected from 11 rehabilitation clinics. 224 of the 1,251 released rehabilitation patients responded. The catamnestic success rate was calculated on the basis of patients who were reported "abstinent" and "abstinent after relapse" in the catamnesis. The values in the indication drugs varied between 2009 and 2013: depending on the type of DGSS-calculation (see above), the proportion for generous estimates lie between 66% and 53%, those for a more conservative estimate at between 9% and 18%. This fluctuation can be explained largely by the changes in the sample and the varying number of participating facilities (2012= 15 clinics / 1,591 cases / 274 respondents).

#### **1.4.6 Social reintegration services (employment/housing/education) for people in drug treatment and other relevant populations (T1.4.6)**

Information on social reintegration services can be found in the DSH Short Comparison Report no. 2/2014: Clients/patients from different living situations in outpatient and inpatient addiction treatment (Künzel et al. 2014).

### **Substitution treatment (OST)**

#### **1.4.7 Main providers/ organisations providing opioid substitution treatment (T1.4.7)**

A total of 2,613 doctors reported patients to the substitution register in 2015. This number of doctors actually performing substitution treatment is slightly lower than in previous years, returning to the level of 2004. In 2015, 517 doctors – thus approximately 20% of substituting doctors – availed themselves of the colleague consultation rule: According to this rule, doctors without an addiction therapy qualification can treat up to three substitution patients simultaneously if they involve a suitably qualified doctor as a consultant in the treatment (BOPST 2016).

Only doctors with a specific qualification in addiction medicine may prescribe substitution drugs. The German Medical Association has established that generally proof of the additional training "addiction primary healthcare" or an equivalent qualification must be produced (BÄK 2010).

#### **1.4.8 Number of clients in OST (T1.4.8)**

As of 1 July 2015, the number of substitution patients was 77,200.

In 2015, around 90,300 registrations, de-registrations or changed registrations of patient codes were recorded in the substitution register. This high number is, amongst other reasons, due to the fact that the same people were registered and deregistered multiple times. In Germany around 120 double treatments were registered on the substitution register – as in 2013 and 2014 – and consequently ended by the doctors concerned (BOPST 2016).

The nationwide average number of registered substitution patients per substitution doctor is 29 but varies considerably between the individual *Laender* (Hamburg: 40.7; Brandenburg: 6.5). Access to substitution treatment is subject to strong regional differences. Firstly, the

proportion of substitution patients in the total population is much higher in the city states (especially Bremen, Hamburg and Berlin), possibly because of the surrounding environment effect, than in the large area states. Secondly, the proportion is significantly higher in the western *Laender* than in the eastern *Laender*.

Substances used in substitution treatment are presented in Table 10.

#### **1.4.9 Characteristics of clients in OST (T1.4.9)**

No additional information is available on this at this time.

#### **1.4.10 Further aspect on organisation, access and availability of OST (T1.4.10)**

Since 2001, substitution based therapy has been regulated in detail in narcotics law and is today a medically recognised treatment form. According to the German Regulation on the Prescription of Narcotic Drugs (Betäubungsmittel-Verschreibungsverordnung, BtMVV) Sec 5, substitution aids the treatment of opioid dependence with the objective of gradually restoring narcotic drugs abstinence including improving and stabilising the patient's state of health (BMJV 2016).

The state of the art in opioid substitution treatment (OST) was established by the guidelines laid down in 2002 and amended in 2010 by the BÄK. The statutory health insurance providers recognised substitution treatment in 2003 and therefore covers the costs of this for those with statutory health insurance. Substances authorised for substitution therapy in Germany are levomethadone, methadone and buprenorphine. Codeine and dihydrocodeine (DHC) can only be prescribed in exceptional cases for this purpose. In July 2009, legal provisions were also passed on diamorphine-based substitution (c.f. Chapter 1.2.2 in the REITOX Report 2009; Pfeiffer-Gerschel et al. 2009). The majority of patients receiving substitution therapy are treated on an outpatient basis by practice-based doctors or in specialised outpatient clinics. In an inpatient setting, substitution treatment is available in around 10% of clinics offering medical rehabilitation for drug addicts (Kuhlmann 2015). Treating substituting and abstinent persons under one roof presents opportunities as well as risks. On the one hand, inpatient substitution is a further development of the support service for drug dependent persons, on the other hand this service is limited to a narrow group of people. Legal and specialist requirements must create a suitable framework and the influencing of abstinent persons must be taken into account. Currently a study is planned in North Rhine-Westphalia to examine the past experiences of those drug rehabilitation departments and clinics that also admit persons to substitution treatment, led by the University Clinic in Duisburg-Essen (ibd.). In 2015 an event, involving the five addiction associations BUSS, CaSu, GVS, FVS and FDR, on the topic "What's next... for the treatment of opiate addicts?" also took place in Berlin. There was discussion on how to bridge the gap between substitution and withdrawal treatment and how access to withdrawal treatment can be made easier for opiate dependent persons (Schwarzer 2015).

According to the BtMVV and the guidelines passed by the Federal Joint Committee (G-BA) and the BÄK, psychosocial care is a part of substitution treatment. There is legal right to psy-

chosocial care for substitution patients (provided the necessary preconditions according to SGB XII are met) which is to be provided by local social welfare providers. As far as organisation, financing and availability is concerned, psychosocial care differs greatly between the *Laender* and municipalities. Deimel and Stöver (2015) offer an inventory of the concepts, practices and conflict lines in the psychosocial treatment of opiate addicts and draw from this ideas for the further development of psychosocial addiction work.

The future provision of substitution, in particular in rural regions, remains a cause for concern (c.f. REITOX Report 2014, Chapter 5.5.2). Ever more older doctors are retiring with hardly any younger doctors taking their place. Furthermore, many opiate dependent persons in small towns or rural areas are receiving inadequate treatment. The result is an ever growing gap in the provision of care.

Furthermore, the support system is facing the challenge of treating (in suitable facilities) long term substitution patients or aging drug addicts with accompanying health limitations right up to nursing care needs. (c.f. REITOX Report 2014, Chapter 5.5.3). Regional studies on substitution treatment support the review and optimisation of support concepts locally. For example, the city of Karlsruhe offers an overview of the living situation as well as of the current and expected needs of substitution patients over 50 years old. Those questioned expressed a clear desire for support in completing everyday tasks, support with social contacts and support in the area of leisure. In answering the question on a future need for support due to increasing nursing care needs, admission to a nursing home was rejected by those questioned. One alternative is an assisted living community (Stadt Karlsruhe 2015).

Furthermore, in December 2015 the National Substitution Conference (Nationale Substitutionskonferenz, NaSuKo) took place in Berlin (Stöver 2016). The guiding theme was: "30 years of substitution treatment: bringing patients, carers and laws closer together". Under this heading, the topics of the consideration of the individual competence of patients affected, the transition from substitution treatment to medical rehabilitation treatment, the treatment based on heroin in Switzerland as well as the legal situation of doctors providing substitution treatment and the need to amend the BtmVV were discussed.

### **1.5 Quality assurance of drug treatment services (T1.5)**

As a result of various professional societies and experts working together, guidelines and recommendations for action for the treatment of drug dependence are constantly being developed (see also Chapter 11 of the REITOX Report 2010). An overview in chronological order:

- In 2006, the Working Group of the Scientific Medical Professional Societies (Arbeitsgemeinschaft der medizinisch-wissenschaftlichen Fachgesellschaften, AWMF) published the AWMF-guidelines on diagnostics and treatment of substance-related disorders which had been developed up to that point, under the title "Evidence-based addiction medicine – treatment guidelines for substance-related disorders" (Evidenzbasierte Suchtmedizin – Behandlungsleitlinie substanzbezogene Störungen).

- At a consensus conference held in 2006, the guidelines of the German Society for Addiction Medicine (Deutschen Gesellschaft für Suchtmedizin, DGS e.V.) for the treatment of chronic hepatitis C in injecting drug users were approved (Backmund et al. 2006). At the beginning of 2014, the final version of the guidelines, "Therapy for opiate dependence - Part 1: substitution treatment" of the DGS were passed (Backmund et al. 2014).
- The revised version of the S3-Guideline of 2004 on "Prophylaxis, diagnostics and treatment of the hepatitis C virus (HCV) infection, AWMF-Register No. 021/012" from the German Society for Digestion and Metabolic Diseases (Deutsche Gesellschaft für Verdauungs- und Stoffwechselkrankheiten e.V., DGVS) was published in 2010 (Sarrazin et al. 2010); see also Chapter 7.3 of the REITOX Report 2010 (Pfeiffer-Gerschel et al. 2010).
- The recommendations on the strengthening of the integration of employment measures in the medical rehabilitation of persons with dependency disorders came into force on 1 March 2015. They were prepared by the joint working group "Focus on employment in medical rehabilitation of persons suffering from dependence" (Berufliche Orientierung in der medizinischen Rehabilitation, BORA). These recommendations were intended to encourage facilities to support rehabilitation patients in an even more targeted manner according to their individual participation needs. The aim is to contribute to a further optimisation of the rehabilitation and integration process. The rehabilitation facilities should base any decisions concerning the issue of which employment related services on these recommendations (Müller-Simon & Weissinger 2015).
- Currently, the consultation version of the new S3 guidelines on the treatment of methamphetamine related disorders has been released to reflect the need for differentiated evidence-based therapeutic options (Die Drogenbeauftragte der Bundesregierung et al. 2016).
- Furthermore, in 2016 the Joint Addiction Commission of the Child and Youth Psychiatrists Specialist Society and the Specialist Associations presented a position paper on the requirements on the qualified withdrawal treatment of children and young persons (Thomasius et al. 2016). It concludes that withdrawal measures on minors should be carried out in accordance with the child and youth psychiatric psychotherapeutic standards. Children and adolescents with addiction disorders should not be treated together with patients who are in inpatient facilities due to other psychiatric disorders.

Furthermore, the medical rehabilitation of people with dependency disorders may only be provided by specialist staff with the relevant supplementary training. In this context, the German Statutory Pension Insurance Scheme has produced guidelines for the supplementary training of specialist staff working in individual and group therapy within the framework of the medical rehabilitation of drug addicts, in which supplementary training courses can receive a "recommendation for recognition". Cooperation between different professional groups from

social work, psychology, psychiatry and other medical fields forms an essential part of the treatment standards. As for outpatient options (in particular counselling centres), quality assurance and specialist monitoring are mainly in the hands of the institutions that provide these facilities, or the *Laender* and municipalities. The responsibility for detoxification and rehabilitation, however, lies with the respective funding agency (statutory health insurance providers (Gesetzliche Krankenversicherung, GKV) and pension insurance providers (Rentenversicherung, RV)) (c.f. also Chapter 11.3 of the REITOX Report 2012).

### 1.5.1 Quality assurance in drug treatment (T1.5.1)

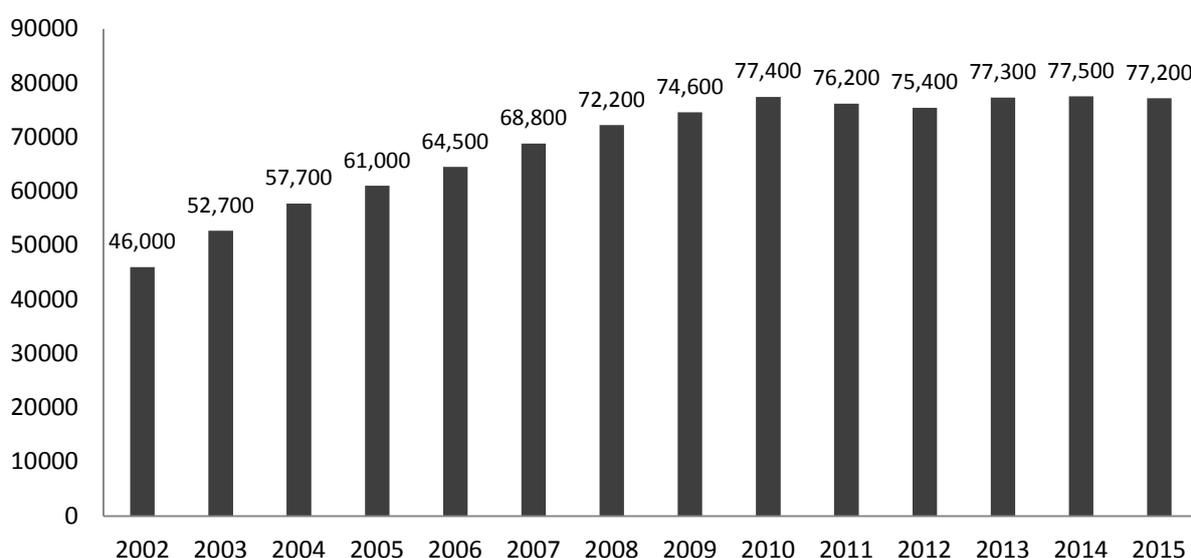
No new information.

## 2 Trends (T2)

### 2.1 Long term trends in outpatient and inpatient treatment data (T2.1)

#### Substitution

From 2002, when reporting became obligatory, the number of substitution patients reported continuously increased until 2010. Since then, the number has remained largely stable and was at 77,200 persons on 1 July 2015. There are still considerable regional differences regarding the supply of and demand for substitution treatments.



BOPST 2016.

Figure 4 Number of reported substitution patients in Germany from 2002 to 2015 (reference date 1 July)

The share of substances used in substitution treatment has shifted in the past few years away from methadone (2015: 44%) and towards levomethadone (2015: 31.8%) and buprenorphine, which in 2015 was used in about every fifth substitution (23%) treatment (Table 10).

The proportion of persons receiving substitution therapy with methadone or levomethadone has fallen since 2005 from 82.0% to the current level of 75.8%.

Table 10 Type and proportion of substances (%) reported to the substitution register (2005-2015)

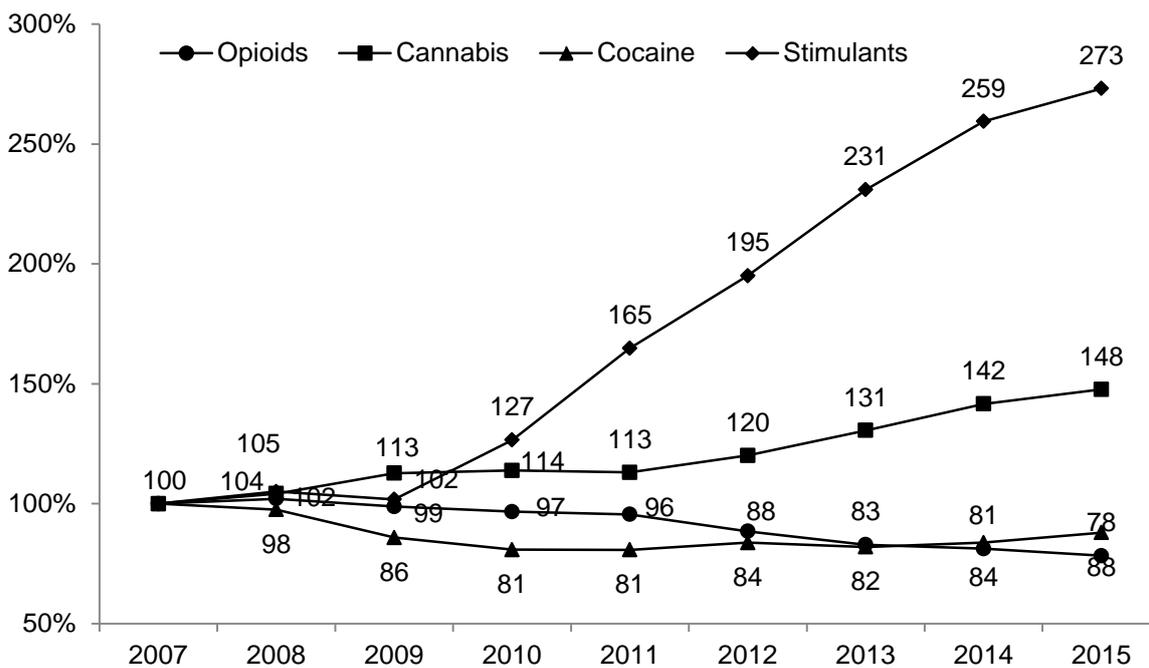
Substitution drug	2005	2010	2011	2012	2013	2014	2015
Methadone	66.2	57.7	54.8	51.6	49.3	46.1	44.0
Levomethadone	15.8	23.0	25.4	27.0	28.6	30.3	31.8
Buprenorphine	17.2	18.6	19.2	20.4	21.3	22.6	23.0
Dihydrocodeine	0.7	0.3	0.2	0.2	0.2	0.2	0.2
Codeine	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Diamorphine		0.3	0.4	0.7	0.5	0.7	0.8

BOPST 2016.

### Changes in admissions to outpatient treatment

In the area of health care, according to the DSHS data, the problems in inpatient and outpatient facilities continue to be dominated, as far as illicit drugs are concerned, by disorders caused by the use of heroin, cannabinoids and stimulants (Braun et al. 2016b; 2016c).

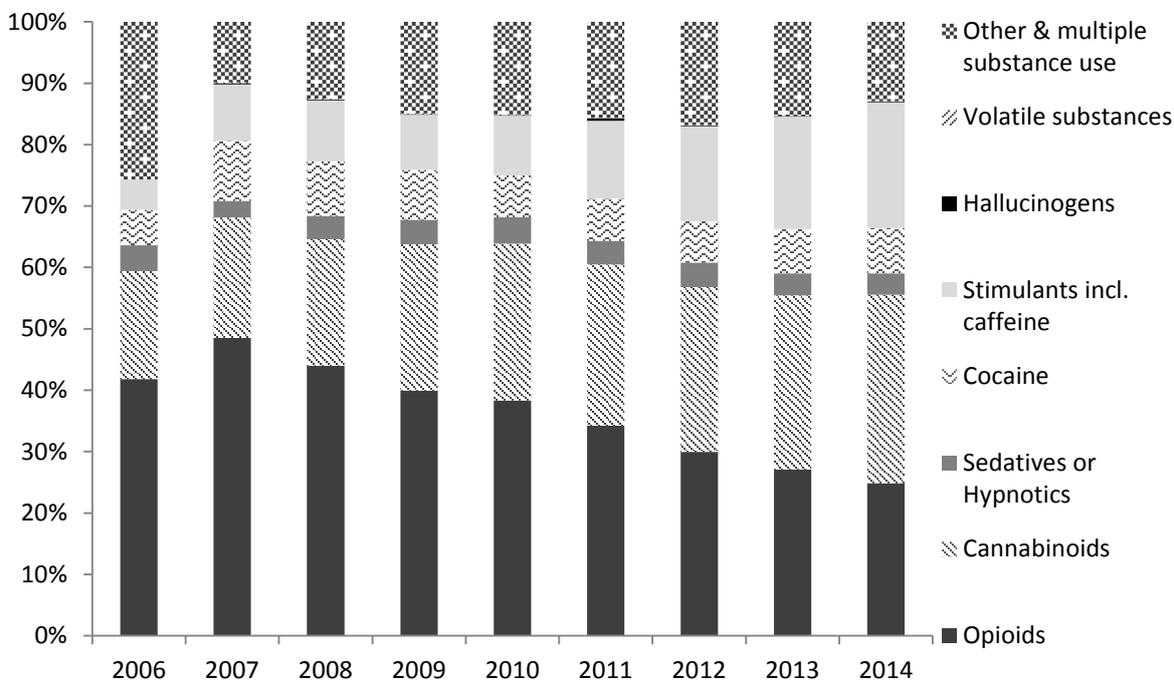
Furthermore, cannabis is in clear first place in terms of requests for treatment, when it comes to persons seeking outpatient therapy for the first time (first time patients), whereas opioids are, in this group, increasingly rarely the reason for making contact with a treatment facility. In 2013, the proportion of clients with the main diagnosis cannabis exceeded for the first time the proportion with the main diagnosis opioids amongst admissions to outpatient treatment and thereby comprised the largest single population within that subgroup (Braun et al. 2016b). If one calculates the changes in admissions of clients to the outpatient setting, according to the proportions of various main diagnoses since the introduction of the new Core Data Set in 2007 (Index=100%), one finds a slight increase in the share of clients with main diagnosis cannabis since 2007, a slight decline in clients with opioid problems. In the last three reporting years there has been a slight increase in clients with cocaine problems as well as an almost tripling of the proportion of clients with the main diagnosis stimulants (Figure 5).



Braun et al. 2016b.

Figure 5 Changes in admissions to outpatient addiction treatment for various main diagnoses since 2007 (DSHS ambulant)

**Changes in admissions to inpatient treatment**



Braun et al. 2016c.

Figure 6 Changes in admissions to inpatient addiction treatment for various main diagnoses (DSHS ambulant)

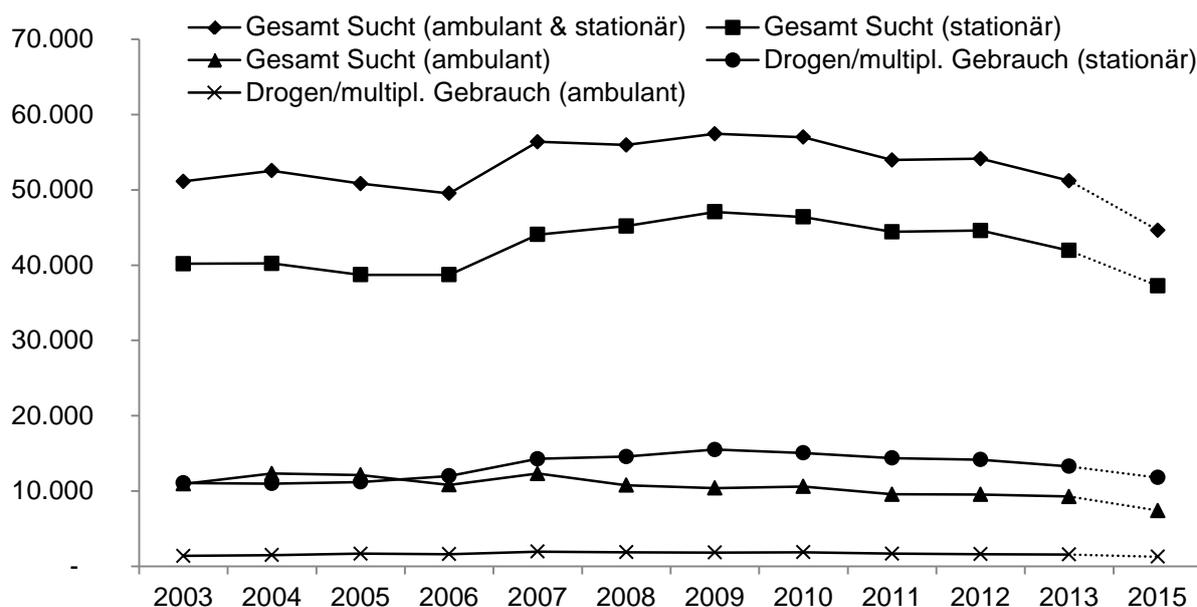
In the area of inpatient treatment, the proportion of patients with a main diagnosis based on a dependence on or harmful use of cannabis (33.4%; 2014: 30.7%; 2013: 28.3%) has, since 2013, exceeded the proportion of treatments based on opioids (22.0%; 2014: 24.9%; 2013: 27.1%) (Braun et al. 2016c).

In 2015, the third largest single group in inpatient treatment was those with a main diagnosis based on stimulants (23.1%; 2014: 20.5%; 2013: 18.3%) the share of which has been continually increasing since 2009 (Braun et al. 2016c).

The total number of rehabilitation services funded by the RV in the area of addiction rose by over 10% between 2003 (51,123) and 2009 (57,456) and has since then been continually decreasing (2010: 56,997; 2015: 44,637) (Figure 7). The greatest proportion of these services (69.7%) is provided for alcohol related disorders. Disorders due to the use of illicit drugs and multiple substance use together comprise 29.2% of the treatments provided (medicinal drugs: 1.1%). This proportion has increased by approximately five percent since 2003 (24.3%) In contrast, the proportion of services on the basis of alcohol related disorders has been falling since 2003 (74.8%) (DRV 2016).

The ratio of inpatient to outpatient treatments is (across all services) is 5:1. Since 2013 this ratio has shifted slightly towards inpatient treatments (from 3.7:1 in 2003). Looking only at the rehabilitation services for drugs and multiple substance use, one finds that the ratio between inpatient and outpatient treatment has, at 9.4:1, shifted even more markedly towards the inpatient treatments. Between 2003 and 2009 (according to the data of the DRV), the number of rehabilitation cases for drug patients (drugs/multiple use) in inpatient treatment continuously increased before falling slightly since then. In the area of outpatient treatment, the respective numbers of cases continuously increased until 2007, then remained stable until 2010 before falling again since then (Figure 7).

Since the reporting year 2015 the available statistics from the DRV for day care treatments have been listed separately. This new breakdown does lead to a more differentiated view, however it also means that the data can no longer be compared to previous years and this year seem comparatively low (see the hatched line in Figure 7 as well as Table 11).



Note. No data available for 2014.

DRV 2016.

Figure 7 Changes in outpatient and inpatient rehabilitation treatments

Table 11 Effect of the new breakdown by the DRV on treatment data

	2012		2013		2015		
	inpatient	outpatient	inpatient	outpatient	inpatient	day care*	outpatient
Alcohol	29.990	7.865	28.199	7.618	25.047	1.916	6.072
Drugs	12.242	1.322	13.225	1.535	11.764	412	1.258
Medicines	461	83	467	87	423	21	58
Multiple	1.907	272	51	29	15		
<b>Total</b>	<b>44.600</b>	<b>9.542</b>	<b>41.942</b>	<b>9.269</b>	<b>37.249</b>	<b>2.349</b>	<b>7.388</b>

\* all day outpatient.

The total number of acute addiction or drug treatments in hospitals has increased slightly since 2010, following slight fluctuations in the preceding years (German Federal Statistical Office 2016). Massive increases have been recorded in the number of treatments due to stimulants (+48% in comparison to the previous year, +208% in comparison to 2010), cocaine (respectively +29% and +104%), cannabinoids (+29% and +86%), hallucinogens (+16% and 42%) and opioids (+20% and +4%). Decreases were only observed in treatment due to volatile substances in comparison to the situation four year ago (-7%) and treatments due to multiple substance use (-18% and -14%) (Table 12).

Table 12 Inpatient treatment of drug problems in hospitals

Main diagnosis substance	Year					Change (%)	
	2010	2011	2012	2013	2014	2014 - 2013	2014 - 2010
Alcohol	333,357	338,355	345,034	338,204	340,500	+1	+2
Opioids	32,538	28,956	26,512	27,962	33,686	+20	+4
Cannabinoids	8,145	9,094	10,142	11,708	15,153	+29	+86
Sedatives/ Hypnotics	9,270	10,241	9,999	9,707	10,082	+4	+9
Cocaine	1,076	1,222	1,417	1,702	2,200	+29	+104
Stimulants	2,805	3,878	4,519	5,810	8,627	+48	+208
Hallucinogens	430	574	472	526	610	+16	+42
Tobacco	310	269	225	238	190	-20	-39
Volatile sub- stances	171	198	155	135	159	+18	-7
Multiple use/ other sub- stances	41,449	41,777	43,063	43,826	35,798	-18	-14
<b>Total addiction</b>	<b>429,551</b>	<b>434,564</b>	<b>441,538</b>	<b>439,818</b>	<b>447,005</b>	<b>+2</b>	<b>+4</b>
<b>Total drugs</b>	<b>95,884</b>	<b>95,940</b>	<b>96,279</b>	<b>101,376</b>	<b>106,315</b>	<b>+5</b>	<b>+11</b>

Destatis 2015a.

### 3 New developments (T3)

#### 3.1 New developments (T3.1)

##### Treatment of persons dependent on methamphetamine

In previous years the relevance of the treatment of persons dependent on methamphetamine in Germany rose due to rising regional consumption and the demand for specific treatment options. However, up to 2017, methamphetamine will only be recorded together with amphetamine in the scope of the German Core Data Set for Documentation of Addiction Treatment (Deutscher Kerndatensatz). Until that year there will be no detailed information on popularity and use. There is a call for treatment services aimed at specific groups, from low-threshold counselling services to effective therapeutic interventions and support in occupational and social reintegration (Rilke 2015). In January 2016 the new S-3 treatment guideline "Methamphetamine related disorders" was published and adopted by the board of the BÄK in September. Its objective is to enable better care for persons affected and greater professional competence for therapeutic staff in clinical practice, on the basis of substance specific studies (Die Drogenbeauftragte der Bundesregierung et al. 2016).

In order to meet the growing need for information on treatment, the DHS has produced a further tool for counsellors to aid in dealing with clients that use methamphetamine (DHS 2016a). To this end, the tool presents all important information on substance, popularity and in particular aids for a counselling situation.

Currently, a target group specific online self-help portal<sup>3</sup> for methamphetamine users from the Centre for Interdisciplinary Addiction Research (Zentrum für Interdisziplinäre Suchtforschung, ZIS) of the University of Hamburg is being developed and evaluated (Milin & Schäfer 2015; ZIS 2015).

The FreD programme (Early Intervention with Drug Users Coming to the Attention of Law Enforcement for the First Time, Frühintervention bei erstaußälligen Drogenkonsumenten) of the Coordination Office for Drug Related Issues of the LWL has received an extension to its approach, to include (meth)amphetamine type stimulants in the current "FreD-ATS" project, funded by the BMG. The project began in May 2015 and is planned to run for 20 months. As the *Laender* Bavaria, Saxony and Thuringia have been particularly affected, the project will concentrate on these regions and North Rhine-Westphalia. The project aims to develop an ATS supplement to the FreD manual and to subsequently trial and evaluate it in practice (LWL-KS 2016a).

The globally used treatment manual MATRIX for people dependent on stimulants is being made available to the German speaking world. This is being translated by the Thuringia based association "SuPraT" (Suchtfragen in Praxis und Therapie, Addiction Issues in Practice and Treatment) and adapted for the client pool of people dependent on methamphetamine. (Thüringer Ministerium für Arbeit, Soziales, Gesundheit, Frauen und Familie 2016, personal communication).

Hamdorf and colleagues(2015) have, in addition, presented catamnesis results of the withdrawal treatment of patients dependent on methamphetamine at the AGH Clinic Mecklenburg. This shows no difference in abstinence rates after one year in a comparison between methamphetamine users (41.7%) and other drug users (40.4%). Furthermore, in this catamnesis methamphetamine users ended treatment in a regular manner more often than other drug users.

### **Cooperation between psychiatry and addiction support**

Germany has a differentiated care system for addicts and psychiatric patients. However, it has become clear time and again and at various interfaces, that resources and skills are not being sufficiently coordinated and consultation on the basis of different competences falls short.

"Motivation" and "capacity for rehabilitation" are essential prerequisites for the approval of a withdrawal treatment. For people who view abstinence as not worth the effort or unrealistic, the motivation to change their behaviour is too low. However these afflicted persons also

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<sup>3</sup> <https://breaking-meth.de> [accessed: 24 Aug. 2016].

appear in the support systems, primarily in psychiatry – in acute emergency and crisis situations, for physical detoxification or for treatment of comorbid disorders.

Psychiatry is of essential importance in the treatment of people with addiction, as is cooperation and coordination with other institutions which might be involved in the treatment of the people concerned or resume involvement after inpatient treatment. An exchange between experts is crucial in dispelling the discrimination and double stigmatisation against the persons concerned.

With the cooperation conference "Addiction support and Psychiatry" in May 2016 in Weimar, which was held jointly by the DHS and the Addiction Working Group of the Federal Directors Conference of Psychiatric Hospitals (Bundesdirektorenkonferenz der Psychiatrischen Krankenhäuser, BDK), the intention was to intensify the exchange between the support systems. Important representatives of the participating fields of psychiatry and addiction support were brought into conversation with one another, sensitised to the perceptions of the other participants and, through discussion of successful examples of cooperation, motivated to overcome the discrepancies between the systems and thereby to improve care and provide it in a more needs based manner.

### **Migration and addiction support**

In the context of the current migration and refugee issue, questions are also being asked in the context of the national addiction support landscape about the prevalence of use of addictive substances and the need of support by refugees, as well as suitable treatment options for persons with migration backgrounds. To this end a variety of events are being held, among others an expert discussion by invitation of the Federal Government Commissioner on Narcotic Drugs in May 2016 on the topic of "Refugees in Germany – a challenge also for addiction- and drugpolicy?", as well as a meeting of the Coordination Office for Drug Related Issues of the LWL on the topic "Escape - Trauma - Addiction" – What is in store for addiction support?" (LWL-KS 2016b) and the 11th Berlin Addiction Dialogue of the German General Association for Addiction Support (Gesamtverband für Suchthilfe, GVS) with the title "Addiction Support in Cultural Diversity" (both in November 2015) (GVS 2016). Furthermore, the Bavarian Academy for Addiction Issues (Bayerische Akademie für Suchtfragen, BAS) organised, in March 2016, a workshop on addiction problems among refugees (Tretter & Arnold 2016). In July 2016 the *Land* Congress of the *Land* Office for Addiction Issues in Baden-Württemberg (Landesstelle für Suchtfragen in Baden-Württemberg e.V. 2016) with the title "Seeking Refuge" took place.

During the expert meeting with the Federal Government Commissioner on Narcotic Drugs it became clear that no epidemiological data regarding illegal substance use of refugees are available. Drug related crime has increased in the immigrant population, however, it did so in parallel with the total number of immigrants. The proportion of drug related crime in all crimes is still at low levels (around 5%). The term "addiction" should be handled with care and the primary focus should lie on use and prevention. Education about the prevailing legal norms and handling of substances are required. The patients arriving with an existing substance

use problem or addiction are a minority. However, these are often based on posttraumatic stress disorders. Other risk factors include young age, being male, having no social network or bad access to educational facilities. The use of different kinds of substances and the access to the support system has been further discussed during the meeting. An essential problem is that of communication and understanding due to language barriers.

It was highlighted at the LWL-Conference that stressful experiences and traumatisation can encourage the use of addictive substances by refugees. In coping with refugees, the professional addiction support system faces special challenges: Language barriers, a culturally influenced different understanding of illness, a (for the affected person) unknown, complex public health system and many existential problems overlie addiction problems and make effective support more difficult. The topic was examined from various perspectives and impulses were given for the work at a local level (LWL-KS 2016b). At the Berlin Addiction Dialogue it was also highlighted that the topic "addiction and migration", in connection with an increased development of intercultural skills in the addiction support facilities, will represent one of the most important challenges of the next few years. In particular, an increased cultural sensitivity was called for in the area of treatment (GVS 2016). At the BAS workshop, in addition to a inventory of the problems, in particular experiences in treatment practice were presented (Tretter & Arnold 2016). The *Land* conference in Baden-Württemberg is also intended to enable a discussion on prevention and support for refugees (Landesstelle für Suchtfragen in Baden-Württemberg e.V. 2016).

Rommel and Köppen(2016) analysed, on the basis of the DSHS, the utilisation of addiction support by people with a migration background (Menschen mit Migrationshintergrund, MMH). They come to the conclusion that addiction support is not, in general, utilised less often by MMH. Within the MMH group, needs and usage behaviour varies. A higher number of MMH born in Germany make use of addiction support for problems with cocaine, opioids, cannabinoids and pathological gaming than those who emigrated to Germany. MMH who emigrated to Germany, particularly women, are in contrast usually underrepresented in addiction support facilities.

Röhnsch and Flick (2015) also concerned themselves with care for MMH, in particular with perceptions of treatment of migrants from the former Soviet Union with alcohol or drug problems. On the basis of episodic interviews with those affected and expert interviews they conclude that the support system should take the cultural specifics of perceptions of treatment among migrants into account to a greater extent. Holistic support that contained spiritual-religious components but was also control-based were important for those questioned.

## **4 Additional information (T4)**

### **4.1 Additional sources of information (T4.1)**

No additional information is currently available on this.

## **4.2 Further aspects of drug treatment (T4.2)**

There are currently no further aspects to report.

# **5 Notes and queries (T5)**

## **5.1 Misuse of substitution drugs (T5.1)**

The most recent Federal Situation Report 2015 on Drug Related Crime gives information on the causes of drug-related deaths. Out of the total of 1,226 deaths, 34 people with monovalent poisoning died from opiate substitution drugs (methadone (i.a. polamidone): 31; buprenorphine (i.a. subutex): 3). In cases of polydrug poisonings from opioid substitution drugs in connection with other substances, 174 cases were recorded (methadone: 147; buprenorphine: 15; other: 12) (BKA 2016).

Reimer and Colleagues (2016) drew up a review paper on misuse in substitution treatment and examined the effects. There are direct risks both for the person themselves (overdosing, damage to health) as well as their surroundings (unsupervised use, unintentional child endangerment). Economic costs, crime and loss of productivity were identified as indirect effects. They conclude that the misuse of substitution drugs must be understood and reduced. Studies from Germany were not included.

In 2009 and 2011 the use of substitution drugs contrary to their intended purpose in Germany was studied by ZIS Hamburg (Reimer 2011). In surveys, the use of, amongst other things, substitution drugs that were not prescribed was recorded. Whilst in 2008 the prevalence of use of "any substitution drug" within the last 24 hours was still at 9.3%, in 2011 15.4% of those questioned in the scene reported using non-prescribed substitution drugs in the last 24 hours. However there are differences in the target group as not only people in the open drug scene were interviewed but also people in and around substitution clinics/outpatient substitution clinics. In this survey, only 2.8% of respondents admitted to using substitution drugs that had not been prescribed. As far as the use of other substances within the last 30 days was concerned, among members of the scene survey heroin was used by nearly three quarters (73.6%), but among the groups in the vicinity of the clinics by not even one third (31.7%). There is a similar ratio for cocaine (scene 46.2%; clinic 22.0%) and non-prescribed benzodiazepines (scene 49.8%; clinic 23.2%).

## **5.2 Internet-based drug treatment (T5.2)**

Internet based drug treatment is in its infancy in Germany. The German Society for Addiction Research and Addiction Treatment (DG Sucht) put the topic of "Web based interventions in addiction treatment and prevention" on the agenda at their closed conference in 2015 (Rumpf & Thomasius 2015). The papers presented examined, among other things, whether personal or computerised alcohol interventions are more effective (Freyer-Adam et al. 2015) and how young people can be reached with an internet and text message program on the topic alcohol (Haug et al. 2015).

For treatment in the area of illicit drugs, the results of the European study "Click for Support"<sup>4</sup>, designed to investigate web based support and ultimately to develop guidelines for effective programs, are relevant (Sarrazin & Steffens 2015). In Germany, ten web based information and advice portals were analysed and evaluated, including five that explicitly focussed on illicit drugs. "Quit the shit"<sup>5</sup> was the only one to fulfil all six of the quality criteria and was also evaluated in respect of its effectiveness (ibid.). The guidelines developed in the project can be found at <http://www.clickforsupport.eu/> [accessed: 25 Aug. 2016].

In addition, Hoch and Colleagues (2016) point out, in their systematic review paper on digital interventions for problem cannabis use in non-clinical settings, that these can contribute to a decrease in use and can reduce barriers to seeking treatment. Four studies were reviewed including the German programme "Quit the Shit". Tossmann and Colleagues (2016) also analysed systematic online interventions for alcohol and cannabis users. They too come to the conclusion that "Quit the Shit" was able to demonstrate a medium-term effectiveness on the reduction of cannabis use in the scope of random control studies.

The program "Realize it"<sup>6</sup> has also demonstrated its effectiveness in reducing cannabis use. Over a 10 week period, risk situations, control strategies and alternatives to use are discussed in five private sessions and one group session. The central component of this program is the accompanying book for the clients. The aim is to further develop the program by extending it to smartphones and improving its quality. This should increase the attractiveness of the program for its users. On the side of the counselling centres, the counselling process should be even more structured and interactive. Since March 2016 the accompanying book has also been accessible to clients via smartphone. Currently, the use of "Realize It" e-books is being tested in 18 counselling centres across Germany. The implementation process will be accompanied by an evaluative review (Kasten 2016, personal communication).

Further extensive information portals on particular narcotics and different target groups are available. These include, for example, the facility register of the DHS<sup>7</sup> or the information portal of the BZgA<sup>8</sup> which contains information on legal and illicit drugs. In some cases, counselling is also offered. The newly developed database MethCare from the association, SuPraT<sup>9</sup>, offers literature from around the world on methamphetamine (including on prevalence, secondary harm, treatment options, comorbidity).

Addiction associations, counselling centres and self-help groups also extend their "offline hours" by offering counselling via email (e. g. Caritas). The project, ELSA, was conducted as a pilot, providing counselling to parents whose children used addictive substances<sup>10</sup>. The

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<sup>4</sup> <http://www.clickforsupport.eu/> [accessed: 25 Aug. 2016].

<sup>5</sup> <https://www.quit-the-shit.net/qts/> [accessed: 25 Aug. 2016].

<sup>6</sup> <https://www.realize-it.org/> [accessed: 25 Aug. 2016].

<sup>7</sup> [www.suchthilfeverzeichnis.de](http://www.suchthilfeverzeichnis.de) [accessed: 25 Aug. 2016].

<sup>8</sup> <http://www.drugcom.de/> [accessed: 25 Aug. 2016].

<sup>9</sup> <http://suprat.de/methcare.html> [accessed: 25 Aug. 2016].

<sup>10</sup> <https://www.elternberatung-sucht.de/> [accessed: 25 Aug. 2016].

Federal Conference on Educational Counselling (Bundeskonzferenz für Erziehungsberatung, BKE) offers online counselling for young people and parents<sup>11</sup>.

Weissinger (2016) observes that caution is advised regarding use of the term treatment as online therapy is – in contrast to counselling and prevention – currently not (yet) permitted in Germany (personal communication).

### 5.3 Specific treatment programmes for NPS users (T5.3)

No specific treatment programmes for NPS users are known in Germany. Simon and Colleagues (2016) recommend, on the basis of reporting by the EMCDDA, the use of elements of good clinical and acute medical practice, tailored to individual circumstances and supplemented by specific elements where this is possible.

## 6 Sources and methodology (T6)

### 6.1 Sources (T6.1)

The sources are assigned to the respective information and can be found in the bibliography.

The main sources for the section Treatment are:

- Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS) (Base: German Core Data Set, Deutscher Kerndatensatz)
- Statistical Report on Hospital Diagnoses (Krankenhausdiagnosestatistik)
- Statistical Report of the German Pension Insurance Scheme (Statistik der Deutschen Rentenversicherung)
- Regional monitoring systems
- Substitution register
- Addiction Yearbook 2016 from the DHS

### 6.2 Methodology (T6.2)

#### Outpatient Treatment

The DSHS provides extensive data, based on the KDS, on outpatient clients from the vast majority (2015: 858 or 73.56%) of the outpatient facilities funded by the *Laender* and municipalities (Braun et al. 2016b). In most facilities for addiction support in Germany, the current KDS (DHS 2010b) is used which was revised in 2007 and for which a new version will also be released in 2017. Therefore, the comparability of data from different time periods will always be limited.

Since 2010, unlike in previous years up to and including 2009, no facility has been excluded from the data in the DSHS reported here on the grounds of their missing rate being too high

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<sup>11</sup> <http://www.bke.de/> [accessed: 25 Aug. 2016].

(>33%), in order to avoid an overestimation of the missing figures and to achieve a maximum facility sample for each table. Therefore, caution needs to be exercised when comparing the data from 2010 onwards with that of 2007 to 2009.

The "Treatment Demand Indicator (TDI)" of the EMCDDA is integrated in the KDS. However, there is still a certain blurriness between the TDI and the KDS because the German treatment system is aligned with the International Classification of Diseases (ICD-10), which renders analysis at the substance level in part difficult or impossible.

### **Inpatient Treatment**

In the inpatient area, 212 facilities (respective 63.88%) participated in 2015 in the Federal evaluation of the DSHS (2014: 206) (Braun et al. 2016c).

Many larger facilities, especially psychiatric clinics, which also offer addiction-specific treatments, are not represented in the DSHS. In order to close this gap as far as possible in the REITOX Report, data from other sources is being used.

The KDS, produced by the German Federal Statistical Office, documents the diagnosis on discharge of all patients leaving inpatient facilities as well as the main diagnoses, age and gender. Though complete, the KDS is not specific to the topic of addiction and thus offers little detailed information in this area. It does however allow a differentiation of the number of cases in line with the ICD-classification (F10-F19). Apart from accounting information on services provided by hospitals, there is no systematic collection of comprehensive statistical data on hospital treatments. However, general documentation standards do exist, for example for psychiatric clinics or facilities for child or youth psychiatry. These contain, amongst other things, information on the treatment of patients with addiction problems. So far, no systematic analysis has been carried out for the transfer of this data to the standard of the KDS.

The statistics from the DRV document all cases for which the costs were borne by the funding agency. However, the proportion of inpatient treatments which were acute treatments or which were financed from other sources, is missing.

A categorisation of the data of these two statistical reports by main diagnosis broadly matches if one takes into account the substantially higher proportion of undifferentiated diagnoses according to F19 (multiple substance use and consumption of other psychotropic substances) in the data recorded by the DRV.

Data from regional monitoring systems can be compared to the nationwide figures, insofar as the regional systems used the KDS, and thus serve as a valuable complement to the national statistics.

### **Substitution treatment**

Since 1 July 2002, data on substitution treatment in Germany has been recorded by the substitution register which was set up with the purpose of avoiding double prescriptions of substitution drugs as well as of monitoring quality standards on the treatment side. The short-term use of substitution drugs for the purpose of detoxification is not recorded in this register

insofar as the detoxification treatment lasts no longer than four weeks and the patients no longer require substitution drugs directly upon completion of the treatment. Since 2010, this data source has provided findings on the number of clients treated and on the substitution drugs used, complete with a list of names of the doctors in charge of treatment. Since an amendment to the psychotherapy guidelines in 2011, patients receiving substitution treatment still have a right to psychotherapy if they have not achieved abstinence after more than 10 treatment sessions (G-BA 2013).

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