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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 1,300 addiction counselling and treatment centres, approximately 300 psychiatric outpatient institutes, 800 facilities for integration support and about 500 (all-day) outpatient and 320 inpatient therapy facilities. 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. There is also a host of self-help organisations working in parallel or cooperating with professional support services in the area of addiction.

When looking at the data from the Statistical Report on Substance Abuse Treatment in Germany (DSHS) and confining oneself to illicit substances, in over a third of cases clients sought treatment or counselling primarily for dependence on or harmful use of opioids. Over one third of cases concerned clients primarily with cannabis problems. Amongst persons who received addiction specific treatment for the first time, cannabis was by some margin the most used substance, with its share once more increasing slightly. After a distance, the second largest group is first-time clients with the main diagnosis of stimulants, as in the year before, followed by first-time clients with opioid related disorders. The proportion of first-time clients with cocaine related disorders, as well as all other substance groups, have remained practically unchanged in size since last year.

Of the inpatient 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 continued to rise whilst the proportion of treatments due to opioids 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 due to the consumption of opioids has been declining since 2007, the proportion due to cannabis has been constantly rising since 2007. The next largest group consists of treatments due to the use of stimulants.

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 77,500 patients on 1 July 2014. There are still considerable regional differences regarding the supply of and demand for substitution treatments.

New developments in the treatment system can be seen in the discussion regarding e-health, participation in employment and in the treatment of ATS/methamphetamine users.

1. National profile (T1)

1.1. Policies and coordination (T1.1)

1.1.1. 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 in 2012 replaces the Action Plan for Drugs and Addiction from 2003 and places a particular focus on addiction prevention and early intervention (c.f. Die Drogenbeauftragte der Bundesregierung 2012). The primary objective is the prevention and reduction of the use of legal and illegal addictive substances. The National Strategy also stresses, however, the necessity for counselling and treatment services in Germany: "This should be maintained and strengthened so that every person suffering from addiction can utilise the counselling and treatment services which he or she needs".

Within the National Strategy, Objective 3 in particular (expansion of indicated prevention and therapy for people with high-risk cannabis use) addresses aspects of therapeutic provision for people who use illicit drugs (Die Drogenbeauftragte der Bundesregierung 2012).

In the past, counselling facilities were especially focussed on alcohol dependent persons and opiate users; in recent years, the services for cannabis users in particular have been expanded ("AVerCA"¹, "Quit the Shit"², "CANDIS"³, "CANStop"⁴ and "INCANT"⁵ as well as programmes with a cross-substance approach, "SKOLL"⁶ and "FreD"⁷). The transfer and popularity of these services are to be supported on a municipal level (loc. cit.). The measures comprise the following:

- Broadening and improvement of the availability of existing cannabis treatment and counselling programmes for specialists through the internet platform AVerCa
- Transfer and broad implementation of evaluated interventions for the reduction of cannabis use such as "Quit the Shit", "CANDIS", "CANStop" and "INCANT" through the promotion of specialist conferences and specific further training services
- Development of a cross-substance approach and transfer in addiction counselling practice through the project, "SKOLL" (self-control training)
- Special evaluation of the existing representative surveys (Epidemiological Survey of Substance Abuse (ESA) and Drug Affinity Study (DAS) of the Federal Centre for Health

¹ www.averca.de [last accessed: 5 Oct. 2015].

² www.quit-the-shit.net [last accessed: 5 Oct. 2015].

³ www.candis-projekt.de [last accessed: 5 Oct. 2015].

⁴ www.canstop.med.uni-rostock.de [last accessed: 5 Oct. 2015].

⁵ www.incant.eu [last accessed: 5 Oct. 2015].

⁶ www.skoll.de/ [last accessed: 5 Oct. 2015].

⁷ www.lwl.org/FreD/ [last accessed: 5 Oct. 2015].

Education (BZgA) as well as studies from individual German Laender and cities on the use of illicit drugs (especially cannabis) amongst adolescents and young adults

- Extension of the "FreD" programme (early intervention for drug users who have come to the attention of the police for the first time) especially to include adolescents who have come to the attention due to their cannabis use.

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

The German treatment system for people with drug-related problems or their relatives is very differentiated. Planning of the treatment demand in the various segments of the medical and/or social support system at a national level, however, does not fit within the federal structure of Germany. Planning is done instead at Laender or municipal level. The German Federal Government Drug and Addiction Commissioner fulfils a cross-departmental and cross-institutional coordinating role at a federal government level.

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 information (T1.1.3)

The German Centre for Addiction Issues (DHS) recently presented a comprehensive description of the addiction support and care 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).

Further information on treatment guidelines can be found in the national REITOX Report 2010 (Pfeiffer-Gerschel et al. 2010).

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

In Germany there is a sophisticated, nationwide and comprehensive 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 treatment data is available), the approximately 1,300 addiction counselling and treatment centres, approximately 300 psychiatric outpatient institutes, approximately 800 facilities for integration support and about 500 (all-day) outpatient and 320 inpatient therapy facilities. The psychiatric clinics have a particular importance. The majority of the support facilities is run by free, charitable bodies. State and commercial organisations are also found, in particular, in the area of inpatient treatment.

In parallel and in part in cooperation with professional support services, numerous self-help organisations also exist in the area of addiction. So far they have mostly been aimed at alcohol addicts and older target groups, however it is the aim of the German Self Help Associations to open themselves up increasingly to addicts of all addictive substances and to convince more young addicts of the idea of self-help.

1.2.1. Outpatient treatment

Outpatient treatment system - facilities and services (T1.2.1)

Contact, motivation and outpatient treatment are mainly offered by outpatient counselling facilities; withdrawal treatments and detoxification are for the most part done in general hospitals but also in a few specialised clinics (often in the psychiatric ward). Outpatient counselling facilities are often the first port of call for clients with addiction problems insofar as they are not treated by primary care – i.e. generally speaking by practice-based doctors. The counselling is free of charge, the facilities are mainly financed by the municipalities and Laender as well as by their not inconsiderable, own resources (donations, church taxes, etc.).

Table 1 Network of outpatient treatment facilities (total number of units)

	Number of facilities	Description
Specialised drug treatment centres	1,300	Counselling and/or treatment facilities, specialist outpatient clinics or outpatient departments
Low-threshold agencies	>300	Emergency overnight accommodation, consumption room, streetwork, etc.
General/Mental health care	2,650* / 8,416**	Substitution doctors
Prisons	186	External services for counselling/treatment in prison
Other outpatient units	300	Psychiatric outpatient institutes
Other outpatient units	100	(Whole day) outpatient rehabilitation
Other outpatient units	460	Outpatient assisted living
Other outpatient units	250	Employment projects/qualification measures
Other outpatient units	8,700	Self help groups

* In 2014, 2,650 doctors reported to the substitution register (BOPST 2015).

** 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 is not updated.

Pfeiffer-Gerschel et al. 2014; BOPST 2015.

It must be considered 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).

Further information on the availability of outpatient treatments (T1.2.2)

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 local authorities on the basis of municipal

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).

Outpatient treatment system (T1.2.3)

Table 2 Number of places available in outpatient addiction support

	Number of places	Description
Specialised drug treatment centres	>500,000	Counselling and/or treatment facilities, specialist outpatient clinics or outpatient departments
Low-threshold agencies	>300	Emergency overnight accommodation, consumption room, streetwork, etc.
General/Mental health care	77,500	Substitution doctors
Prisons	n.s.	External services for counselling/treatment in prison
Other outpatient units	91,800	Psychiatric outpatient institutes
Other outpatient units	> 1,000	(Whole day) outpatient rehabilitation
Other outpatient units	12,000	Outpatient assisted living
Other outpatient units	>4,800	Employment projects/qualification measures
Other outpatient units	n.s.	Self help groups

Pfeifer-Gerschel et al. 2014; BOPST 2015.

It must be considered when looking at the information concerning the number of available places that 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).

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.

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

No information.

Further information on the availability of outpatient treatments (T1.2.5)

With regard to the availability of individual treatment and support services, there are differences to be found between the Laender. For example, not all Laender offer consumption rooms as a component of harm reduction measures. Moreover it has repeatedly been reported that there are difficulties in providing region-wide care for patients who would like to undergo substitution treatment in rural areas (in particular in the eastern Laender).

All in all, the situation with regard to support services available has not changed significantly recently. The only partially secured legal basis for the funding of outpatient services continues to lead to financing problems. The municipalities, which provide the funds for most of these services, are struggling with extremely tight budgets. Since the municipalities are not legally

obligated to provide funding for outpatient addiction support, a lot of services are cut at various locations (despite municipal services of general interest, which are enshrined in the constitutional law Social State Principle as per Art. 20 (1) German Constitution, c.f. Bürkle & Harter 2011). At the same time however, facilities have started to engage in a professionalisation of their operational and technical procedures.

Further information can be found in section 1.4.

1.2.2. Inpatient treatment

Inpatient treatment - facilities and services (T1.2.6)

Inpatient treatment is a fundamental element of the treatment and rehabilitation forms of drug dependent persons. In Germany, there are approximately 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 treatment facilities (total number of units)

	Number of facilities	Description
Hospital-based residential drug treatment	>300	Specialist hospital departments
Residential drug treatment (non-hospital based)	320 (97)*	Inpatient rehabilitation services
Therapeutic communities*	n.s.**	
Other inpatient units	300	Psychiatric clinics
Other inpatient units	190	Withdrawal with motivational elements
Other inpatient units	115	Adaption facilities
Other inpatient units	268	Social therapy inpatient facilities
Other inpatient units	112	Social therapy daycare facilities

* Inpatient rehabilitation facilities which treat users of illicit drugs.

** In Germany, there is no statistical data on therapeutic communities as that term is 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 [last accessed: 5 Oct. 2015]). The problem was already addressed in the REITOX Report 2012.

Pfeiffer-Gerschel et al. 2014.

It must be considered 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 the features of individual facilities can be found in sections 1.3 and 1.4.

Further information on the availability of inpatient drug treatment provision (T1.2.7)

If addiction problems and their harms are too problematic, the consequences too massive and the general situation for the drug addict himself and his environment too stressful, the patient will be admitted to inpatient therapy. However, the transfer from outpatient to inpatient therapy involves an administrative effort. Furthermore, it needs to be clarified who will assume the costs (generally the statutory pension insurance fund; for patients without employment, other regulations apply) (c.f. on this point Pfeiffer-Gerschel et al. 2012, section 11.2.1). In some cases, inpatient measures are not appropriate for the client's situation (for example if it could jeopardise an existing job) or even impossible (for instance if there is no childcare available to give a mother the time to go to treatment). In recent years we have seen increased flexibility in the structure of treatments offered and this has enabled clients to make use of other, demand specific treatment services, including day care and outpatient treatment options.

Withdrawal treatments are carried out by specialised clinics or in therapeutic communities. 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 addicts. All these fields of work are staffed with specialists who, for the most part, have received supplementary training specific to the field. All services offered aim at stabilising abstinence from drugs.

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 main diagnosis for all patients treated in German hospitals is reported to the Federal Statistical Office (Statistisches Bundesamt) which regularly publishes the respective data (Statistical Report on Hospital Diagnoses).

Rehabilitation serves to stabilise long-term abstinence and to restore the patient's ability to work. Therefore, the costs of rehabilitation are generally borne by the statutory pension insurers who also decide on the type, scope and duration of the treatment. Statistical data on the services rendered are available from the pension insurance funds.

One must take into account that the following individual information from the care areas are not immediately comparable to one another and some of the data is redundant.

Treatments: Psychiatry

In addition to the data from the Statistical Report on Substance Abuse Treatment in Germany (DSHS) and the German Statutory Pension Insurance Scheme (DRV), the report on the basic data set on addiction psychiatry can also be used. The figures on addiction treatment cannot, however, be simply added to those from the DSHS or the DRV due to possible overlapping. 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 addiction care in Germany. These facilities offer low-threshold, qualified withdrawal treatment, however emergency cases are also treated and crisis interventions and complex treatments in cases of

comorbidity are also performed. 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 provides a comprehensive medical, psychosocial and psychotherapeutic system of care.

According to an extrapolation of the data, approximately 300,000 inpatient addiction treatments took place in psychiatric clinics in 2010. In addition there are 300,000 quarterly treatments that were carried out in psychiatric outpatient institutions of the clinics. 31% of inpatient psychiatric cases involved patients with dependencies. 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 Federal Government. Most patients 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 2012).

A shift in demand towards increasingly intensive treatment forms has been observed for a long time. Outpatient care for addiction patients in psychiatric facilities has been greatly expanded, particularly through the establishment of outpatient psychiatric clinics in institutions tasked with carrying out treatment for addiction patients.

At the local and regional level, psychiatric-psychotherapeutic facilities closely cooperate with the psychosocial counselling facilities and the outpatient and inpatient rehabilitation facilities. In some Laender, for example Baden-Wuerttemberg, well-established municipal addiction support networks for drug patients now exist.

Except for a few specific cases, there is no statutory basis for funding provided by the German Code of Social Law (SGB) Volumes IV and XII for the integration or after-care phase. Here, the legally and economically responsible bodies of the facilities often have to rely on financing models tapping federal government resources or resources from the social security funds and employment agencies.

Inpatient treatment system (T1.2.8)

Table 4 Number of places available in inpatient addiction support

	Number of places	Description
Hospital-based residential drug treatment	>7,500	Specialist hospital departments
Residential drug treatment (non-hospital based)	13,200* (>4,000)**	Inpatient rehabilitation services
Therapeutic communities	n.s.	
Prisons	n.s.	External services for counselling/treatment in prison
Other inpatient units	>220,000	Psychiatric clinics
Other inpatient units	>2,000	Withdrawal with motivational elements
Other inpatient units	>1,200	Adaption facilities
Other inpatient units	>10,700	Social therapy inpatient facilities
Other inpatient units	>1,200	Social therapy daycare facilities

* bezogen auf alle 320 stationären Rehabilitationseinrichtungen, die also auch Alkoholkonsumenten behandeln.

** bezogen auf Drogenabhängige.

Pfeiffer-Gerschel et al. 2014.

It must be considered 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).

Further information (T1.2.9)

Based on the data of the DSHS, Hildebrand and colleagues (2009) reported estimates for percentages of relevant persons reached by outpatient and inpatient addiction treatment 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 cannabis users.

Further information on the availability of outpatient treatment services (T1.2.10)

No information.

1.3. Key data (T1.3)

1.3.1. Summary tables on treatment (T1.3.1)

Outpatient treatment

In 2014 data was collected from a total of 342,453 therapies (not including one-off contacts) carried out in 837 outpatient facilities within the framework of the DSHS. For the following explanations, 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 50% of all recorded cases in 2014 by themselves). For 2014, the Statistical Report on Substance Abuse Treatment in Germany contains data on the main diagnoses from a total of 70,707 treatments from 837 facilities that were started or completed in outpatient psychosocial addiction support centres due to problems with illicit drugs. If one looks just at the data from the DSHS pertaining to illicit substances, 35.3% of cases today (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 (2014: 40.2%; 2013: 38.7%; 2012: 36.5%) concerned clients primarily with cannabis problems (Braun et al. 2015a).

Amongst persons who received addiction specific treatment for the first time, cannabis was by some distance the most used substance, with its share once more increasing slightly (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 (19.1%; 2013: 18.7%; 2012: 16.6%) followed by first-time clients with opioid related disorders (11.9%; 2013: 12.7%; 2012: 15.0%). The proportion of first-time clients with cocaine related disorders (5.1%; 2013: 5.5%; 2012: 6.0%), as well as all other substance groups, have remained practically unchanged in size since last year (Table 5) (Braun et al. 2015b).

Table 5 Main diagnosis in outpatient therapy (DSHS outpatient data, 2014)

Main diagnosis harmful use/addiction of ... (ICD10: F1x.1/F1x.2x)	All persons treated ¹⁾ (%)			Persons treated for the first time (%)		
	Males ²⁾	Females ²⁾	Total ²⁾	Males ²⁾	Females ²⁾	Total ²⁾
Opioids	34.3%	38.8%	35.3%	11.6%	13.3%	11.9%
Cannabinoids	42.9%	30.2%	40.2%	64.2%	47.9%	60.8%
Sedatives/Hypnotics	1.1%	4.9%	1.9%	0.7%	4.7%	1.5%
Cocaine	6.1%	3.5%	5.6%	5.5%	3.5%	5.1%
Stimulants	13.8%	20.7%	15.3%	16.5%	29.1%	19.1%
Hallucinogens	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%
Volatile substances	0.0%	0.2%	0.1%	0.0%	0.3%	0.1%
Multiple/other substances	1.6%	1.4%	1.6%	1.3%	1.1%	1.3%
Total (Number)	55,325	14,999	70,324	17,662	4,555	22,221

Braun et al. 2015a; 2015b.

Additional addiction diagnoses in addition to the main diagnosis are relatively common. Out of the clients with primary opioid-related problems in 2014, approximately one in four clients (26.1%) also displayed an alcohol-related disorder (dependence or harmful use) or a disorder in connection with the use of cocaine (22.4%) (Braun et al. 2015b).

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 discriminate by type of funding and not by 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 between acute hospital treatment (Statistical Report on Hospital Diagnoses) and rehabilitation therapy (Statistical Report of the German Statutory Health Insurance Scheme). Furthermore, there is data from the DSHS available for a section of specialist clinics and facilities in accordance with the German Core Data Set on Documentation in the area of Addict Support (KDS; see also section 6.2.1).

Out of the total of 49,297 inpatient treatments of substance-related disorders in 206 facilities, documented in the DSHS in 2014, 10,972 were related to illicit substances (including sedatives/hypnotics and volatile solvents) (Braun et al. 2015c). 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 continued to rise (30.7%; 2013: 28.3%) whilst the proportion of treatments based on opioids continued to fall (27.0%; 2013: 27.1%). Treatments based on cannabis thus remain the largest single group in the inpatient setting (without main diagnosis alcohol). The proportion of treatments on the basis of the use of opioids has been declining since 2007 (48.6%); the proportion due to cannabis has been constantly rising since 2007. The next largest group is treatments on the basis of stimulant use (20.5%; 2013: 18.3%).

Table 6 Inpatients broken down by addiction diagnosis

Main diagnosis	Hospital	DRV	DSHS			
	2013	2013	2013	2014		
	Total	Total	Total ¹⁾	Total ²⁾	Males ²⁾	Females ²⁾
Opioids	27.6 %	22.8 %	27.1%	24.9 %	24.3 %	27.0 %
Cannabinoids	11.5 %	20.5 %	28.3%	30.7 %	33.1 %	21.7 %
Sedatives/Hypnotics	9.6 %	2.4 %	3.6%	3.5 %	2.0 %	8.7 %
Cocaine	1.7 %	4.3 %	7.2%	7.4 %	8.3 %	4.2 %
Stimulants	5.7 %	10.8 %	18.3%	20.5 %	19.0 %	25.9 %
Hallucinogens	0.5 %	0.0 %	0.1%	0.1 %	0.1 %	0.0 %
Volatile substances	0.1 %	0.1 %	0.0%	0.0 %	0.1 %	0.0 %
Multiple/other substances	43.2 %	39.1 %	15.3%	13.0 %	13.1 %	12.4 %
Total (Number)	101,376	13,151	10,352	10,972	8,617	2,355

1) The data corresponds with the TDI-table: 14.1.1 from 2012.

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

Braun et al. 2015c; DRV 2014; Statistisches Bundesamt 2014.

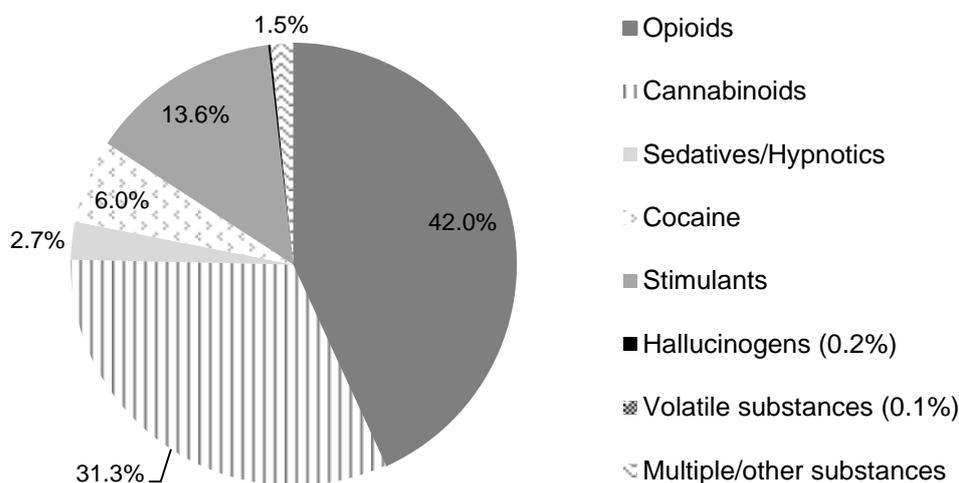
Table 7 Summary - patients in treatment

	Number of patients
All patients in treatment	According to the DSHS 2014 with main diagnosis drugs: 70,707 outpatients 10,972 inpatients
All patients in OST	77,500
Total	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 practically impossible to derive overall estimates from the routine data, in particular when one takes into account family doctors.

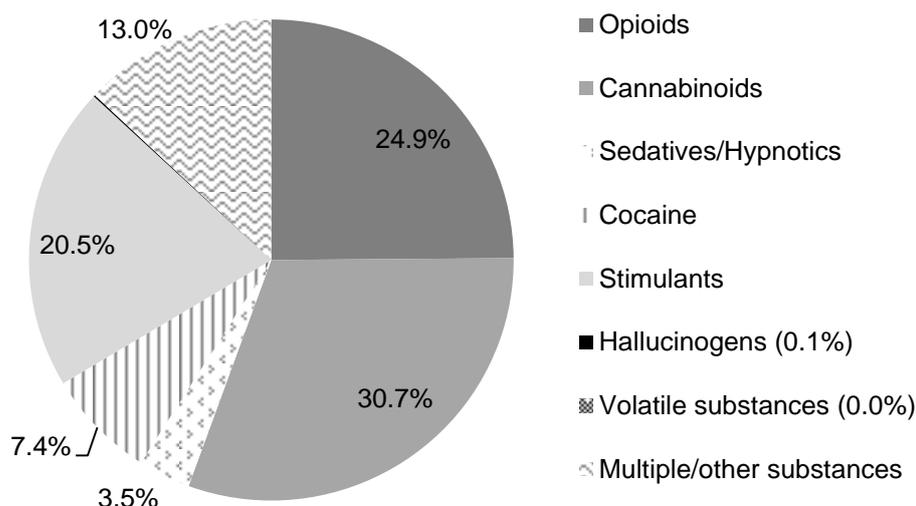
Braun et al. 2015a; 2015c; BOPST 2015.

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



Braun et al. 2015a.

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



Braun et al. 2015c.

Figure 2 Proportion of all patients treated by main diagnosis (inpatient)

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

DRV - Rehabilitation 2013

The German Statutory Pension Insurance Scheme provides comprehensive statistics of their medical rehabilitation benefits, 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 2014).

In total 13,151 people (10,643 males, 2,508 females) have utilised the services of the statutory pension insurance, under the diagnosis "Mental and behavioural disorders due to medicinal drugs / illicit drugs". Of those, 1,323 were foreigners. On average 95 days of care were used. The average age at the end of the treatment was 32.8 years old and is the lowest age in comparison to other rehabilitation services (for the purposes of comparison, alcohol rehabilitation: 45.2 years old) (DRV 2014).

1.3.4. Characteristics of treated patients (T1.3.4)

Outpatient treatment

In 2014, 78.7% of the 70,707 outpatient supported clients with a drug problem recorded by the DSHS were male (2013: 78.2%). 49.3% (2013: 50.2%) of all treated patients were between 15 and 29 years of age. 83.9% (2013: 83.3%) were German nationals, 3.2% (2013: 3.2%) were from other EU countries and 8.5% (2013: 8.4%) were from non-EU member states such as Turkey or the former Soviet Union (unknown citizenship: 4.4%) (Braun et al. 2015a).

Table 8 Socio-demographic data by main drug (DSHS outpatient data, 2014)

Characteristics	Main diagnosis			
	Opioids	Cannabis	Cocaine	Stimulants
Age when starting treatment (m) ¹⁾	37.5	24.6	33.7	28.1
Age of first drug use (m) ²⁾	21.4	15.3	21.6	18.6
Gender (ratio males) ³⁾	76.5%	84.0%	86.5%	71.0%
Living alone ⁴⁾	53.0%	62.6%	46.6%	54.2%
Employment status ⁵⁾				
Unemployed	62.2%	33.0%	41.0%	49.5%
in school/education	1.9%	33.9%	4.7%	10.5%
Homeless ⁶⁾	3.2%	0.7%	1.9%	1.5%

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

Braun et al. 2015a.

Inpatient treatment

Among the 10,972 clients recorded by the DSHS who were treated for illegal substances, 8,617 were male, which corresponds to a share of 78.5% (2013: 77.7%). In nearly three quarters of the cases (71.5%) alcohol-related disorders were the primary reason for inpatient treatment (30,791 treatments; 2013: 29,724) (Braun et al. 2015c). In comparison with the outpatients recorded within the framework of the DSHS, the opioid users treated in the inpatient setting tended to be somewhat younger and cannabis users somewhat older; there are only minor differences between users of cocaine and stimulants.

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 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 of support/treatment, during and at the end of the support/treatment.

Table 9 Socio-demographic data by main drug (DSHS inpatient data, 2014)

Characteristics	Main diagnosis			
	Opioids	Cannabis	Cocaine	Stimulants
Age when starting treatment (m) ¹⁾	35.4	27.4	33.2	28.4
Age of first drug use (m) ²⁾	20.9	15.1	20.3	18.1
Gender (ratio males) ³⁾	76.7%	84.8%	87.9%	72.8%
Living alone ⁴⁾	55.1%	62.9%	52.1%	60.4%
Employment status ⁵⁾				
Unemployed	69.1%	62.1%	62.9%	68.5%
in school/education	0.8%	6.6%	1.2%	3.3%
Homeless ⁶⁾	1.6%	1.5%	0.9%	1.5%

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

Braun et al. 2015c.

1.3.5. Further sources of information on treatments (T1.3.5)

- Statistical Report on Substance Abuse Treatment in Germany (DSHS) 2014
- Statistical Report on Rehabilitation from the German Pension Insurance Scheme 2013
- Statistical Report on Hospital Diagnoses

1.4. Treatment services and facilities (T1.4)

The following sections will set out which actors, occupational groups and facilities in the addiction support system (should) play a role and which responsibilities they assume within the treatment system. In that context, there is often an overlap in practice between the responsibilities and services provided. The main source for the presentation is the inventory of addiction support in the regional treatment system in the DHS (2010a). In that inventory, the structure of the treatment system is divided into 6 support segments:

(1) Acute treatment

- Practice-based doctors
- Psychotherapists and specialist doctors for psychiatry and psychotherapy
- Psychiatric outpatient institutes
- General hospitals

- Psychiatric clinics

(2) Support and counselling in the interconnected system of addiction support.

- Low threshold facilities
- Addiction counselling and treatment facilities
- Temporary facilities

(3) Support and counselling in the health care system

- Public health authorities
- Socio-psychiatric services
- Social services in hospitals

(4) Support and counselling in the social security system

- Work-based addiction support
- Counselling by rehabilitation providers

(5) Promotion of participation

- Social rehabilitation
- Work, employment and qualification services
- Self-help

(6) Treatment

- Qualified withdrawal facilities
- Outpatient rehabilitation
- Inpatient facilities for medical rehabilitation
- Adaption facilities

In this context, the close interconnection between outpatient and inpatient treatment is clear. Nevertheless, only selected types of facility will be looked at in greater detail.

1.4.1. Outpatient treatment services (T1.4.1)

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

Psychosocial counselling facilities as well as addiction counselling and treatment facilities have a central responsibility for counselling and supporting people with dependency disorders and serve as the first point of contact. The specialists employed there support affected persons in building their motivation and accepting help, they create support plans and refer patients to further services (social, occupational, medical rehabilitation). Addiction support and

treatment facilities also often undertake the psychosocial support for substitution patients, they support self-help projects and are specialist facilities for prevention.

- Nationwide, approximately 1,300 positions with circa 500,000 clients
- Legal basis: German Public Health Service Act (Gesetz über den öffentlichen Gesundheitsdienst, ÖGDG)
- Planning and financing by municipalities and Laender

(Source: DHS 2010a; Leune 2014).

Low-threshold facilities

Low-threshold facilities are a service which leads into the support system. Here there is a contact service as the basis for further help, including through consumption rooms, street work or drop-in centres with sociopedagogical support.

- Legal basis: voluntary state services and projects
- Planning by: municipalities, in some cases also the Laender

For further information see section 1.2.1

Practice-based doctors

Practice-based doctors are usually the first point of contact for addicts or at-risk persons, in particular if physical and/or psychological disorders are present. Doctors have a special role and responsibility for the early diagnosis and early intervention. It is their responsibility, in the scope of the diagnosis and treatment of a disease, to address a detected or looming dependence problem and its consequences and to inform the patients through targeted advice as to how to take advantage of suitable support such as an addiction counselling facility, and if necessary to refer the patient accordingly.

- Nationwide, 123,200 practice-based doctors with approximately 20%⁸ patients suffering from addiction
- Legal basis: German Code of Social Law (SGB) Volume 5
- Planning by: Associations of SHI-accredited doctors

(Source: DHS 2010a; Leune 2014).

Information on substitution can be found in section 1.4.7.

External services for counselling/treatment in prison

Prisons cooperate with outpatient addiction support facilities at local level. Social workers advise and help by, amongst other things, helping people into external interventions and arrange the substitution and support measures. Regular consultations or services are offered as required. The advisers are not employees of the prison and are thus bound by

⁸ Estimate of the DHS.

confidentiality obligations. The abstinence oriented department, as is offered, for example, in Duesseldorf prison, is an open department run as a living community in which drug dependent inmates are admitted on a voluntary basis and are prepared for external inpatient treatment. By way of preparation for treatment, an intensive case management is performed (as defines a social work flow-chart) (JVA Düsseldorf 2015).

Psychiatric outpatient institutes

Outpatient institutes are generally in psychiatric hospitals and in part also in psychiatric departments of general hospitals. They are characterised by the multi-professional composition of their team of staff.

- Nationwide, there are approximately 300 facilities with 97,500 patients
- Legal basis: SGB V
- Planning by: Health insurance providers

(Source: DHS 2010a; Leune 2014).

Outpatient medical rehabilitation

Services are available in a variety of facilities 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 details for the conditions for the provision of outpatient rehabilitation treatments arise from the medical and psychosocial treatment requirements.

- Nationwide, approximately 400 recognised facilities and circa 11,000 measures annually
- Legal basis: SGB Vol. 6, and SGB Vol. 5
- Planning and quality control through: pension insurance funds

(Source: DHS 2010a; Leune 2014).

Outpatient assisted living

Outpatient assisted living enables addicts, 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 realised 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. Work and employment must be offered at an early stage in various use, abstinence or substitution phases through suitable addiction support projects.

- Legal basis: SGB Vol. 2, SGB Vol. 3, SGB Vol. 6, SGB Vol. 12

- Planning by: Employment agencies, German Statutory Pension Insurance Scheme, social welfare providers

(Source: DHS 2010a).

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

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.

- Nationwide there are 190 facilities with over 2,000 places
- Legal basis: SGB Vol. 5
- Planning by: Laender

(Source: DHS 2010a; Leune 2014).

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 treatments. Social counselling and preparation for the subsequent support services (e.g. "after-care") are always part of withdrawal treatment. In addition to somatic, psychiatric and psychotherapeutic services, the spectrum of medical rehabilitation also includes work related services. Unspecific, work-related services as well as specific occupational therapy services are offered. Medical rehabilitation is limited in time, the treatment time of the individual forms of treatment is set individually.

- Nationwide there are 320 facilities with 13,200 places and annually approximately 60,000 measures
- Legal basis: SGB Vol. 6, and SGB Vol. 5
- Planning and quality control through: pension insurance funds and statutory health insurance providers

(Source: DHS 2010a; Leune 2014).

Therapeutic communities (TC)

There are only a few TCs left in Germany as per 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 therapeutic communities in 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 prison

See abstinence oriented department (AoA) in section 1.4.1.

Psychiatric clinics

Psychiatric-psychotherapeutic specialist clinics play an important role in the care system for people suffering from addiction. The services offered range from "qualified" withdrawal treatment to treatment for addicts with psychiatric additional disorders.

- Nationwide over 220,000 places in over 300 facilities for "addiction patients"
- Legal basis: SGB Vol. 5
- Planning by: Laender

(Source: DHS 2010a; Leune 2014).

Withdrawal with motivational elements

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

Adaption facilities

Inpatient medical rehabilitation can, for a particular group of rehabilitation patients, include a so-called adaption phase or such a phase can follow. These are also performed in the inpatient setting.

- Nationwide, there are approximately 115 facilities with more than 1,200 places.
- Legal basis: SGB Vol. 6, and SGB Vol. 5
- Planning and quality control through: pension insurance funds

(Source: DHS 2010a; Leune 2014).

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

These include, for example, day-care centres under Sec. 53 et seqq. / Sec. 67 et seqq. German Code of Social Law Volume 12 or also whole-day outpatient assisted living (DHS 2015).

Inpatient social therapy facility

This type of facility is residential or transitional accommodation according to the criteria of the German Code of Social Law Vol. 12 Sec. 53 et seqq. or Sec. 67 et seqq. as well as Sec. 35a German Child and Youth Services Act (DHS 2015).

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

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).

1.4.5. Treatment outcomes (T1.4.5)

The 2013 rehabilitation statistics report of the German Statutory Pension Insurance Scheme (DRV) show the following data on treatment success out of the total of 13,151 services for persons with the diagnosis "mental and behavioural disorders due to medicines/drugs": the treatment outcome is described as unchanged for 3,805 people (29%), for 8,679 it was improved (66%), for 69 clients the outcome worsened (0.5%) and for 598 no conclusion was possible (4.5%) (DRV 2014).

The Association of Addiction Professionals (Fachverband Sucht, FVS) performed a catamnesis for patients discharged from specialist drug rehabilitation clinics in 2012 and thus investigated the effectiveness of inpatient abstinence oriented drug rehabilitation (Fischer et al. 2015). 70.3% of the 1,275 persons looked at lived completely in abstinence ("abstinent after relapse 30 days", German Society for Addiction Medicine, Estimation Form 1 (DGSS 1)). A conservative estimate is that 21.2% of patients experience abstinence success one year after inpatient drug rehabilitation (Estimation Form 4 (DGSS 4)). According to the Association, the true value for treatment success will be found between those two extremes.

1.4.6. Social reintegration services (T1.4.6)

Comparisons short report no. 2/2014: clients/patients from different living situations in outpatient and inpatient addiction treatment (Künzel et al. 2014).

1.4.7. Substitution treatment (OST)

Providers of opioid substitution treatment (OST) (T1.4.7)

The number of doctors qualified to administer addiction therapy reported by the medical associations and registered in the substitution register is considerably higher than the number of doctors actually performing substitution treatments. A total of 2,650 doctors reported patients to the substitution register in 2014. The number of doctors who actually perform substitution treatments has been stagnating at a practically unchanged level since 2004. In 2014, 506 doctors - namely approximately 19% of substituting doctors - availed themselves of the colleague consultation rule: according to that 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 2014).

Number of OST patients (T1.4.8)

The available snapshot of the substitution register enables one to make inferences about the number of persons reached on a reference date - 1 July 2014 - but not over the course of a year. On this reference date, the number of OST patients was 77,500.

In 2014, 92,200 registrations, deregistrations or changed registrations of patient codes were recorded in the substitution register. This high number is due, amongst other things, to the fact that the same patients were registered and deregistered multiple times – either by the same doctor or by different doctors. The reasons for this could lie with the patient themselves (e. g. change of attending doctor, longer stays in a clinic or correctional facilities) or with the doctors (e.g. change in personnel in outpatient substitution clinics). In 2014, approximately 120 double treatments were confirmed by the substitution register which were then ended by the doctors concerned upon notification by the register (BOPST 2015).

The average number of registered substitution patients per doctor varies considerably between the individual Laender with the nationwide average being 29. 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, than in the large area states. Secondly, it is significantly higher in the western Laender than in the eastern Laender. Only 2.6% (n=2,040; 2013: 2.7%) of patients reported to the register (reference date: 1 Jul. 2014) and 5.1% (n=135; 2013: 4.8%; n=130) of OST doctors came from the eastern Laender (excluding Berlin). The number of registered patients per OST doctor is accordingly also subject to considerable variations between the Laender. A substitution doctor in Berlin treated on average 38 patients (followed by Hamburg with an average of 37.9 and Saarland with 36.1), whilst in Brandenburg it is only 5.6 (Mecklenburg-Western Pomerania: 12.6; Thuringia: 13).

Substances used in substitution treatment are presented in Table 10.

Characteristics of OST patients (T1.4.9)

No information.

Further information on the organisation of, access to and availability of OST (T1.4.10)

Since 2001, substitution based therapy has been regulated in detail by the narcotics law and is today a medically recognised treatment form. Substitution has been the standard treatment for opioid dependent patients in Germany for many years. This treatment method reaches a large number of drug addicts and has been proven within the framework of numerous studies to produce beneficial effects on the mental and physical well-being of the patients (Michels et al. 2007). The results of a study conducted by Wittchen and colleagues (Wittchen et al. 2008) underline the effectiveness of various types of opioid substitution treatments with methadone and buprenorphine. Concomitant use (especially of cannabis and benzodiazepines as well as of other opioids and cocaine) is in many cases the decisive factor for dropping out of therapy or other complications occurring during therapy. Patients in long-term substitution therapy

appear furthermore to be a group of patients subject to an extremely high level of distress caused by somatic and mental disorders.

The state of the art in OST had already been established in 2002 by the guidelines passed by the German Medical Association (Bundesärztekammer, BÄK). In 2010, a revised version of the guidelines was presented by the BÄK (cf. also Sections 1.2.1, 1.2.2 and chapter 11 of the REITOX Report 2010; Pfeiffer-Gerschel et al. 2010). In 2003, OST was acknowledged by the statutory health insurance providers without any qualification as an SHI- accredited care service to be borne by the SHI. 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. Doctors carrying out substitution therapy must hold a qualification in addiction medicine. If they do not have this additional qualification they may treat up to a maximum of three patients under the colleague consultation rule. Today, a few inpatient facilities admit patients for OST.

In the current discussion on OST, which is firmly established in the care system, the question as to what goals are to be pursued by OST continues to play an important role. In this context, what constitutes success can vary depending on the observer's perspective: the reduction of concomitant use of other psychotropic substances can be considered as much a success as the cessation of opioid dependence or the successful treatment of other (somatic and mental) disorders.

Psychosocial care has been established as a necessary part of OST by the Regulations on the Prescription of Narcotic Drugs (BtMVV) and the guidelines passed by the Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA) and the National Medical Association (BÄK). As a result of different interpretations of psychosocial care in the Länder and municipalities, this type of care is subject to wide variations nationwide in terms of organisation, funding and treatments offered.

The guidelines of the German Medical Association (BÄK 2010) specify the type and scope of psychosocial care, noting that the provision and integration of measures suitable for eliminating psychosocial problems is essential for the treatment of opioid addiction. The guidelines furthermore underline the necessity of coordinating psychosocial care and medical care (see also chapters 1.2.2. and 5.5.2 of the REITOX Report 2010; Pfeiffer-Gerschel et al. 2010).

It was confirmed by a judgement of the Hamburg Higher Administrative Court in April 2008 that there is a legal right to the service of necessary psychosocial counselling/care for substitution patients (provided the necessary preconditions according to SGB Vol. XII are met) to be provided by the local social welfare providers.

An effective integration of general health care and specialised drug support into an effective system has not yet been satisfactorily achieved. At a regional level however, cooperation and coordination of the treatments offered are much better. Any attempt to give an overview of the care situation in Germany is associated with major problems as a result of the differing objectives and the consequent regional differences.

A differentiation between drug-free and pharmacologically assisted treatment – especially substitution – is of limited use in describing the therapy system in Germany. A clear classification of psychosocial counselling facilities, which play a central role in the care for drug addicts, is problematic, for example in the case of psychosocial care for clients in substitution programmes (with the exception of a few cases in which the counselling facilities themselves dispense the substitution drugs according to existing guidelines). Generally, medical substitution treatment takes place outside of the counselling facilities. Psychosocial care and therapy, by contrast, take place in the counselling facilities and are thus, per se, neither obligated to a drug-free nor a medication-assisted approach.

As already hinted in section 1.4.7, the debate surrounding the future provision of substitution is being conducted in particular in rural regions (c.f. REITOX Report 2014, chapter 5.5.2). Increasing numbers of older doctors are retiring with hardly any younger doctors taking their place. Furthermore, many opiate dependent patients in small towns or rural areas are receiving inadequate treatment. The result is an ever growing gap in the provision of care. Regional practice projects such as in Ortenaukreis (Baden-Württemberg) are trying to counteract this trend (Falch-Knappe & Schoen-Blum 2014). In addition, the German Society for Addiction Medicine, the German Aids Service Organisation and Akzept e.V. have launched an initiative to ensure care for opiate dependent persons. Its declared objective is to acquire more doctors for substitution based treatment of chronically ill opiate dependent people, in need of treatment. More information on the initiative is available at www.bitte-substituieren-sie.de (Initiativkreis Substitutionstherapie 2014).

1.5. Quality assurance (T1.5)

Quality assurance

Various professional societies and experts have worked together in recent years to develop guidelines for the treatment of drug dependence and addiction problems (see also chapter 11 of the REITOX Report 2010). These publications are a summary of the current state of knowledge and provide practical guidance – with information on the quality of the empirical basis for the individual comments - for carrying out treatments. In 2006, the Working Group of the Scientific Medical Professional Societies (Arbeitsgemeinschaft der medizinisch-wissenschaftlichen Fachgesellschaften, AWMF) published the AWMF-guidelines on diagnostics and therapy of substance-related disorders under the title “Evidence-based addiction medicine – treatment guide for substance-related disorders” (Evidenzbasierte Suchtmedizin – Behandlungsleitlinie substanzbezogene Störungen). The aim of the evidence-based guidelines is to make treatment of drug addicts more transparent and make the

scientific discussions about the most efficient therapy approaches more objective (Schmidt et al. 2006).

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 German Society for Addiction Medicine (DGS) were passed (Backmund et al. 2014).

Moreover, 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 (DGVS) was published in 2010 (Sarrazin et al. 2010; see also chapter 7.3 of the REITOX Report 2010).

Addiction therapy may only be provided by adequately skilled staff with supplementary training in the specific relevant field. In this context, the German Pension Insurance Fund has produced guidelines for the supplementary training of therapy staff working in individual and group therapy within the framework of medical rehabilitation of drug addicts, in which supplementary training courses can receive a "recommendation for acknowledgement". As part of the restructuring of the higher education system in Germany on the basis of European standards (introduction of Master and Bachelor programmes at universities and technical colleges) the requirements on therapeutic staff in addiction support are also being newly developed and defined. In the restructuring of the courses for social workers, psychologists and medical staff in the area of addiction support, post-graduate education plays a particularly important role.

Cooperation between different professional groups from social work/education, psychology, psychiatry and other medical fields forms an integral part of the addiction 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, namely the Laender and municipalities. The responsibility for detoxification and rehabilitation, however, lies with the respective funding agency (statutory health and pension insurance organisations) (c.f. also chapter 11.3 of the REITOX Report 2012). With outpatient treatments now being increasingly funded by the pension insurance scheme, the above mentioned standards have also gained in importance in this setting, although this relevance is today almost exclusively limited to the area of alcohol and drugs have so far not played any major role. In many Laender, cooperation between the different fields of work and different organisations is promoted by Laender-financed institutions.

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

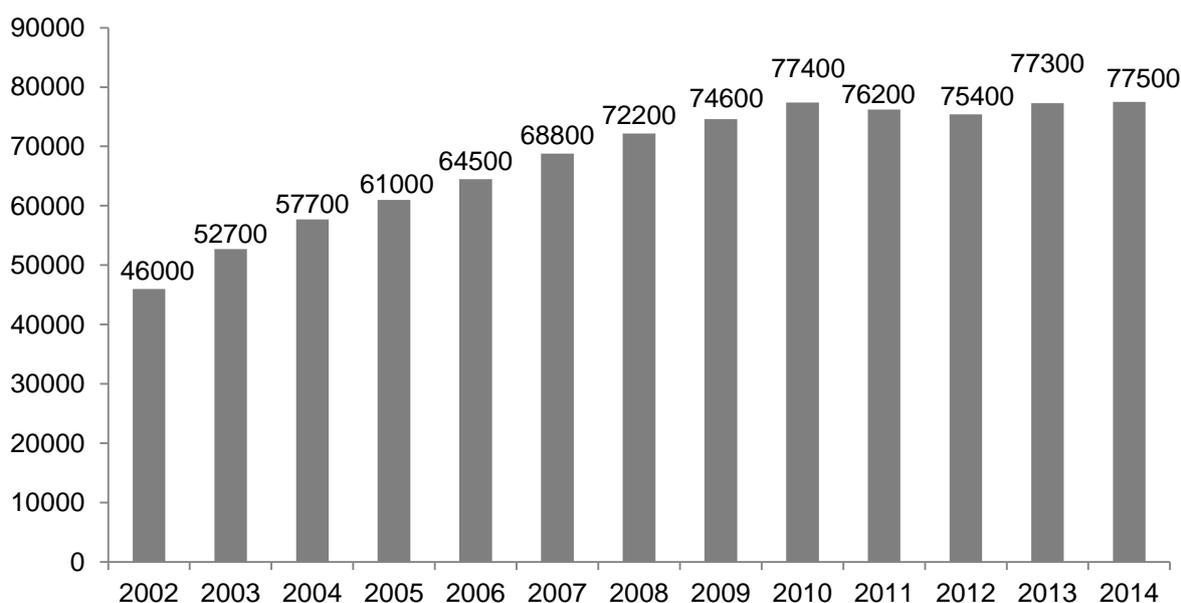
No new information.

2. Trends (T2)

2.1. Long-term trends in the number of OST patients (T2.1)

2.1.1. Substitution treatment

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 77,500 patients on 1 July 2014. There are still considerable regional differences regarding the supply of and demand for substitution treatments.



BOPST 2015.

Figure 3 Number of reported substitution patients in Germany from 2002 to 2014 (reference date 1 July)

The share of substances used in substitution treatment has shifted in the past few years away from methadone (2014: 46.1%) and towards levomethadone (2014: 30.3%) as well as buprenorphine, which in 2014 was used in approximately every fifth substitution (22.6%) (Table 10). The proportion of patients receiving substitution therapy with methadone or levomethadone has fallen since 2005 from 82.0% to the current level of 76.4%.

Table 10 Type and proportion of substitution drugs reported to the substitution register (2005-2014)

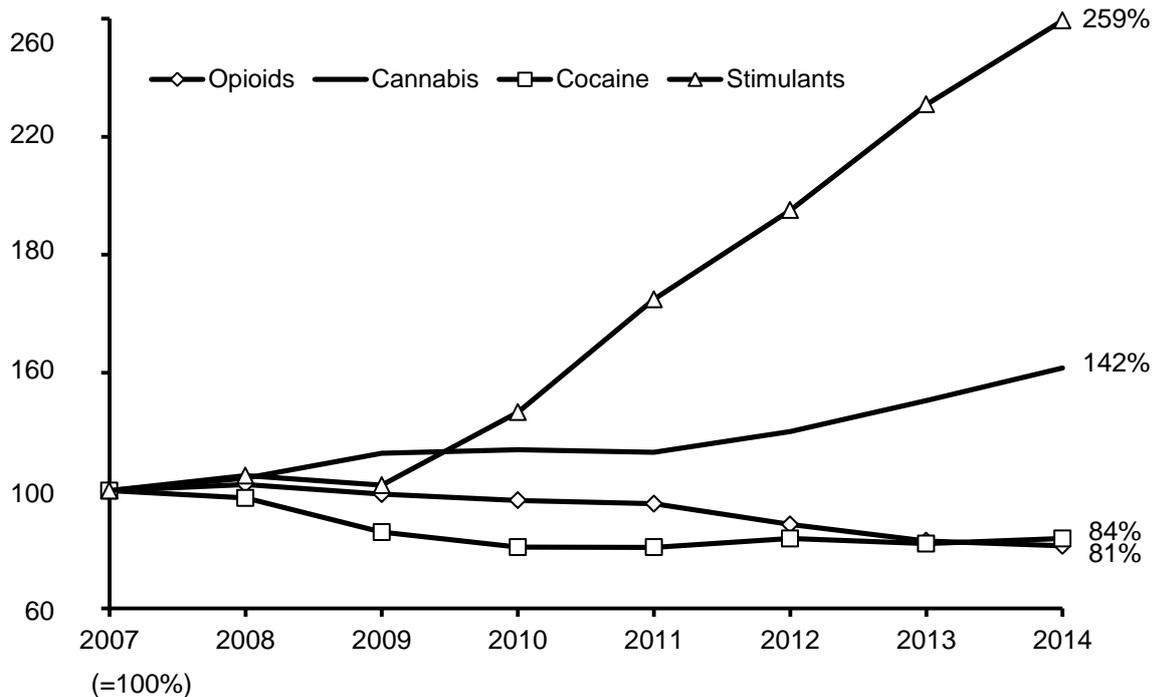
Substitution drug	2005	2010	2011	2012	2013	2014
Methadone	66.2%	57.7%	54.8%	51.6%	49.3%	46.1%
Levomethadone	15.8%	23.0%	25.4%	27.0%	28.6%	30.3%
Buprenorphine	17.2%	18.6%	19.2%	20.4%	21.3%	22.6%
Dihydrocodein	0.7%	0.3%	0.2%	0.2%	0.2%	0.2%
Codein	0.1%	0.1%	0.1%	0.1%	0.1%	0,1%
Diamorphine		0.3%	0.4%	0.7%	0.5%	0.7%

BOPST 2015.

2.1.2. Developments in the outpatient and inpatient setting

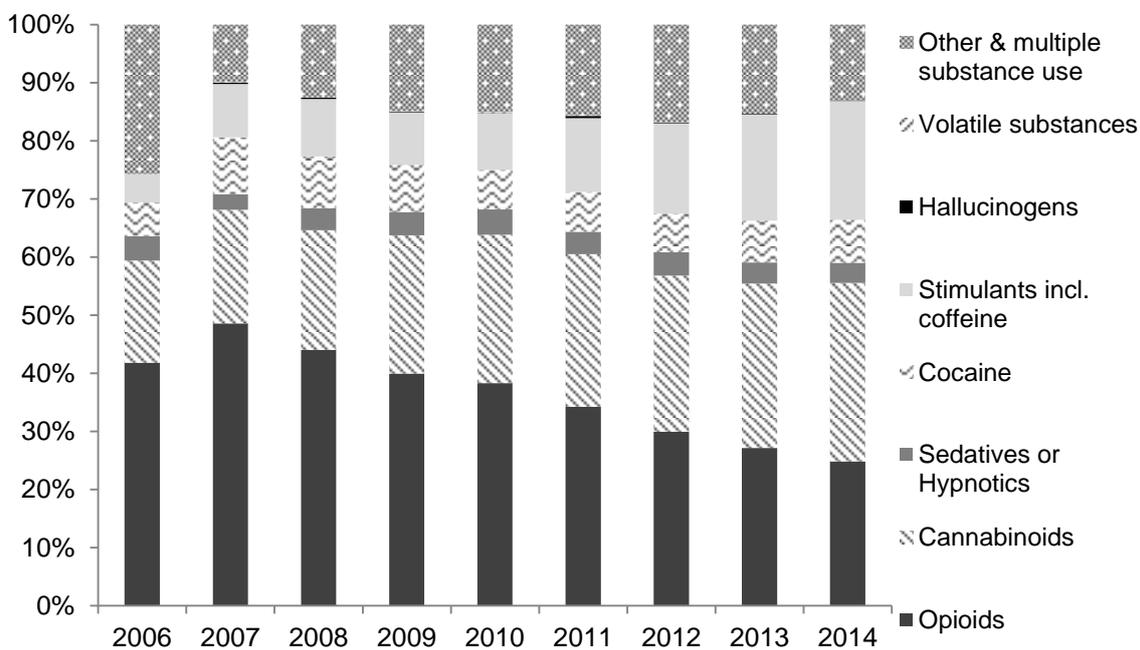
All in all, according to the DSHS data disorders caused by the use of heroin, cannabinoids and stimulants continue to play a predominant role among the illicit drugs in outpatient and inpatient facilities (Braun et al. 2015a; 2015c).

Furthermore, cannabis is in clear first place when it comes to treatment requests made by persons seeking outpatient therapy for the first time, whereas opioids are, in the same group, the reason for making contact with a treatment facility in fewer than one in eight users. Eight years ago, this proportion was still at approximately a third of the first-time patients. Among all admissions to outpatient therapy, the proportion of clients with disorders due to the use of opioids has been shrinking continuously for several years, whereas the proportion of clients with the main diagnosis cannabis has been increasing continuously. 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. 2015a). If one calculates the changes in admissions of clients to the outpatient setting, broken down by main diagnosis since the introduction of the new Core Data Set in 2007 (Index=100%), one finds a slight increase in the share of patients with main diagnosis cannabis since 2007, a slight decline in patients with opioid problems, in the last three reporting years, a slight increase in clients with cocaine problems as well as a more than doubling of the proportion of clients with the main diagnosis stimulants (Figure 4).



Braun et al. 2015a.

Figure 4 Changes in admissions to outpatient addiction therapy for various main diagnoses (DSHS outpatient data)



Braun et al. 2015c.

Figure 5 Changes in clients in inpatient addiction treatment for various main diagnoses (DSHS inpatient data)

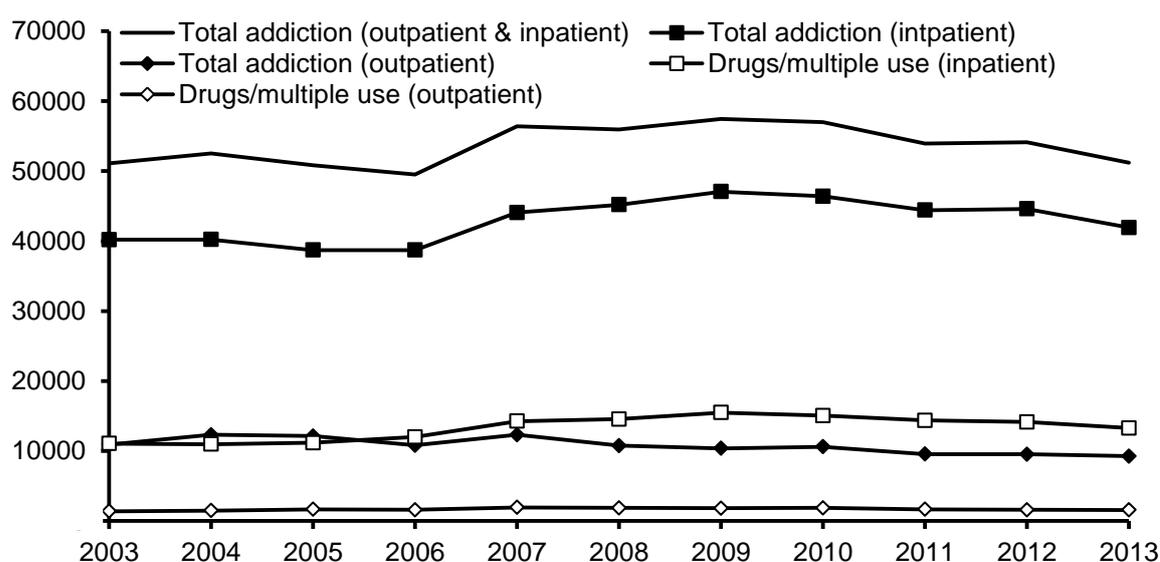
In the area of inpatient treatment, the proportion of patients with a main diagnosis based on dependence or harmful use of cannabis (30.7%; 2013: 28.3%) exceeds the proportion of

treatments based on opioids (24.9%; 2013: 27.1%) (Figure 5). In 2014, the third largest single group in inpatient treatment was those with a main diagnosis based on stimulants (20.5%; 2013: 18.3%) the share of which has been continually increasing since 2009 (Braun et al. 2015c).

The total number of rehabilitation services funded by the pension insurance scheme in the area of addiction rose by over 10% between 2003 (51,123) and 2009 (57,456) and since then has been continually decreasing (2010: 56,997; 2013: 51,211) (Figure 6). The largest part of these services (69.9%) is provided for alcohol related disorders. Disorders due to the use of illicit drugs and multiple use together comprise 29.0% of the treatments provided (medicinal drugs: 1.1%). This proportion has increased approximately five percent since 2003 (24.3%). In contrast, the proportion of treatments on the basis of alcohol related disorders has been falling since 2003 (74.8%) (DRV 2014).

The ratio of inpatient to outpatient treatments is (across all services) almost 5 : 1. Since 2013 this ratio has been shifting slightly, in favour of inpatient treatments (from 3.7 : 1 in 2003 to 4.5 : 1 in 2013). Looking only at the rehabilitation services for drugs and multiple use, one finds that the ratio between inpatient and outpatient treatment has, at 8.5 : 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 6).

So far, the available statistics do not show the treatments carried out in day care settings separately. An attempt to take a differentiated view of the statistical data could enable an in-depth analysis of developments in the reporting years to come.



DRV 2014.

Figure 6 Changes in outpatient and inpatient rehabilitation treatments

The total number of acute addiction or drug treatments in hospitals has increased slightly after slight fluctuations in the previous years between 2010 and 2012 (Statistisches Bundesamt 2015). A growth was observed in the number of treatments due to stimulants (+28.6%), cocaine (+20.1%), cannabinoids (+15.4%), hallucinogens (+11.4%) and opioids (+5.5%). Decreases were observed in the treatments of volatile substances (-12.9%). The number of treatments due to sedatives/hypnotics and other substances or multiple substance use remained almost unchanged (Table 11).

In the inpatient area (DSHS), opioid users represented only the second largest patient group after cannabis users in 2013, followed by users of stimulants (Figure 5). In the rehabilitation statistics of the pension insurance scheme, opioid users still represent the largest patient group amongst users of illicit drugs (apart from multiple substance use), closely followed by cannabis users (Table 6). According to those findings, inpatient treatment of cannabis cases therefore plays an increasingly important role. This development becomes most apparent in the data collected by DSHS, while acute treatments for cannabis use (Statistical Report on Hospital Diagnoses), by comparison, are still relatively rare (Table 6). In this respect, cases due to opioid use and multiple substance predominate.

Table 11 Inpatient treatment of drug problems in hospitals 2009-2013

Main diagnosis	Year					Changes
	2009	2010	2011	2012	2013	2012 vs. 2013
Alcohol	339,092	333,357	338,355	345,034	338,204	-2.0%
Opioids	31,496	32,538	28,956	26,512	27,962	5.5%
Cannabinoids	7,251	8,145	9,094	10,142	11,708	15.4%
Sedatives/Hypnotics	9,094	9,270	10,241	9,999	9,707	-2.9%
Cocaine	1,050	1,076	1,222	1,417	1,702	20.1%
Stimulants	1,848	2,805	3,878	4,519	5,810	28.6%
Hallucinogens	431	430	574	472	526	11.4%
Tobacco	258	310	269	225	238	5.8%
Volatile substances	194	171	198	155	135	-12.9%
Multiple/other substances	42,468	41,449	41,777	43,063	43,826	1.8%
Total addiction	433,182	429,551	434,564	441,538	439,818	-0.4%
Total drugs	93,832	95,884	95,940	96,279	101,376	5.3%

Statistisches Bundesamt 2011a; 2011b; 2013a; 2013b; 2015.

2.2. Additional trends in drug treatment (T2.2)

No information.

3. New developments (T3.1)

3.1. Counselling and treatment on the internet - e-health

Addiction counselling and treatment using internet based services are still at an early stage in Germany. Advocates of this type of treatment see advantages primarily in the reach of addiction support and thus an improvement in the access of people with addiction problems (c.f. Krausz et al. 2014; Blankers & Schippers 2014). Extensive information portals on particular narcotics and different target groups have become established on the internet and are being added to all the time. The addiction support directory of the German Centre for Addiction Issues (DHS) provides an overview of all outpatient and inpatient addiction support facilities in Germany from which affected persons can seek help⁹. Addiction associations, counselling centres and self-help groups extend their "online surgery hours" by offering counselling via email (e.g. the Caritas). The project, ELSA, was conducted as a pilot, providing counselling to parents whose children used addictive substances¹⁰. Currently, a target group specific online self-help portal for methamphetamine users ("Breaking Meth")¹¹ from the Centre for Interdisciplinary Addiction Research (ZIS) of the University of Hamburg is being developed and evaluated (Milin & Schäfer 2015; ZIS 2015). Various apps also help affected persons reduce their use of addictive substances such as drinking diaries.¹² Despite the range of information and advice services available, addiction treatment via the internet is not yet established, however it is encouraged and the subject of discussions (c.f. EMCDDA 2014).

3.2. Participation in working life

The topic of "participation and integration of addicts in employment" is the focus of support for dependent persons, not only due to the planned Federal Participation Act (Bundesteilhabegesetz). Participation in employment is a decisive influencing factor on the stabilisation and improvement of the mental and physical health of persons suffering from addiction. Different working groups and projects address this topic. Of particular note are, by way of example, the working group, "Focus on employment in medical rehabilitation of persons suffering from dependence" (Berufliche Orientierung in der medizinischen Rehabilitation, BORA), in which representatives of the pension insurance scheme, of addiction support facilities and of specialist addiction associations prepared recommendations for how to strengthen the ability to find work which came into effect on 1 March 2015 (c.f. Die Drogenbeauftragte der Bundesregierung 2015; Müller-Simon & Weissinger 2015). On a federal level, the sub-working group, "Participation in and remaining in working life" of the National Board on Drugs and Addiction with representatives of addiction support, employment services and funding agencies are consulting on recommendations for action for the participation and integration of addicts in working life (Die Drogenbeauftragte der

⁹ www.suchthilfeverzeichnis.de [last accessed: 5 Oct. 2015].

¹⁰ www.elternberatung-sucht.de [last accessed: 5 Oct. 2015].

¹¹ <https://breaking-meth.de> [last accessed: 5 Oct. 2015].

¹² www.trinktagebuch.org [last accessed: 5 Oct. 2015].

Bundesregierung 2014). The pension insurance schemes also address the topic with participation specific projects: the Central German Pension Insurance Scheme carries out the project, "Cross-interface work-related case support in addiction treatment aftercare as the key to integration into employment and relapse prophylaxis" which aims to increase abstinence rates through systematic case management and integration into employment. Positive results are still outstanding (c.f. Die Drogenbeauftragte der Bundesregierung 2015). The Baden-Württemberg Pension Insurance Scheme supports former drug addicts to enter employment in the primary job market through the project "Employment integration after inpatient addiction treatment" (BISS). Following a successful pilot phase, the project has now been included in the standard care programme (Die Drogenbeauftragte der Bundesregierung 2015). The Land of Berlin also implements measures for the qualification and employment of people with addiction problems, with the aim of stabilising the living conditions of the affected individuals and improving their chances of participation in working life. The measures were funded from 2011 to 2013 from resources of the European Social Fund (ESF).¹³

3.3. Treatment of methamphetamine users

The increased prevalence of methamphetamine poses major challenges for those working in addiction support. Evidence based medical treatment concepts do not as yet exist. In response to this situation, the German Agency for Quality in Medicine (ÄZQ) was tasked with the project "Creation of recommendations for action for the treatment of methamphetamine addicts". The aim is to research the current state of knowledge and have discussions on this basis within an expert committee before preparing recommendations for action regarding treatment. The intention is to produce an evaluated guideline by 2016 which will be made available nationwide to all treatment facilities. The project, "MethCare", from the association, Addiction Matters in Practice and Theory (SuPraT), aims to provide a comprehensive database, free of charge, which concentrates specifically on the literature available worldwide on the prevalence, secondary harm, treatment options and comorbidities in connection with methamphetamine (Die Drogenbeauftragte der Bundesregierung 2015).

4. Additional information (T4)

4.1. Additional sources of information (T4.1)

4.2. Further aspects (T4.2)

Due to the differentiation in the support system and the need for seamless transitions in the treatment and care of persons suffering from dependence, cooperation between the support systems is more necessary than ever. Addiction and its treatment is a cross-cutting task whereby the multitude of support systems are often working at cross purposes (c.f. Berthel et al. 2015).

¹³ http://opus.kobv.de/zlb/volltexte/2013/17842/pdf/brosch_re_sengs_arbeit_schafft_perspektiven_bf_v03.pdf [last accessed: 5 Oct. 2015].

Under the project leadership of the Koblenz University of Applied Sciences and the German Institute for Addiction and Prevention Research of the Catholic University of Applied Sciences of North Rhine-Westphalia, the project "Drug dependence in old age: Experience, living environment and care system oriented case management for older drug dependent persons in three regions (Alters-CM³)" is carried out. The aim of this project, funded by the Federal Ministry of Education and Research (BMBF), is, in addition to improving the state of knowledge regarding the living situation of older, drug dependent persons, to contribute to the sustained optimisation of the care structures and the care situation in order to achieve an increase of the quality of life of this target group. To this end, firstly the existing knowledge as to the health and psychosocial situation of older drug dependent persons will be expanded by examining data on various dimensions of the living situation (including psychosocial situation, physical health, victim and violence experience) and of need for care (e.g. help, support and care requirements) of the clients by means of a quantitative study (Module 1). In addition, the networking structures involved in the care of older drug addicts will be analysed. This network analysis is intended to reveal findings on the type, frequency and intensity of networking efforts (Module 2). The findings of this analysis will serve as preparation for the development of a target group specific case management model, tailored to the individual case, for older drug dependent persons (Module 3)" (Katholische Hochschule NRW 2015).¹⁴

5. Notes and queries (T5)

5.1. Misuse of substitution drugs (T5.1)

There is no blanket monitoring in place. The issuing of such drugs is only more closely monitored where problems arise. The topic "Substitution and Parenthood" was investigated by the German Centre for Addiction Issues (DHS). A statement and recommendations for action were published (DHS 2014).

The Hamburg Centre for Interdisciplinary Addiction Research conducted a project from 2007 to 2009 on the evaluation of abuse of substitution drugs (Reimer et al. 2009). In ten German cities, 404 patients were interviewed in and substitution clinics and 420 drug addicts in and around the scene about their patterns of drug use, their substitution status and the state of their health. The focus of project was in the open drug scene. As such, conclusions cannot be drawn from the data regarding the basic population of all substituting persons in Germany. The authors come to the conclusion that substitution treatment is a key protective factor in terms of the use of substitution drugs not in accordance with the intended purpose, life-threatening drug emergencies as well as mixed or concomitant use of psychotropic substances. However, one in six users of non-prescribed substitution drugs stated that the motive for this use was that they could not find a place on a substitution treatment programme.

¹⁴ <http://www.katho-nrw.de/katho-nrw/forschung-entwicklung/institute-der-katho-nrw/deutsches-institut-fuer-sucht-und-praeventionsforschung-disup/forschungsprojekte/alters-cm3-drogenabhaengigkeit-im-alter-erfahrungs-lebenswelt-und-versorgungssystemorientiertes-case-management-fuer-aeltere-drogenabhaengige-menschen-in-drei-regionen/> [last accessed: 27 Oct. 2015].

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

Internet based drug treatment is not offered in Germany but is currently being considered (c.f. section 3 "New developments" as well as Krausz et al. 2014). On the other hand, there is a number of information portals (e.g. www.averca.de or www.drugcom.de) as well as project related counselling programmes for parents of children and adolescents at risk of addiction as well as, for example, ELSA (www.elternberatung-sucht.de) or online consultation of the German Federation for Educational Counselling (BKE) for adolescents and parents (www.bke.de). The Caritas has an own addiction counselling service on the internet for affected persons (www.caritas.de).

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

No information.

6. Sources and methodology (T6)

6.1. Sources (T6.1)

Information on the characteristics and patterns of use of clients in treatment is available from various sources. However, comparability of the data is limited – in particular in respect of inpatient treatment – due to the different ways it is collected. Sources used are:

- Statistical Report on Substance Abuse Treatment in Germany (DSHS) (Base: German Core Data Set)
- Statistical Report on Hospital Diagnoses
- Statistical Report of the German Pension Insurance Scheme
- Regional monitoring systems
- Substitution register
- Addiction Yearbook 2015 from the German Centre for Addiction Issues (DHS 2015)

6.2. Methodology (T6.2)

6.2.1. Outpatient Treatment

Based on the German Core Data Set for Documentation of Addiction Treatment (Deutscher Kerndatensatz, KDS), the Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS) provides extensive data on outpatient clients from the large majority (2013: 822) of outpatient facilities funded by the Laender and municipalities (Braun et al. 2014). Since January 2007, the Core Data Set is used in most addiction support facilities in Germany (DHS 2010b).

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 high¹⁵ (>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 EMCDDA¹⁶ is integrated in the Core Data Set. However, there is still a certain blurriness between the TDI and the Core Data Set 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.

6.2.2. Inpatient Treatment

In 2014, 206 facilities participated in the DSHS (2013: 200) (Braun et al. 2015c).

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

The Statistical Report on Hospital Diagnosis (KDS), produced by the German Federal Statistical Office (Statistisches Bundesamt), 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 addiction and thus offers little detailed information in this area. It does however allow a differentiation of the number of cases according to 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 Core Data Set.

The statistics from the German Statutory Pension Insurance (Deutsche Rentenversicherung, DRV) document all cases for which the costs were borne by the funding agency (DRV 2014). However, the proportion of inpatient therapies which were acute treatments or which were financed by other sources, is missing.

The distribution of main diagnoses in the two statistical reports is identical to a large extent, if one takes into account the substantially higher portion of undifferentiated diagnoses in respect

¹⁵ By default, up to 2009, a facility-related missing rate (proportion of missing data in the total data for the respective table) of 33% or less was required for an inclusion in the overall evaluation for all tables with single choice questions. Facilities with a missing rate of more than 33% in such a table were not taken into account in the summary of the data in order to prevent overall data quality being disproportionately impacted by a few facilities with a high missing rate. Although this would inevitably lead to a reduction of the facility sample for the respective table, this could be accepted in the interpretation of the results in favour of a higher validity of the included data (Pfeiffer-Gerschel, T. et al. 2010a).

¹⁶ The TDI is one of five epidemiological key indicators, which are documented nationally and aggregated on an EU level. Standardised core data is collected in respect of problem drug use, dependence and resulting consequences (EMCDDA 2012).

of 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.

6.2.3. Substitution treatment

Since 1 July 2002, data on substitution treatment in Germany has been recorded by the substitution register with the purpose of avoiding double prescriptions of substitution drugs as well as of monitoring the implementation of specific quality standards on the treatment side. The short-term use of substitution drugs for the purpose of detoxification is not documented in this register insofar as the detoxification treatment lasts a maximum of four weeks and the patients no longer require substitution drugs directly upon completion of the treatment. Since 2010, this data source has provided information 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 have also had a right to psychotherapy if they have not achieved abstinence after more than 10 treatment sessions (Gemeinsamer Bundesausschuss 2013).

7. Bibliography

- Backmund, M., Hinrichsen, H., Rossol, S., Schütz, C., Soyka, M., Wedemeyer, H. & Reimer, J. (2006). Leitlinien der Deutschen Gesellschaft für Suchtmedizin (DGS e.V.): Therapie der chronischen Hepatitis C bei intravenös Drogengebrauchern. Suchtmedizin in Forschung und Praxis **8** (3) 129-133.
- Backmund, M., Lüdecke, C., Isernhagen, K., Walcher, S., Rüter, T. & Leitliniengruppe der DGS (2014). Leitlinie zur Therapie der Opiatbehandlung - Teil 1: Substitutionsbehandlung. Suchttherapie **15** (2) 91-92.
- BÄK (Bundesärztekammer) (2010). Richtlinien der Bundesärztekammer zur Durchführung der substitions-gestützten Behandlung Opiatabhängiger - vom Vorstand der Bundesärztekammer in seiner Sitzung am 19. Februar 2010 verabschiedet. Bundesärztekammer, Berlin.
- Berthel, T., Vogel, F. & Kläusler, C. (2015). Plädoyer für eine integrierte Zusammenarbeit in der Suchthilfe. Suchtmagazin **2015** (1) 13-17.
- Blankers, M. & Schippers, G. M. (2014). Die Zukunft des Internets als Antwort auf Alkohol, Tabak und andere Drogen. Editorial. Suchtmedizin **16** (4) 165-166.
- Braun, B., Brand, H., Künzel, J. & Pfeiffer-Gerschel, T. (2014). Deutsche Suchthilfestatistik 2013. Alle Bundesländer. Tabellenband für ambulante Beratungs- und/oder Behandlungsstellen, Fachambulanzen und Institutsambulanzen (Typ 3 und 4). Bezugsgruppe: Zugänge Beender ohne Einmalkontakte. IFT Institut für Therapieforschung, München.
- Braun, B., Brand, H., Künzel, J. & Pfeiffer-Gerschel, T. (2015a). Deutsche Suchthilfestatistik 2014. Alle Bundesländer. Tabellenband für ambulante Beratungs- und/oder Behandlungsstellen, Fachambulanzen und Institutsambulanzen (Typ 3 und 4). Bezugsgruppe: 1 Zugänge Beender ohne Einmalkontakte. IFT Institut für Therapieforschung, München.
- Braun, B., Brand, H., Künzel, J. & Pfeiffer-Gerschel, T. (2015b). Deutsche Suchthilfestatistik 2014. Alle Bundesländer. Tabellenband für ambulante Beratungs- und/oder Behandlungsstellen, Fachambulanzen und Institutsambulanzen (Typ 3 und 4). Bezugsgruppe: 7 Zugänge Beender Erstbehandelte ohne EK. IFT Institut für Therapieforschung, München.
- Braun, B., Brand, H., Künzel, J. & Pfeiffer-Gerschel, T. (2015c). Deutsche Suchthilfestatistik 2014. Alle Bundesländer. Tabellenband für (teil-)stationäre Rehabilitationseinrichtungen und Adaptionseinrichtungen. Bezugsgruppe: 4 Beender mit Einmalkontakte. IFT Institut für Therapieforschung, München.
- BOPST (Bundesopiumstelle) (2013). Bericht zum Substitutionsregister. Januar 2013. Bundesinstitut für Arzneimittel und Medizinprodukte, Bonn.
- BOPST (Bundesopiumstelle) (2014). Bericht zum Substitutionsregister. Januar 2014. Bundesinstitut für Arzneimittel und Medizinprodukte (BfArM), Bonn.
- BOPST (Bundesopiumstelle) (2015). Bericht zum Substitutionsregister. Januar 2015. Bundesinstitut für Arzneimittel und Medizinprodukte (BfArM), Bonn.

- Bürkle, S. & Harter, K. (2011). Perspektiven einer zukunftsorientierten ambulanten regionalen Suchthilfe. Diskussionspapier der Caritas Suchthilfe. [online]. Available: <https://www.google.de/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCQQFjAAahUKEwjsiru4zOLIAhXF6CwKHRJGADk&url=http%3A%2F%2Fwww.caritas-suchthilfe.de%2Fcms%2Fcontents%2Fcaritas-suchthilfe.d%2Fmedien%2Fdokumente%2Fpositionen-und-stell%2Fambulante-regionale%2F11-03-18diskussionspapierambulantesuchthilfe.pdf%3Fd%3Da%26f%3Dpdf&usq=AFQjCNGexMcef3CEjCiGrCv8IT3YnyxIA&cad=rja> [accessed: 28.10.2015].
- Die Drogenbeauftragte der Bundesregierung (2012). Nationale Strategie zur Drogen- und Suchtpolitik, Berlin.
- Die Drogenbeauftragte der Bundesregierung (2014). Drogenbeauftragte beruft neuen nationalen Drogen- und Suchtrat. (Pressemitteilung) [online]. Available: <http://www.drogenbeauftragte.de/presse/pressemitteilungen/2014-04/drogen-und-suchtrat.html> [accessed: 05.10.2015].
- Die Drogenbeauftragte der Bundesregierung (2015). Drogen- und Suchtbericht. Mai 2015. Die Drogenbeauftragte der Bundesregierung, Berlin.
- DHS (Deutsche Hauptstelle für Suchtfragen) (2010a). Suchthilfe im regionalen Behandlungsverbund. Bestandsaufnahme und Entwicklungsperspektiven [online]. Hamm. Available: http://www.dhs.de/fileadmin/user_upload/pdf/dhs_stellungnahmen/2011_02_28-DHS_Verbundpapier-DIN_neu_2.pdf [accessed: 05.10.2015].
- DHS (Deutsche Hauptstelle für Suchtfragen) (2010b). Deutscher Kerndatensatz zur Dokumentation im Bereich der Suchtkrankenhilfe. Definitionen und Erläuterungen zum Gebrauch. Stand: 05.10.2010. DHS, Hamm.
- DHS (Deutsche Hauptstelle für Suchtfragen e.V) (2014). Kindeswohl und Substitution. [online]. DHS. Available: http://www.dhs.de/fileadmin/user_upload/pdf/dhs_stellungnahmen/Kindeswohl_und_Substitution.pdf [accessed: 28.08.2015].
- DHS (Deutsche Hauptstelle für Suchtfragen e.V.) (2015). Versorgungsstrukturen. [online]. Available: <http://www.dhs.de/dhs-stellungnahmen/versorgungsstrukturen.html> [accessed: 31.08.2015].
- DRV (Deutsche Rentenversicherung Bund) (2014). Rehabilitation 2013. Statistik der Deutschen Rentenversicherung. Band 199. DRV, Berlin.
- EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2012). Treatment demand indicator (TDI) [online]. Available: <http://www.emcdda.europa.eu/themes/key-indicators/tdi> [accessed: 31.08.2015].
- EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2014). Internet-based drug treatment. [online]. Available: <http://www.emcdda.europa.eu/topics/pods/internet-based-drug-treatment> [accessed: 28.08.2015].
- Falch-Knappe, M. & Schoen-Blum, T. (2014). "Praxis für Suchtmedizin" der Stadt Kehl (Baden-Württemberg, Deutschland) - ein grenzüberschreitendes Projekt.

- Fischer, M., Kemmann, D., Weissinger, V., Dewitz, M., Kunert, H., Post, Y., Susemihl, I., Bachmeier, R. & Missel, P. (2015). Effektivität der stationären abstinenzorientierten Drogenrehabilitation. FVS-Katamnese des Entlassjahrgangs 2012 von Fachkliniken für Drogenrehabilitation. Sucht Aktuell **2015** (1) 68-75.
- Gemeinsamer Bundesausschuss (2013). Richtlinien des Gemeinsamen Bundesausschusses über die Durchführung der Psychotherapie in der vertragsärztlichen Versorgung in der Fassung vom 19. Februar 2009, veröffentlicht im Bundesanzeiger Nr. 58 (S. 1399) vom 17. April 2009, in Kraft getreten am 18. April 2009, zuletzt geändert am 18. April 2013, veröffentlicht im Bundesanzeiger (BAZ AT 18.06.2013 B6), in Kraft getreten am 19. Juni 2013. Gemeinsamer Bundesausschuss, Berlin.
- Hildebrand, A., Sonntag, D., Bauer, C. & Bühringer, G. (2009). Versorgung Suchtkranker in Deutschland: Ergebnisse der Suchthilfestatistik 2007. Sucht **55** (Sonderheft 1) 15-34.
- Initiativkreis Substitutionstherapie (2014). Bitte substituieren Sie! Die Kampagne [online]. Available: <http://www.bitte-substituieren-sie.de/bitte-substituieren-sie.de/die-kampagne.html> [accessed: 28.08.2015].
- JVA (Justizvollzugsanstalt) Düsseldorf (2015). Abstinenzorientierte Abteilung (AoA) [online]. Available: http://www.jva-duesseldorf.nrw.de/aufgaben/sozialdienst/4_aoa/index.php [accessed: 01.09.2015].
- Katholische Hochschule NRW (2015). Drogenabhängigkeit im Alter: Erfahrungs-, lebenswelt- und versorgungssystemorientiertes Case Management für ältere drogenabhängige Menschen in drei Regionen (Alters-CM3). (Forschungsprojekt) [online]. Available: <https://www.rlp-forschung.de/public/projects/19897> [accessed: 27.10.2015].
- Krausz, M., Ramsey, D., Neumann, T., Vogel, M. & Backmund, M. (2014). Paradigmenwechsel als Markenkern - das Netz als Rahmen der Suchtmedizin der Zukunft? Suchtmedizin **16** (4) 167-172.
- Künzel, J., Braun, B. & Brand, H. (2014). Klienten/Patienten aus unterschiedlichen Wohnsituationen in ambulanter und stationärer Suchtbehandlung. IFT Institut für Therapieforschung, München.
- Leune, J. (2014). Versorgung abhängigkeitskranker Menschen in Deutschland. In: Jahrbuch Sucht 2014, Deutsche Hauptstelle für Suchtfragen (DHS) (Hrsg.), S. 181-202. Pabst, Lengerich.
- Michels, I., Stöver, H. & Gerlach, R. (2007). Substitution treatment for opioid addicts in Germany [online]. Harm Reduction Journal 4 (5). Available: <http://www.harmreductionjournal.com/content/4/1/5> [accessed: 05.10.2015].
- Milin, S. & Schäfer, I. (2015). Breaking Meth - Ein Bundesmodellprojekt des ZIS Hamburg zur Online-Suchtselbsthilfe (Nov. 2014 - April 2016), Hamburg.
- Müller-Simon, B. & Weissinger, V. (2015). "BORA-Veranstaltung. Empfehlungen zur Stärkung des Erwerbsbezugs in der medizinischen Rehabilitation Abhängigkeitskranker.", Berlin.
- Pfeiffer-Gerschel, T., Jakob, L., Stumpf, D., Budde, A. & Rummel, C. (2014). Bericht 2014 des nationalen REITOX-Knotenpunkts an die EBDD. Neue Entwicklungen und Trends. Deutschland. Drogensituation 2013/2014. Deutsche Beobachtungsstelle für Drogen und Drogensucht (DBDD), München.

- Pfeiffer-Gerschel, T., Kipke, I., Flöter, S., Lieb, C. & Raiser, P. (2009). Bericht 2009 des nationalen REITOX-Knotenpunkts an die EBDD. Deutschland. Neue Entwicklungen, Trends und Hintergrundinformationen zu Schwerpunktthemen. Drogensituation 2008/2009. Deutsche Beobachtungsstelle für Drogen und Drogensucht (DBDD), München.
- Pfeiffer-Gerschel, T., Kipke, I., Flöter, S., Karachaliou, K., Lieb, C. & Raiser, P. (2010). Bericht 2010 des nationalen REITOX-Knotenpunkts an die EBDD. Deutschland. Neue Entwicklungen, Trends und Hintergrundinformationen zu Schwerpunktthemen. Drogensituation 2009/2010. Deutsche Beobachtungsstelle für Drogen und Drogensucht (DBDD), München.
- Pfeiffer-Gerschel, T., Kipke, I., Flöter, S., Jakob, L., Hammes, D. & Rummel, C. (2012). Bericht 2012 des nationalen REITOX-Knotenpunkts an die EBDD. Deutschland. Neue Entwicklungen, Trends und Hintergrundinformationen zu Schwerpunktthemen. Drogensituation 2011/2012. Deutsche Beobachtungsstelle für Drogen und Drogensucht (DBDD), München.
- Reimer, J., Schulte, B., Thane, K. & Wickert, C. (2009). Ergebnisse zum "Projekt zur Evaluation der missbräuchlichen Verwendung von Substitutionsmitteln in Deutschland" - Kurzfassung. Zentrum für Interdisziplinäre Suchtforschung der Universität Hamburg, Hamburg.
- Sarrazin, C., Berg, T., Ross, S., Schirmacher, P., Wedemeyer, H., Neumann, U., Schmidt, H., Spengler, U., Wirth, S., Kessler, H., Peck-Radosavljevic, M., Ferenci, P., Vogel, W., Moradpour, D., Heim, M., Cornberg, M., Protzer, U., Manns, M., Fleig, E., Dollinger, M. & Zeuzem, S. (2010). Update der S3-Leitlinie Prophylaxe, Diagnostik und Therapie der Hepatitis-C-Virus(HCV)-Infektion. Zeitschrift für Gastroenterologie **48** 289-351.
- Schmidt, L. G., Gastpar, M., Falkai, P. & Gaebel, W. (Hrsg.) (2006). Evidenzbasierte Suchtmedizin. Behandlungsleitlinie Substanzbezogene Störungen. Deutscher Ärzte-Verlag, Köln.
- Statistisches Bundesamt (2011a). Diagnosedaten der Patienten und Patientinnen in Krankenhäusern (einschl. Sterbe- und Stundenfälle) 2009. Fachserie 12, Reihe 6.2.1. Statistisches Bundesamt, Wiesbaden.
- Statistisches Bundesamt (2011b). Diagnosedaten der Patienten und Patientinnen in Krankenhäusern (einschl. Sterbe- und Stundenfälle) 2010. Fachserie 12, Reihe 6.2.1. Statistisches Bundesamt, Wiesbaden.
- Statistisches Bundesamt (2013a). Diagnosedaten der Patienten und Patientinnen in Krankenhäusern (einschl. Sterbe- und Stundenfälle) 2012. Fachserie 12, Reihe 6.2.1. Statistisches Bundesamt, Wiesbaden.
- Statistisches Bundesamt (2013b). Diagnosedaten der Patienten und Patientinnen in Krankenhäusern (einschl. Sterbe- und Stundenfälle) 2011. Fachserie 12, Reihe 6.2.1. Statistisches Bundesamt, Wiesbaden.
- Statistisches Bundesamt (2014). Krankenhausdiagnosestatistik. Aus dem Krankenhaus entlassene vollstationäre Patienten (einschl. Stundenfälle, ohne Sterbefälle). Statistisches Bundesamt, Wiesbaden.

- Statistisches Bundesamt (2015). Krankenhausdiagnosestatistik. Aus dem Krankenhaus entlassene vollstationäre Patienten (einschl. Stundenfälle, ohne Sterbefälle). 2013. Statistisches Bundesamt, Wiesbaden.
- Wittchen, H.-U., Apelt, S. M., Soyka, M., Gastpar, M., Backmund, M., Götz, J., Kraus, M. R., Tretter, F., Schäfer, M., Siegert, J., Scherbaum, N., Rehm, J. & Bühringer, G. (2008). Feasibility and outcome of substitution treatment of heroin-dependent patients in specialized substitution centers and primary care facilities in Germany: A naturalistic study in 2694 patients. Drug and Alcohol Dependence **95** (3) 245-257.
- ZIS (Zentrum für Interdisziplinäre Suchtforschung) der Universität Hamburg (2015). Breaking Meth - ein Selbsthilfe-Angebot für Menschen mit Methamphetamin / Crystal - Erfahrung [online]. Available: <https://breaking-meth.de> [accessed: 27.08.2015].

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