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Prison

Loretta Schulte, Esther Dammer & Tim Pfeiffer-Gerschel
IFT Institute for Therapy Research

Gabi Bartsch, German Centre for Addiction Issues

Maria Friedrich, Federal Centre for Health Education

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Contents

0 Summary (T0)

As the percentage of addicts and users of illicit drugs in German correctional institutions cannot be precisely quantified, the number of persons incarcerated as a result of violations of the German Narcotic Drugs Act (Betäubungsmittelgesetz, BtMG) is frequently used as an approximation, even though this estimate must be seen as highly imprecise. As of 31 March 2016, there were a total of 6,415 persons (12.6% of all inmates) serving time in prison institutions as a result of violations against the BtMG. 12.2% (381) of imprisoned women and 3.8% (154) of imprisoned adolescents were serving sentences due to offences against the BtMG. The proportion of all inmates imprisoned for BtMG offences has been falling since 2007 both among adults as well as among adolescents and young adults (Table 2). From 2007 to 2016, the total number of all inmates increased by 21.4% whilst the number of inmates serving sentences due to BtMG offences decreased by 33.6% (Destatis 2017).

The legal administration of the penal system in Germany was placed in the hands of the *Laender* in 2006. Since then, some individual *Laender* have introduced their own prison laws. The absence of binding, nationwide guidelines in the area of drug-related health care in detention also leads to differences in the type and availability of therapy services in the *Laender*.

The seventh title of the German Prison Act (Strafvollzugsgesetz, StVollzG) lays down regulations governing health care for prisoners. As a general rule, there is an obligation to care for the physical and mental health of prisoners (Sec. 56 StVollzG). In addition to this, prisoners have a "right to health treatment, provided it is necessary to diagnose or cure a disease, prevent it from deteriorating or alleviate its symptoms". No individual remarks are made in the StVollzG regarding drugs, substitution or addiction.

On World Drug Day 2017, the German Centre for Addiction Issues (Deutsche Hauptstelle für Suchtfragen e.V., DHS) called for improved medical treatment of imprisoned drug users. In view of the frequently accompanying psychological and physical problems of addicts in prison, nationwide access to substitution programmes should be ensured and a reduction of health risks through syringe exchange programmes should be promoted. A right to appropriate medical treatment and healthcare should be recognised and support in the transition as well as a linking of addiction support and offender support services should be guaranteed. Additionally, the DHS calls for participation for inmates suffering from addiction within internal prison services (school, training, exercise), which require special privileges, which addicts are often excluded from.

In order to reduce fatal overdoses amongst opiate users following their release from prison, in August 2016 the German Aids Service Organisation (Deutsche Aidshilfe, DAH), in collaboration with Fixpunkt e.V., launched a naloxone dispensing pilot project in which prisoners with a current or past opiate use, as well as prisoners currently in substitution, were

to be offered training on the effects of drugs and first aid in the form of information sessions. However, this project could not yet be successfully implemented.

The Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS) for external outpatient counselling in prisons has been producing a collection of tables since 2008, which includes just 18 institutions for the reporting year 2016 (2015: 19 institutions). Since it cannot be ruled out that individual findings are only available for one or two facilities or heavily influenced by them, these figures must be interpreted extremely cautiously. The average age of men with illicit drug problems who made use of outpatient support in prison in 2016 was 32.6 years, and the average age of women was 29.1. It is particularly noteworthy that 79.6% of women serving sentences in prison who underwent treatment as a result of an illegal drug problem were treated for a primary opioid problem, while this percentage among men was only 25.0%.

The distribution of substances among those who have never sought treatment prior to their prison sentence is different from those who have previously had experience with the addiction support system. Inmates with a primary diagnosis hypnotics/sedatives was the group which utilised the opportunity of prison for a first-time treatment, at 36%, closely following by those with the primary diagnosis cannabinoids (31%), cocaine and stimulants (29% each). Opioid users were the group most seldom treated for the first time (7%) and therefore most often in contact with addiction support before or during their imprisonment.

1 National profile (T1)

1.1 Organisation (T1.1)

1.1.1 Prison services (T1.1.1)

According to the provisions of the German Prison Rules of Procedure (Vollzugsgeschäftsordnung, VGO, No. 73), a monthly report must be produced by the correctional institutions, containing information about inmates incarcerated at the end of the reporting month as well as on admissions and releases during the reporting month. The German Federal Statistical Office (Deutsche Statistische Bundesamt, Destatis) prepares overviews for Germany from those reports, which are aggregated to produce results on a *Land* basis, for three selected calendar months (March, August and November) and publishes them on the internet. The overviews cover the correctional facilities of the *Laender*. Secure psychiatric facilities and youth detention facilities are not included.

On 31 March 2016, according to the annual Destatis report, 50,585 inmates were in preventive custody or serving time in correctional institutions. 6.1% (3,125) of these were women and 28.1% (14,195) were persons without German citizenship. 70.0% (35,389) were single, 15.6% (7,896) married, 1.3% (702) widowed and 13.6% (6,871) divorced. 16.3% (8,236) of inmates were in an open prison. 0.4% (226) of those imprisoned under general criminal law were between 18 and 21 years old, 25.2% (12,769) were between 21 and 29, 51.8% (26,221) were between 30 and 49 and 14.0% (7,092) were aged 50 and over.

65.1% (32,908) of inmates in prison or preventive custody were serving a sentence of up to 2 years, 30.7% (15,547) had a sentence of over 2 and up to 15 years and 3.7% of inmates (1,863) were serving a life sentence (Destatis 2017).

An overview of the number of correctional institutions, their capacity and actual population as of 30 November in each year in the individual *Laender* is shown in Table 1. According to that data, there were 182 organisationally independent institutions in Germany in 2016 with a total capacity of around 73,627 inmates which, with 62,865 inmates, were at 85% capacity at the time of the survey (Destatis 2017).

Table 1 Number of institutions and capacity as at 30 November

Year	Number of institutions		Total capacity	Population	Population[1)]
	Total	Open prison			
2003	205	22	78,753	79,153	101
2004	202	21	79,209	79,452	100
2005	199	20	79,687	78,664	99
2006	195	19	79,960	76,629	96
2007	195	19	80,708	72,656	90
2008	193	18	79,713	72,259	91
2009	194	17	78,921	70,817	90
2010	188	16	77,944	69,385	89
2011	186	15	78,529	68,099	87
2012	186	15	77,490	65,902	85
2013	185	14	76,556	62,632	82
2014	184	13	75,793	61,872	82
2015	183	13	73,916	61,737	84
2016	182	14	73,627	62,865	85

1) Population as % of total capacity

Destatis 2017.

Of note among developments in recent years is the reduced number of correctional facilities which has nevertheless, at least until last year, been accompanied by an improved situation regarding the capacity available. Whereas at the beginning of the 2000s, prisons were still operating beyond their capacity, there is a maximum utilisation of 70-90% in most *Laender* today (with the exception of Saxony at 91%, Bavaria at 92% and Baden-Württemberg now at 94%), in spite of a reduction in total number of prisons available. Since 2015, the capacity utilisation has risen significantly in Bremen (from 71% to 84%) and Baden-Württemberg (84% to 94%). In Thuringia it has fallen by 5% (from 82% to 77%).

1.2 Drug use and related problems among prisoners (T1.2)

1.2.1 Prevalence of drug use (T1.2.1)

As the percentage of addicts and users of illicit drugs in German correctional institutions cannot be precisely quantified, the number of persons incarcerated as a result of violations of the BtMG is frequently used as an approximation. This estimate is imprecise, however. Firstly, it counts people who, although they have violated the law in connection with drugs, may not consume any illicit substances themselves, as can be the case, for example, with some dealers. Secondly, a large proportion of drug users are not taken into account because, for example, persons who have been sentenced for economic compulsive crimes are listed in the statistics under categories other than violations against the BtMG.

As of 31 March 2016, there were a total of 6,415 persons (12.6% of all inmates) serving time in prison institutions as a result of violations against the BtMG. 12.2% (381) of imprisoned women and 3.8% (154) of imprisoned adolescents were serving sentences due to crimes in violation of the BtMG. The proportion of all inmates imprisoned for BtMG offences has been falling since 2007 both among adults as well as among adolescents and young adults (Table 2). From 2007 to 2016, the total number of all inmates increased by 21.4% whilst the number of inmates serving sentences due to BtMG offences decreased by 33.6% (Destatis 2017).

Table 2 Imprisoned persons and narcotics offences

		Prisoners and persons in preventive custody			Custodial sentences for adults		Juvenile punishments		Preventive custody
		Total	Males	Females	Males	Females	Males	Females	
2016	Inmates N	50,858	47,733	3,125	43,328	2,980	3,866	144	540
	BtMG N	6,415	6,034	381	5,884	376	149	5	1
	BtMG %	12.6	12.6	12.2	13.6	12.6	3.9	3.5	0.2
2015	BtMG %	13.0	13.0	13.4	14.1	13.8	3.4	4.3	0.4
2014	BtMG %	13.1	13.0	14.3	14.2	14.9	3.2	4.4	0.2
2013	BtMG %	13.4	13.3	14.9	14.5	15.3	3.4	7.6	0.0
2012	BtMG %	14.0	13.9	15.9	15.2	16.5	3.6	7.5	0.2
2011	BtMG %	14.7	14.7	15.4	16.0	15.8	4.6	10.7	0.2
2010	BtMG %	14.6	14.5	16.2	15.8	16.7	5.0	10.2	0.2
2009	BtMG %	15.0	14.9	16.5	16.2	17.0	5.1	10.5	0.4
2008	BtMG %	15.3	15.1	18.2	16.3	18.9	6.7	9.8	0.7
2007	Inmates N	64,700	61,323	3,377	54,212	3,072	6,685	304	427
	BtMG N	9,665	9,077	588	8,763	461	413	27	1
	BtMG %	14.9	14.8	17.4	16.2	15.0	6.2	8.9	0.2

Note: "BtMG N": Number of persons imprisoned due to offences against the BtMG, "BtMG%": Proportion of persons imprisoned due to offences against the BtMG.

(Destatis 2017).

1.2.2 Drug related problems among the prison population (T1.2.2)

No additional information is available on this.

1.2.3 Drug supply (T1.2.3)

No additional information is available on this.

1.3 Drug-related health responses in prisons (T1.3)

1.3.1 National policy or strategy (T1.3.1)

Legal framework conditions

The German Prison Act (Strafvollzugsgesetz, StVollzG) from 1976 still applies in some German *Laender*. It regulates "the execution of custodial sentences in correctional institutions and measures of rehabilitation and prevention involving imprisonment" (Sec. 1 StVollzG). Since the reform of federalism, which was passed by the German Bundestag on 30 June 2006 and came into force on 1 September 2006, legislative power has been devolved from the Federal Government to the *Laender*. The StVollzG is being replaced, in stages, by the respective *Laender* prison laws and administrative regulations (Sec. 125a German Constitution, GG), which in part cite the StVollzG. Some German *Laender* now have their own prison laws, whilst others have, in a working group comprising representatives of the justice administrations, presented a draft of a uniform prison act for the adult detention, which has since been passed by some *Laender*. At the time of reporting, the StVollzG was still in force in three *Laender* (Berlin, Saxony-Anhalt and Schleswig-Holstein). The *Laender* laws are however largely based on the nationally applicable StVollzG and usually only differ in terms of individual details. The type and scope of the provision of services in the area of health care are based, for example, on the German Code of Social Law, Volume 5, (Sozialgesetzbuch V, SGB V) in all German *Laender* which have their own prison laws.

The seventh title of the StVollzG lays down regulations governing health care for prisoners. As a general rule, there is an obligation to care for the physical and mental health of prisoners (Sec. 56 StVollzG). In addition to this, prisoners have a "right to health treatment, provided it is necessary to diagnose or cure a disease, prevent it from deteriorating or alleviate its symptoms". This means, amongst other things, treatment by a doctor and the supply of pharmaceuticals, dressings, medicines and medical aids (Sec. 58 StVollzG). The provisions of SGB V apply in respect of the type and scope of health services (Sec. 61 StVollzG). No individual remarks are made in the StVollzG regarding drugs, substitution or addiction. Medical care of inmates is paid for by the ministries of justice of the *Laender*. In the case of work related accidents, the statutory health insurance provider or the respective *Land* accident insurance scheme assumes the costs (German Federal Ministry of Justice (Bundesministerium der Justiz, BMJ) (publisher) 2009).

Although the *Laender* laws scarcely differ from the StVollzG or from each other, there are nevertheless subtle differences. The Hessian prison law stipulates a right on the part of inmates to psychological or psychotherapeutic treatment or care (Sec. 26, (2) Hessian Prison Act, Hessisches Strafvollzugsgesetz, HStVollzG). In addition, in Lower Saxony, Hesse and Baden-Württemberg preventive measures are also explicitly mentioned: in Lower Saxony, the right of prisoners to vaccinations (Sec. 57 (1) Lower Saxony Prison Act, Niedersächsisches Justizvollzugsgesetz, NJVollzG) is codified in law. In Hesse and Baden-Württemberg, the need to educate inmates about healthy living habits is also codified (Sec. 23 (1) HStVollzG and Sec. 32 (1) Prison Code for Baden-Württemberg, JVollzGB IV). The

codes of Hesse and Baden-Wuerttemberg furthermore state that it is possible to use controls to combat abuse of addictive substances (Sec. 4 HStVollzG and Sec. 64 JVollzGB III).

In a comprehensive analysis by the Associations of Addiction Professionals for 2009, it was shown that for a large number of rehabilitation patients in addiction treatment who have been released from prison (39% alcohol and 77% drugs), no health insurance was in place at the beginning of the treatment and that this could only be obtained in some cases after several weeks (Drogen- und Suchtrat 2013). To solve this problem, clarification is needed as early and as unbureaucratically as possible as to which institution is responsible in terms of the point in the process, the geographical area and the specialist competence (job centres, health insurance providers). That can usually only be achieved if respective requests or applications are made prior to the end of the prison sentence. Through the social service of the prison, a clarification of the likely place of residence post release of the affected person should be obtained in good time (around 3 months) prior to the release date, by asking the person. The local job centre thus identified as the closest to the prospective place of residence can then evaluate the capacity for employment as per Sec. 8 SGB II, prior to the inmate even being released from prison, in order to avoid delays in the clarification of social law issues in connection with the start of rehabilitation measures.

Other interventions in the criminal justice system

There is the possibility at all levels of the criminal justice system, to cease proceedings under certain conditions. In many cases, a few hours of community service is the first response of authorities in dealing with problem behaviour in connection with drugs. In order to reduce drug crime as well as economic compulsive crime, many cities have created the legal possibility of issuing banning orders or dispersal orders for particular locations in order to prevent open drug scenes emerging.

At public prosecution level, it is possible to refrain from prosecuting crimes committed by adolescents and young adults, who fall under criminal law relating to young offenders, or to discontinue proceedings in respect of the German Youth Courts Law (Jugendgerichtsgesetz, JGG, Sec. 45 and Sec. 47). This is mostly applied in cases involving only small quantities of cannabis.

In nearly all *Laender*, local prevention projects, such as the widespread programme "Early Intervention with Drug Users Coming to the Attention of Law Enforcement for the First Time – FreD" (Frühintervention bei erstauffälligen Drogenkonsumenten) are used as a way of avoiding criminal proceedings. The programme is aimed at 14 to 18-year-olds but also young adults up to 25 years old who have come to the attention of the police for the first time due to their use of illicit drugs (for more information on the FreD programme, see the Prevention workbook).

Alternatives to prison sentences

According to Sec. 63 and Sec. 64 of the German Criminal Code (Strafgesetzbuch, StGB), it is possible under certain circumstances to place mentally ill or addicted offenders under a hospital treatment order in secure psychiatric units.

The BtMG allows the cessation of proceedings in cases involving minor guilt as well as a lack of public interest in prosecution (Sec. 31a BtMG). This applies mainly to consumption-related offences, in particular when they occur for the first time and no third parties are involved. The application of these regulations differs from region to region, as shown by a study carried out by Schäfer and Paoli (2006). With regard to the prosecution of consumption-related offences involving cannabis, there has been a move towards standardising the definitions of threshold values for determining the "small quantity" by the *Laender*, in line with the requirements issued by the German Federal Constitutional Court. Further details can be found in the Legal Framework workbook, section 1.1.2.

Moreover, it is possible to defer a prison sentence of up to two years in order to provide the drug addict with the chance to undergo treatment ("treatment not punishment", Sec. 35 BtMG).

The study, funded by the German Federal Ministry of Health, entitled "Medical rehabilitation of drug addicts under Sec. 35 BtMG, ("treatment not punishment"): Effectiveness and Trends" was conducted up to April 2013 in the *Laender* Hamburg, Schleswig-Holstein and North Rhine-Westphalia. The results of the study show that the housing of drug addicted criminals in a withdrawal facility under Sec. 64 StGB increased enormously from 2001 to 2011. It also became clear that after the end of a rehabilitation measure, drug addicts were increasingly subject to probation as per Sec. 35, Sec. 36 BtMG. A proper completion of treatment was achieved by 50% of the Sec. 35 BtMG group, thus this group was more successful than the group without this condition, of which 43% completed the treatment normally. A more detailed presentation of the study can be found in the REITOX Report 2013.

1.3.2 Structure of drug-related prison health responses (T1.3.2)

Resolution 37/194 of the General Assembly of the United Nations (Office of the United Nations High Commissioner for Human Rights 1982) stated that health-care personnel in prisons have a duty to support prisoners in maintaining their physical and mental health and, if inmates become ill, to treat them under the same quality standards as afforded to those who are not imprisoned or detained. In dealing with prisons and detained persons, the Council of Europe recommends, under the heading, “Equivalence of care”, that health policy in prisons be in line with national health policy and that it be integrated into it. Furthermore, conditions in prison which violate the human rights of inmates cannot be justified by a lack of resources (2010).

In Germany, the Prison Acts themselves regulate what medical services prisoners are entitled to and refer, with regard to type and scope, to SGB V (Meier 2009). Under these

provisions, prisoners are not entitled to the entire spectrum of health services which statutory health insurance providers (gesetzliche Krankenversicherung, GKV) are obligated to provide.

In 2011 a long-term male heroin addict born in 1955 applied for substitution treatment during his imprisonment as well as, in the alternative, an assessment of the medical necessity of a substitution by a doctor specialised in addiction disorders. The prison denied the request on the grounds that there was no medical necessity for the substitution and also that this was not a suitable method for rehabilitating the prisoner. In 2012, the Regional Court of Augsburg agreed with this argument and added that no assessment by an addiction expert is necessary. At the appeal stage, the Appeal Court of Munich also rejected the request of the prisoner. The German Federal Constitutional Court dismissed the man's appeal in 2013 without giving a reason (Decision No. 2 BvR 2263/12). Following his release from prison in 2014, the man was prescribed substitution treatment by his doctor. The European Court of Human Rights concluded in its judgment of 1 September 2016 (with reference to the principle of equivalence) that the approach by the prison and courts was a breach of Article 3 of the European Convention on Human Rights (ECHR)[1]. The court did not rule on whether the inmate should have received opioid substitution therapy. However, the prison and in particular the courts involved should have consulted an independent doctor with expertise in addiction treatment, in order to have the state of the man's health assessed. Due to the behaviour of the prison and courts, the patient had to suffer physically and psychologically. However, the judges in Strasbourg rejected the man's request for compensation.

On World Drug Day 2017 the German Centre for Addiction Issues (Deutsche Hauptstelle für Suchtfragen e.V., DHS) calls for improved medical treatment of imprisoned drug users (DHS 2016). In view of the frequently accompanying psychological and physical problems of dependents in prison, nationwide access to substitutions programmes should be ensured and a reduction of health risks through syringe exchange programmes should be promoted. A right to appropriate medical treatment and healthcare should be recognised and support in transition guaranteed through a linking of addiction support and offender support services. Additionally, the DHS calls for participation for inmates suffering from addiction within internal prison services (school, training, exercise), which require special privileges, which addicts are often excluded from.

1.3.3 Availability and provision of drug-related health responses in prisons (T1.3.3)

In a systematic review by Hedrich et al. (2012) an overview was published on the effectiveness of maintained substitution treatments (opioid maintenance treatment, OMT) in prison. The results show that the advantages of OMT in prison are comparable with those in the general population. OMT represents a possibility to motivate problem opioid users to submit themselves to treatment, to reduce illegal opioid use and high risk behaviour in prison and possibly also to minimise the number of overdoses after release from prison. If there is a

[1] The judgment is available online at: http://hudoc.echr.coe.int/eng?i=001-165758 [accessed: 16 Aug. 2017].

link to a treatment programme which is close to the community, OMT in prison also facilitates the continuity of treatment and helps with the achievement of long-term, positive effects.

The Statistical Report on Substance Abuse Treatment in Germany (DSHS) has included a series of tables on external outpatient counselling in prisons since 2008 (Braun et al. 2017a). As this series of tables only comprises 18 facilities for the reporting year 2016 (2015: 19 facilities) and it cannot be ruled out that individual results are only available for one or two facilities or are heavily influenced by them, these figures must be interpreted extremely cautiously. This is also because no information whatsoever is available on the selection mechanisms for participation, nor can any conclusions be drawn regarding the representativeness of the participating prisons. The average age of men with illegal drug problems who made use of outpatient support in prison in 2016 was 32.6 years old (2015: 32.1), while the average age for women was 29.1 (2015: 30.4). It is particularly noteworthy that 79.6% (2015: 81.1%, N=99) of women serving sentences in prison who were in treatment as a result of illicit drug problems were treated for a primary opioid problem, while this percentage among men was only 25.0% (2015: 23.8%; N=310) (see **Fehler! Verweisquelle konnte nicht gefunden werden.**).

Table 3 Outpatient treatment of drug problems in prisons

primary diagnosis	**Males**			**Females**			**Total**		
	N	**%**	**Persons treated for the first time**	**N**	**%**	**Persons treated for the first time**	**N**	**%**	**Persons treated for the first time**
Opioids	345	25,02	8,12	74	79,57	0,00	419	28,46	7
Cocaine	133	9,64	30,08	6	6,45	16,67	139	9,44	29
Stimulants	514	37,27	28,79	2	2,15	50,00	516	35,05	29
Hypnotics/ sedatives	12	0,87	25,00	2	2,15	100,00	14	0,95	36
Hallucinogens	6	0,44	0,00	0	0,00	0,00	6	0,41	0
Cannabinoids	361	26,18	29,92	7	7,53	71,43	368	25,00	31
Multiple/other substances	8	0,58	37,50	2	2,15	0,00	10	0,68	30
Total	1.379		26,26	93		13,22	1.472		26

(Braun, B. et al. 2017a; Braun, B. et al. 2017b).

The distribution of substances among those who have never sought treatment prior to their prison sentence is different from those who have previously had experience with the addiction support system. Inmates with a primary diagnosis hypnotics/sedatives was the group which utilised the opportunity for an intramural treatment, at 36%, closely following by those with the primary diagnosis cannabinoids (31%), cocaine and stimulants (29% each).

Opioid users were the group most seldom treated for the first time (7%) and therefore most often in contact with addiction support before or during their imprisonment.

Prevention, treatment and dealing with infectious diseases

Detailed information on prevention, treatment and dealing with infectious diseases in prisons can be found in the Selected Issue Chapter 11 of the REITOX Report 2011 (Pfeiffer-Gerschel at al. 2011).

Prevention of overdoses after release from prison

In its action plan on the implementation of the HIV/AIDS strategy, the Federal Government established that prisons represent a setting that requires special health promotion measures. In particular, the transition from incarceration to life on the outside carries a special risk of overdosing.

Given the high mortality risk of injecting drug use (IDU) by way of overdose after release from prison, the guidelines of the German Medical Association (BÄK) on opioid substitution therapy (OST) (BÄK 2010) explicitly allow OST to be commenced even in the case of persons who are currently abstinent.

In August 2016, DAH, in collaboration with Fixpunkt e.V., launched a naloxone dispensing pilot project in which prisoners with a current or past opiate use, as well as prisoners currently in substitution, were to be offered training on the effects of drugs and first aid in the form of information sessions. On release from prison, the trained inmates were to receive an emergency kit fitted with naloxone. The recruitment of volunteer participants ran until the end of 2017. In May 2018, a final report was to be produced, which would summarise the values from experience to date of the participants as well as the participating employees (Dettmer & Knorr 2016). To date however, this project has not been able to be implemented as planned.

Reintegration of drug users after release from prison

The legal framework stipulates that the inmate be provided with support at release (Sec. 74 StVollzG in conjunction with Sec. 15 StVollzG), the objective of which is to assist with reintegration into society after release from prison. In order to achieve this aim, prison services should cooperate across departments (Sec. 154 StVollzG).

Moreover, providers of social welfare should work together with groups which have shared goals as well as other organisations involved, with the aim of mutually complementing each others' work (Sec. 68 (3) SGB XII and Sec. 16 (2) SGB II). Corresponding strategies and measures are developed and implemented under the term transition management. On the one hand, an attempt is being made to bring those being released, both in prison and after release, as smoothly as possible into training, employment or occupational activity; on the other hand, efforts are being made to tackle problems linked with incarceration and criminal careers. The main task of transition management is to improve the situation of the clients by offering them counselling and care but also opportunities for professional qualifications and training as well as job placement. Although from a historic viewpoint there have been, with

the introduction of "assistance for offenders" efforts in this vein dating back over 150 years as well as the introduction of the probation service in the 1950s, there is still a great need for improvement in the discussion and implementation of transition management.

It is currently a challenge for addiction support services to be able to offer people at risk of addiction or people suffering from dependence an adequate service upon release from prison. For this reason, the Professional Association on Drugs and Addiction (Fachverband Drogen und Suchthilfe e.V., fdr) issued a recommendation on transition management which contained, amongst other things, the following elements (fdr 2013):

- Improvement of the addiction medicine care situation, including substitution treatment in prison and drug emergency training sessions
- Participation in work and training opportunities within prison also for inmates suffering from addiction
- Step by step support in transition and networking with addiction support system services and offender support, e. g. placement in assisted living, outpatient clinics etc.
- Provision of outpatient rehabilitation during imprisonment, beginning around 6 months prior to release, in a treatment centre outside prison and continued after release.

1.3.4 Opioid substitution treatment clients in prison (T1.3.4)

According to the WHO indicator registry (BMJ 2009) the following types of drug treatment were available in varying numbers of correctional institutions in 2008: Medication-assisted short term detoxification (14 *Laender*), short term detoxification without medication (7 *Laender*), abstinence-based treatment with psychosocial care (PSC) (11 *Laender*), antagonist treatment (4 *Laender*) and substitution treatment (9 *Laender*). Only in six *Laender* was complementary PSC performed in every case. According to the report, medication-assisted short term detoxification is offered by nearly all *Laender* and long term substitution treatment by just over half of the *Laender*. According to the results of a study (Schulte et al.2009), substitution treatment is possible in only approximately 75% of the detention facilities examined (n = 31).

In 2010, the DAH organised the first expert discussion on "Administering heroin in prison – new challenges and opportunities for the penal system". Staff from the ministries of health and justice, AIDS services and prison doctors took part. The trigger for the meeting was that outside of prisons, administration was to pass over to regular health care, hence allowing the administration of diamorphine in prison was discussed. The meeting of experts came to the conclusion that the required preconditions for this would be the broadening of intramural substitution treatment as well as sufficient political backing. Additionally, attitudes of staff towards drug users in prison would have to be addressed and reflected upon to a greater extent. Since 2011, intramural substitution with diamorphine has been possible in detention facilities in the *Land* Baden-Württemberg.

Since detailed information is only available from individual *Laender*, and much of it relatively outdated, it is not possible to make any definite statements regarding either the current situation or trends in availability of and conditions surrounding the provision of OST in German correctional institutions.

1.3.5 Additional information (T1.3.5)

No additional information is available on this point.

1.4 Quality assurance of drug-related health prison responses (T1.4)

1.4.1 Treatment quality assurance standards, guidelines and targets (T1.4.1)

In Germany there are numerous institutions whose work covers quality assurance of health care outside of prison, such as the associations of SHI-accredited doctors (Kassenärztlichen Vereinigungen, KV), the statutory health insurance providers (gesetzliche Krankenversicherung, GKV) and the medical associations. The control of health care in prison, and thus also for ensuring the quality of drug-related services, is the domain of the ministries of justice in Germany. The German prison system maintains its own health care system, comparable with the health care system for the police or the army (Stöver 2006). This means there are differences in health care for patients within these systems, in contrast to the general population, for example inmates do not have the ability to choose their doctor freely.

Due to the special structure of prisons, supervision of medical services in German correctional institutions is regulated differently than it is externally. Thus, the director of the facility is not entitled to issue medical related instructions to the facility doctor (Keppler et al. 2010). The doctor is subject to professional supervision, however, which may be regulated as follows:

- The specialist in charge of supervision (medical director) is a doctor.
- The specialist in charge of supervision in the ministry is not a doctor, but for example a lawyer or psychologist. In the case of technical medical questions, this person makes use of specialist knowledge of medical experts who do not belong to the ministry of justice, for example staff at the Ministry of Health or external doctors who are not affiliated with any public institution.
- Supervision is not the charge of any one specialist (staff member of the Ministry of Justice), rather external doctors, for example experienced facility doctors from another *Land*, doctors from the Ministry of Health or retired doctors.

The CPT (Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment) functions as external consultant. The European Treaty on this issue stipulates that prison facilities be visited on a regular basis (European Commission 2002). The last visit but one by the CPT in Germany took place between 20 November and 2 December 2005 (CPT 2006), in the course of which 17 facilities were visited. Statements made in the CPT

report in connection with "healthcare" are only based on three facilities, however. The main criticism was that there was an insufficient number of general practitioners available to prisoners. In the opinion of the CPT, there should be one full time general practitioner available for every 300 inmates. In addition, the CPT was of the opinion that psychiatric care and care for drug-dependent inmates was inadequate. A further criticism was that not every detention facility offered every new inmate information on healthcare or on the prevention of infectious diseases (for example with the aid of an information brochure).

In North Rhine-Westphalia, the control of medical activities is governed by the technical agencies of the supervisory authorities (North Rhine-Westphalia Ministry of Justice & Westphalia-Lippe and North Rhine Medical Associations 2010) as laid down in the "Recommendations for Treatment by Doctors Providing Medical Treatment for Opioid Dependency in Prison". It issues orders if the limits of conscientious medical discretion are exceeded or incorrectly exercised. Orders issued by supervisory authorities are limited to specific individual cases.

Imprisonment continues to carry the risk that substitution treatment commenced before entering a penal institution will not be continued (Stöver 2010). Guidelines and rules could help counteract uncertainty and ignorance on the part of prison health care personnel. In order to provide prison doctors with greater certainty, the framework conditions, e. g. treatment strategies, accompanying psychosocial therapy or criteria for discontinuation, should be clearly described. These must especially take the specific conditions in prison into account. At an international level, there are, amongst other things, the declaration on "Prison Health as part of Public Health" (WHO 2003), adopted by the WHO European region in Moscow as well as the treatment recommendations, "Opioid Substitution Treatment in Custodial Settings" (Kastelic et al. 2008). However a few German bodies of rules also exist.

In the recommendations on treatment by doctors and medicinal therapy for opioid dependence in prison in North Rhine-Westphalia (2010) the positive effect of substitution treatment in prison is stressed, with regard to both the progression of opioid dependence and to the achievement of correctional objectives. Thus, the stated objective is "to increase the number of substitution treatments in prisons significantly". According to the recommendations for treatment, the objectives are:

- the prevention of deaths as a result of reduced tolerance in prison and following release from prison,
- the reduction of illegal and subculture activities,
- the improvement of physical and mental health and
- permanent abstinence.

Similar to the situation outside prison, the patient has to sign a treatment agreement prior to starting treatment, in which the rules are laid out. Among other things, that document sets out in writing when the treatment will be discontinued (for example in the event of repeated problem concomitant use, drug dealing/trafficking or violence in connection with the OST)

and that discontinuation does not necessarily mean permanent exclusion from OST. The decision to cease treatment is made by the medical service; there are no set conditions with respect to recommencement. In North Rhine-Westphalia the general rule is that patients who are already receiving substitution when entering prison will continue to be treated, while the length of the sentence must not have any influence on the indication for treatment. The recommendation is that a place for continued substitution should be guaranteed in cases of substitute treatment on remand and prison sentences of less than two years. A place for further treatment should be assured, at the latest, on release from prison.

An administrative code issued by the Baden-Wuerttemberg Ministry of Justice has regulated substitution in prisons since 2002. It contains clear statements regarding the general aims of OST as well as requirements regarding indication, exclusion, admittance, execution, documentation and termination of substitution treatment. In addition, substitution with diamorphine has also been possible since the revised and amended version of the administrative code came into force on 15 July 2011 (Justizministerium Baden-Württemberg 2011).

The foundation for substitution treatment in prison in Lower Saxony is a decree from 2003[2] (Deutscher Bundestag 2016) which for the most part is based on provisions in the BtMG and the Guidelines on the Evaluation of Doctors' Examination and Treatment Methods (BUB-Richtlinien). The decree sets out the preconditions and stipulates how substitution is to be performed. As with all treatments by doctors, the attending doctor is responsible for the indication for substitution and establishes, by means of an individual examination, whether the substitution treatment is warranted and whether the intended purpose cannot be achieved in any other way. Substitution is provided, on the basis of the principle of equivalence, in line with the stipulations of SGB V and the respective guidelines.

According to the principle of equivalence, the guidelines issued by the German Medical Association (Bundesaertzekammer, BÄK) on the substitution-assisted treatment of opiate addicts, revised in 2010, also apply within prisons (BÄK 2010). The guidelines apply to all doctors who perform this treatment. Under the guidelines, it must be ensured, when patients move to hospital treatment, rehabilitation, imprisonment or another form of inpatient care, that the treatment is provided on a continuous basis. Furthermore, substitution treatment can also be initiated in individual cases, where warranted, in accordance with ICD 10 F11.21 (opiate dependency, abstinent at present, but in a protected environment – such as a hospital, therapeutic community or prison). In the event of consumption of additional psychotropic substances, the underlying cause thereof, such as inadequate dosage or selection of substitution drug or a co-morbid mental or somatic illness, should first be determined and if possible remedied. If this concomitant use jeopardises the substitution treatment, withdrawal of the additional psychotropic substance must be initiated.

[2] Medical and paramedical guidelines and guiding principles in the Lower Saxony prison system; here: medicinal substitution of opiate dependent prisoners, decree of 1 April 2013 - 4558 - 303.2.13.

Training of prison guards

In comparison to other occupational groups, prison guards are confronted with persons who use drugs to a greater extent. Hence that profession is predestined to receive special training on dealing with, and risk awareness in connection with, drug users. The ministries of justice have reacted to this with corresponding programmes of education and further training.

The handbook "Harm reduction in prisons" ("Schadensminimierung im Justizvollzug"), issued by the Scientific Institute of the German Medical Association (Wissenschaftliches Institut der Aerzte Deutschlands, WIAD) and the result of a project funded by the European Commission, serves to provide further training of staff working in prisons (Wiegand et al. 2011). The handbook provides information on how the negative impact of certain types of behaviour can be reduced, such as the transmission of infectious diseases during injecting (i.v.) drug use through the sharing of syringes or needles. These concepts play a role primarily in correctional institutions, as those places deal with the preservation of the human rights of prisoners, the protection of public health and not least the proven cost effectiveness of preventive measures compared to the costs of treatment, for example after an infection has been contracted. The handbook provides information on the topic of infectious diseases and their different routes of transmission as well as on drug use and related risk behaviour. Among other things, prison guards should be sensitised to the special challenges of drug consumption. Moreover, attitudes and understanding of prison guards surrounding drug use and drug users should be explored.

Baden-Württemberg reported that in 2010, 17 facilities provided counselling for staff in the penal system (Reber 2011). In addition, training of this target group in how to cope with drug-related emergencies was carried out in some Berlin prisons (DAH 2010). In that training, both appropriate behaviour in the event of drug-related emergencies as well as special risks, such as the use of drugs following abstinence, are addressed. The administration of naloxone, an opiate antagonist, also plays a role in this context.

2 Trends (T2)

Not applicable for this workbook.

3 New developments (T3)

3.1 New developments in drug-related issues in prisons (T3.1)

Data collection on ICD-10 diagnoses in German detention facilities

As a result of a lack of meaningful information on drug use in German detention facilities, representatives of the 115th conference of the *Laender* prison committee initiated uniform data collection, the aim of which was retrospectively to disagnose and record inmates from all 16 *Laender* on the basis of ICD-10 for their past drug use (in total 64,397 prisoners, as at 31 March 2016) and from that point forward to do so on a continuous basis. The second date for collection of data was 31 March 2017. In most *Laender*, the majority of prisoners was

included in the survey, total coverage could not be achieved, however. Accordingly, the *Land* representatives decided, at the 125th meeting of the *Laender* prison committee in May 2017, to conduct the data collection for a further two years in all *Laender*, to take into account the problems which have so far arisen in the implementation and where possible to remedy them. Data from a satisfactory, Germany-wide, key date and trend statistics is therefore still pending and expected next year (Abraham 2017).

The parole process and reintegration of offending addicts

The Regional Authority of Westfalen-Lippe (Landschaftsverband Westfalen-Lippe, LWL) carried out a study on the effectiveness of treatment of addicted offenders under a hospital treatment order, in order to draw conclusions on the course of renewed offending and addictive substance use after release from detention (Dimmek et al. 2010). In a retrospective catamnesis, 160 patients were surveyed three years after their release. The sample analysed showed significant biographical risk characteristics such as earlier first use (43% used cannabis before they were 16 years old), a lack of end-of-school or occupational qualifications (35% and 63%) and violence in the family setting (40%). The reasons for being sent to prison institutions amongst addicted patients were mainly robbery (37.7%) and violations of the BtMG (32.1%). 42.4% of delinquents reoffended within the period studied, mainly with property or road traffic offences or violations of the BtMG.

4 Additional information (T4)

4.1 Additional sources of information (T.4.1)

No additional sources of information are available on this.

4.2 Further aspects (T.4.2)

No additional sources of information are available on this.

5 Sources and methodology (T5)

5.1 Sources (T5.1)

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5.2 Methodology (T5.2)

Prison statistics of the German Federal Statistical Office (Destatis)

The statistical report covers all inmates of penal institutions involved in the execution of imprisonment, juvenile sentencing and preventive custody (institutional level) as well as prisoners and people in preventative custody annually on 31 March. The statistical report on the penal system is a complete survey; for this reason no sampling approach has been used.

It was introduced in the early 1960s, with comprehensive results available for the former federal territory from 1965, and from 1992 for Germany as a whole. The processing and publishing of the statistics is carried out annually. Since 1965, the Federal Statistical Office has published the results in a comparable format.

Generally, the findings in the statistical report on the penal system are of a good to very good quality. Firstly, the information for the statistical report is obtained from data which has been collected for administrative and control purposes. Secondly, the statistics data in the *Laender* is subject to automatic routine assessment; the statistics are extensively internally checked for plausibility and compared to external data. Any inconsistencies in the data are clarified through enquiries to the reporting units at the *Laender* statistics offices. However, individual missing or false information in the statistics data cannot be ruled out.

The survey characteristics and guidelines as well as the processing procedures are uniform in all *Laender*. Thus, it is possible to compare data across regions. All findings on the reference date from the statistical report on the penal system contain an inherent methodological distortion: Those with short term sentences are underrepresented compared to long-term detainees. The shorter the custodial or juvenile sentence is, the lower is the probability of being included in the annual census carried out only once a year. This factor has an influence on the results as in the majority of cases the structural data (e.g. age group, type of offence, number of previous convictions) could be different for short-term prisoners than long-term detainees (Destatis 2017)

Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS)

The DSHS is a national documenting and monitoring system in the area of addiction support in Germany. As a documentation system, the DSHS has the task, for all data which is documented in all of the institutions which participate in the DSHS, of collating, archiving, analysing with respect to the core results, identifying important changes in the area of addiction support as well as in the treated population or the treatment itself and of publishing them in an appropriate format.[3]

The core data set (Kerndatensatz, KDS) of the DSHS provides the basis for the uniform documentation in outpatient and inpatient institutions, in which persons with substance related disorders as well as non substance-related forms of addiction in Germany are counselled, cared for and treated.

By default, a facility-related missing quota (= proportion of missing information within the overall information in the respective table) of 33% or less is required for all tables with single choice questions in order for them to be included in the overall evaluation. Facilities with a missing quota of more than 33% in such a table are not taken into account when the data is collated, in order to prevent the overall data quality being disproportionally impacted by few facilities with a high missing quota. Although this inevitably leads to a reduction of the facility sample (N) for the respective table, this can be accepted in the interpretation of the results due to the higher validity of the included data.

6 Tables

[3] www.suchthilfestatistik.de/ [accessed 1 Aug. 2017]