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Gabriele Bartsch, German Centre for Addiction Issues (DHS)

Maria Friedrich, Federal Centre for Health Education (BZgA)

Franziska Schneider, Esther Dammer & Tim Pfeiffer-Gerschel,
IFT Institute for Therapy Research

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0 SUMMARY

The treatment system for people with drug-related problems and their relatives in Germany ranges from counselling, acute treatment and rehabilitation to measures for participation in the workplace and society. Addiction support and addiction policy follow an integrative approach, i.e. in most addiction support facilities users of both legal and illegal addictive substances are offered counselling and treatment. The treatment services for drug dependent persons and their relatives are person-centred. Thus the treatment processes, within the framework of complex cooperations, vary widely. The overarching objective of the funding agencies and service providers is participation in society and employment. Due to Germany's federal structure, the planning and governance of counselling and treatment is carried out at *Land*, region and municipality levels.

Due to the change to the core data set (Kerndatensatz, KDS) of the Statistical Report on Substance Abuse Treatment in Germany (Deutschen Suchthilfestatistik, DSHS), the current data cannot be used in this year's reporting cycle. Data on outpatient and inpatient clients will be available again from the next reporting year.

Since 2002, when reporting became obligatory, the number of substitution patients reported continuously increased until 2010. In recent years the number has remained largely stable. On the reporting date (1 July 2017), the number was 78,800. A total of 2,599 doctors providing substitution treatment reported opioid addicts to the substitution register in 2017.

The percentage proportion of older drug addicts treated and cared for in addiction support institutions has continued to increase in recent years and thus continues the trend seen in a special analysis by the DSHS¹ in 2009.

Data on gender specific treatment as well as on the treatment of children and adolescents is not systematically prepared or evaluable. However, it should be noted that there are specific services for these target groups in many cities and they are part of the permanent repertoire of outpatient and inpatient addiction support.

After cannabis, new psychoactive substances (NPS) are the most widely consumed illicit drugs. There are no indications of regional differences in this respect. Prevalence rates for methamphetamine are significantly lower than for NPS. However, for methamphetamine there are wide regional differences in prevalence. The highest lifetime prevalence rates of use are in Saxony and Thuringia. New data with respect to the treatment of NPS and methamphetamine addicts is not available. Treatment capacity has been expanded in *Laender* which are particularly affected. The support system has reacted to the challenges of the current migration situation and created new services for refugees. Nevertheless, there continue to be numerous barriers which prevent migrants from making use of addiction support.

With the German Act Amending Narcotics and Other Provisions (Gesetz zur Änderung betäubungsmittelrechtlicher und anderer Vorschriften), which came into force on 10 March 2017, the possibility of prescribing cannabis-based pharmaceuticals was expanded. Just two major health insurance providers (Allgemeine Ortskrankenkassen – AOK and Techniker Krankenkasse – TK) have received 13,000 applications to assume costs for cannabis treatment in the first ten months since the

¹ The DSHS is a national documentation and monitoring system in the area of addiction support in Germany. The documented data is based on the KDS. The KDS is a data gathering tool specifically for addiction support, which is widely used in both outpatient and inpatient addiction support.

Act came into force.

Prescribing medications containing opioids to patients with chronic, non-tumour related pain has significantly increased in recent years.

1 NATIONAL PROFILE

1.1 Policies and coordination

1.1.1 Main treatment priorities in the national drug strategy

The drug strategy published in 2012 remains valid for Germany (Die Drogenbeauftragte der Bundesregierung, 2012; Piontek et al., 2017; Bartsch et al., 2017). It places a particular focus on addiction prevention and early intervention, however also stresses the need for counselling and treatment services. The German Federal Ministry of Health (Bundesministerium für Gesundheit, BMG) can, in the scope of its competences, set specific emphasis in the area of treatment, i.a. through promoting projects and research contracts, as it did in 2017 (c.f. section 1.4.5 and 1.4.6).

The Commissioner's focus in relation to treatment continues to be amphetamine, in particular crystal meth, NPS and cannabis. Alongside alcohol, which represents the dominant problem in Germany, they account for the largest and most challenging problem.

The Third Amending Ordinance of the German Ordinance on the Prescription of Narcotic Drugs (Dritte Verordnung zur Änderung der Betäubungsmittelverschreibungsverordnung, 3rd BtMVVÄndV) (BMG, 2017) passed in 2017 regulates the statutory requirements for implementing substitution treatment for opioid addicts. It has a great importance in terms of improving and securing substitution in medical practice. The development of evidence-based guidelines to implement substitution therapy was transferred to the German Medical Association (Bundesärztekammer, BÄK) guideline setting competence. The new guidelines have been in use since 2 October 2017 (c.f. Dammer et al., 2017). Above all, they represent an adjustment to new scientific evidence and thus guarantee treatment quality

1.1.2 Governance and coordination of drug treatment implementation

The care system for people with drug-related problems and their relatives involves a number of very different entities. Planning and governance of treatment in the various segments of the medical and/or social support system at a national level would not be compatible with the federal structure of Germany. Instead, governance and coordination occurs at *Laender*, regional or municipal level. They are jointly agreed upon by the funding agencies, the service providers and other regional steering committees on the basis of the legal provisions as well as the demand and economic possibilities.

The federal ministries, in particular the BMG, fulfil a cross-departmental and cross-institutional coordinating role at a federal level. They prepare and amend federal laws (e.g. narcotics law and social welfare legislation, which also affects treatment).

Health insurance providers and pension insurance providers in Germany play an important role in the governance and coordination of the acute treatment and rehabilitation of addiction disorders. They determine the essential framework conditions and rehabilitation therapy standards. In this respect, they consult, in regular meetings and working groups, with the associations of addiction professionals. The coordination body for charitable organisations working in addiction support is the German Centre for Addiction Issues e.V. (Deutsche Hauptstelle für Suchtfragen, DHS). Privately funded addiction rehabilitation clinics are collectively organised within the Association of Addiction Professionals (Fachverband Sucht e.V., FVS). In addition, they cooperate with other entities involved, such as job centres. Health insurance providers and pension insurance providers are also responsible for assuming the costs of treatment. The health insurance providers are responsible for financing of acute

treatment (i.a. detoxification), pension insurance providers primarily for financing rehabilitation.

The municipalities are involved in the governance of acute treatment within the scope of hospital planning. Furthermore, they support the funding of addiction counselling facilities, which as a rule are provided by non-profit organisations contributing high levels of their own resources. The BÄK plays a leading role in substitution treatment – a service provided by the statutory health insurance providers. They have been responsible for processing and updating the guidelines for substitution-supported treatment in the scope of the German Ordinance on the Prescription of Narcotic Drugs (Betäubungsmittelverschreibungsverordnung, BtMVV). The standards for needs based psychosocial care (PSC), provided as a complement to substitution treatment, are set out by the responsible service providers in the *Laender*, in consultation with the municipalities or *Laender*. The funding for PSC is dealt with in varying ways by the *Laender*, however funding usually comes from the municipalities, either as a general support for counselling facilities in the scope of the municipal services of general interest or as individual support in the scope of integration support (German Code of Social Law, Sozialgesetzbuch, Volume 12 (SGB XII)).

1.1.3 Further aspects of drug treatment governance

No new information is available on this.

1.2 Organisation and provision of drug treatment

The legal basis for the treatment of those with dependency disorders is provided in Germany by various German Codes of Social Law (Sozialgesetzbücher, SGB), the German Public Health Service Act (Gesetz über den öffentlichen Gesundheitsdienst, ÖGDG), as well as the municipal services of general interest. The latter is anchored in constitutional law in the Social State Principle (Sozialstaatsprinzip) as per Art. 20 (1) German Constitution (Bürkle & Harter, 2011, described in detail in Bartsch et al., 2017). Dependent persons can use this support for the most part free of charge, however in some cases approval for costs is required from the social funding agencies defined in the German social laws.

In 2017, the revised German core data set² (KDS 3.0), which is used for documentation purposes by addiction support facilities, was used for the first time. Types of institution were grouped into new categories, such as outpatient counselling and treatment centres, low-threshold facilities, and specialist and outpatient facilities within institutions in the new category "outpatient facilities". Due to the new method of documentation, the 2017 treatment data is only comparable to a limited extent to data from previous years, and does not correspond to standard table 24 (ST 24), which was completed in 2017 according to the categories valid at that time (c.f. Table 1).

Family doctors play a special role in addiction treatment as they are often the first point of contact for addicts and at-risk persons. However, no systematically evaluated data is available on their addiction treatments. The core of the addiction support system is provided by (in addition to family doctors) the approximately 1,660 addiction counselling and treatment centres, low-threshold facilities and outpatient facilities within institutions. Furthermore, treatment and care are provided in 388 inpatient therapy facilities (rehabilitation), and 1,036 sociotherapy facilities (IFT, 2017). The 409 specialist

² The KDS is a data gathering tool specific to addiction support, which is widely used in both outpatient and inpatient addiction support.

psychiatric departments (94 of which are exclusively for the treatment of addiction disorders) with a total of 4,367 beds for addicts (Destatis, 2017) play a key role: they are not only responsible for detoxification, but also for crisis intervention and treating psychiatric comorbidities.

The majority of outpatient addiction support facilities (89 %) are funded by independent, charitable bodies, in particular the Freie Wohlfahrtspflege. In inpatient treatment, independent charitable institutions provide 56 % of the support facilities. In addition, public and private entities are also active in outpatient (8 % and 2 % respectively) and inpatient (14 % and 29 % respectively) addiction treatment. The proportion of other involved parties is small. They make up 1 % of outpatient and 2 % of inpatient facilities (Specht et al., 2018).

The heavily differentiated and compartmentalised support system enables the provision of especially person-centred counselling and treatment. The large number of responsible entities and funding agencies does make cooperation between the various facilities, authorities and facilities involved in treatments difficult, however.

Many addiction support agencies, above all in the larger cities, provide a variety of services for drug addicts, from low-threshold services, to counselling and treatment, psychosocial care of substituting patients and up to rehabilitation, residential and employment projects. There is currently no systematic data collection on the degree of geographical coverage or the reach of the range of services on offer from the various addiction support services. However, the addiction support facilities do state, in their annual reports in the scope of the DSHS, that they cooperate with other facilities and institutions (not only within their own agency network). The cooperation and networking encompasses both written agreements to share workloads and client-related case conferences. Approximately 40 to 60 % of outpatient facilities report that they have binding cooperations with "medical and psychotherapeutic practices", "counselling centres and specialist walk-in clinics" and "assisted living" and "employment agencies and job centres" (DSHS, 2017).

1.2.1 Outpatient drug treatment system – main providers and client utilisation

Counselling and treatment centres and specialist walk-in clinics, low-threshold facilities and outpatient facilities within institutions have been grouped together in one category in the KDS 3.0 since 2017. The data for this year is therefore not comparable with that of previous years. It remains the case, however, that outpatient addiction support facilities make up the largest proportion of counselling, promotion of motivation and outpatient treatment (1,667 facilities). They are the first port of call for clients with addiction problems, to the extent that they are not treated by the family doctor. As with low-threshold support services, they are, in part, funded from public resources. However, a relevant portion of the costs of the outpatient facilities is borne by the providers themselves. With the exception of outpatient medical rehabilitation, outpatient addiction support is, in varying degrees, funded by voluntarily contributions from the *Laender* and municipalities 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). The fact that the funding of outpatient services is only partially guaranteed under the law, leads time and again to financing problems. Generally counselling is carried out free of charge.

Outpatient substitution treatment is as a rule carried out in medical practices. They are an important factor in the treatment of opioid addicts. Doctors perform the medical treatment, including dispensing substitute drugs. The medical treatment is usually accompanied by a psychosocial care which is delivered by counselling and treatment centre providers in close cooperation with the medical

practices, in some cases under the same roof.

Socio-psychiatric services and community psychiatric centres are responsible for addicts, among many other things. They are generally publicly financed. In some *Laender*, these facilities are funded by charities.

Table 1 Network of outpatient addiction support*

Type of facility designation as per EMCDDA	Total number of units	Type of facility National definition	Number of persons treated
Specialised drug treatment centres	1,667	Outpatient facilities (includes: – specialised counselling and treatment centres: 1,500 – Low-threshold facilities 268 – outpatient facilities within institutions: 84 (data from reporting year 2016) (c.f. Bartsch et al., 2017)	Approx. 600,000 – >500,000 – No information – 91,800 (c.f. Bartsch, 2017)
Low-threshold agencies	No information	Low-threshold facilities	No information
General primary healthcare (e.g. GPs)	>2,600	Medical practice / psychotherapeutic practice (mainly outpatient substitution treatment)	>78,800
General mental healthcare	No information	Socio-psychiatric services (Sozialpsychiatrische Dienste, SpDi) / Community psychiatric services	No information
Prisons (in-reach or transferred)	69	Prison facilities (internal and external)	No information

* The KDS was revised in 2017 and the data collection thus changed. The new KDS 3.0 categorises different types of outpatient facility together, which means that only the aggregated data can be reported. Current numbers regarding specialised treatment centres, low-threshold facilities, outpatient facilities within institutions and whole-day outpatient sociotherapy facilities, outpatient assisted living and employment projects are not currently available. For orientation purposes, the respective specialised numbers for 2016 are added in parentheses.

(IFT, 2017; BOPST (Bundesopiumstelle), 2018; Netzwerk Sozialpsychiatrischer Dienste, 2018)

1.2.2 Further aspects on the availability of outpatient drug treatment provision

With regard to the availability and provision of individual treatment and support services, there are differences to be found between the *Laender*. In rural regions especially, there are difficulties in providing region-wide care to patients (e.g. those who wish to receive substitution treatment). Due to the high methamphetamine use in some *Laender* (e. g. in Saxony), the counselling and treatment competence and capacities in relation to (meth) amphetamine has been well-developed (Sächsische

Landesstelle für Suchtfragen e.V., 2018). Answering a "major interpellation from the parliamentary group Bündnis 90/Die Grünen, Printed Paper 6/11188", the Saxon State Ministry for Social Affairs and Consumer Protection confirmed the strengthening of measures for crystal meth-specific addiction support and corresponding residential projects, in order to meet the increased demand for counselling and care (Sächsisches Staatsministerium für Soziales und Verbraucherschutz, 10 Jan. 2018).

All in all, the situation with regard to outpatient counselling and treatment centres has not changed significantly in recent years. However, municipal financing is decreasing in some communities, while at the same time the profile of requirements has expanded. Referrals from addiction counselling and treatment centres continue to make up the largest share of all referrals into medical rehabilitation.

A new study from the Robert Koch Institute (RKI, 2018)³ investigates the treatment of infectious diseases among prison inmates. In Germany, systematic screening for infectious diseases among inmates is not carried out nationwide. Testing strategies for HIV and HCV differ between *Laender* and in some cases between correctional institutions, ranging from a compulsory test on admission to prison, to the offer of a test only on prisoner request or when clinical symptoms present. Screening for TB is also heterogeneous, from systematic chest X-ray screening for everyone in prison in Berlin, to diagnostic screening only when symptoms present, which is the case in most *Laender*.

The goal of the investigation was firstly to estimate the availability and type of medication for the treatment of the specified illnesses among prisoners in Germany, and secondly to estimate the proportion of treated persons among prisoners per *Land* and for the entire study population in the study period, January 2012 to March 2013.

During this period, 67,607 people were detained in 186 prisons in Germany. The study did not evaluate any patient-related data, rather only a secondary analysis of pharmacy sales data was carried out for the medication to treat opioid dependence, TB, HIV and HCV in prisons and prison hospitals in selected *federal states* between January 2012 and March 2013.

The "Defined Daily Dose (DDD) Concept" formed the basis for the secondary data analysis. Substances typically used for the treatment of the illnesses were defined as marker substances for the respective illness. DDDs of the marker substances were used in order to calculate the number of persons treated per day. The DDD was established on the basis of current national treatment guidelines, specialist information and literature research.

During the study period, the 11 participating *Laender*, with their 34,191 inmates in 97 prisons, accounted for almost half of all persons imprisoned in Germany. Overall, 41 % of correctional institutions included in the study were supplied with medication against TB, 71 % were supplied with HIV medication and 58 % with HCV medication. In addition, 58 % of participating prisons received medication for opioid substitution treatment (OST).

The medical treatment of the illnesses studied took place in the study period in the prisons of the participating *Laender*. However, there were in some cases large differences in the extent of treatment, in particular for OST, as well as for HCV therapy.

The wide spread in the prevalence of treatment for OST (0 % in Saarland to 7.9 % in Bremen) suggests very different approaches to treatment possibilities. The northern *Laender* in particular showed high OST rates, which underlines their liberal and harm reduction-oriented policy, whereas in

³ All the data and information which follows in this section is based on the cited RKI study.

Saarland, Bavaria and the eastern *Laender*, OST substances were only supplied to very few prisons. The absence of or low prevalence of treatment in Saarland and Bavaria points to an approach based purely on withdrawal-based treatment rather than substitution and a policy strongly oriented towards abstinence in those prison systems.

The overall OST prevalence of 2.18 % in the study corresponds roughly to the OST treatment prevalence found in other studies for the prison setting (Schulte et al., 2009; Reimer, 2009). Injecting drug use, mostly opioid use, is present in 22 - 30 % of inmates, however, i.e. only around 10 % of these receive adequate substitution; in some *Laender* the figure is much lower. OST is, especially in combination with other strategies for harm reduction, an evidence-based measure for HIV and HCV prevention. OST is well suited to the regulated prison environment with supervised use, regularity of admission and structured daily life. In addition, substitution patients often show higher compliance rates in relation to antiviral and antiretroviral treatment.

The study's authors come to the conclusion that the treatment of chronic infections and OST among inmates seems to be dependent on structural and individual factors, e. g. the structure of healthcare in the respective correctional institution, but also the political attitude towards drug use as well as the allocation of the budget for medical treatment in the respective prison and *Land*. The differences reflect the decentralised, federal system in Germany, in which the *Laender* follow different approaches in relation to the management of medical care (c.f. this year's Prison workbook; Schneider et al., 2018).

1.2.3 Further aspects of outpatient drug treatment provision and utilisation

For additional, current information on the availability and utilisation of outpatient drug treatment services, see section 1.4.5, targeted interventions.

1.2.4 Ownership of inpatient drug treatment facilities

The specialist psychiatric clinics and the addiction psychiatric departments of general hospitals and university clinics play a role in addict care which is often underestimated by the public. Every year, they carry out over 110,000 addiction treatments in total which are not related to alcohol or tobacco dependence. These include detoxification, qualified withdrawal, crisis intervention and comorbidity treatment. The costs for these treatments are generally borne by the statutory (where applicable also by private) health insurance providers or must be paid by the patients themselves.

Inpatient treatment also includes inpatient rehabilitation (withdrawal). The costs of withdrawal treatment are primarily borne by the statutory pension insurance providers, for young people by child and youth support. Health insurance providers have a subordinate responsible.

In addition to acute psychiatric treatment and medical rehabilitation, there are also services in the sociotherapeutic area, which are aimed at patients suffering from chronic multiple issues, frequently patients with psychiatric comorbidity (c.f. section 4.3). The costs of these treatments are generally borne by the social welfare offices of the municipalities, on the basis of SGB XII.

Table 2 Network of inpatient addiction support (number of facilities and people treated)⁴

Type of facility EMCDDA term	Total number of units	Type of facility National definition	Number of persons treated
Hospital-based residential drug treatment	344*	Specialised psychiatric hospitals / specialist departments	110,000***
Residential drug treatment (non-hospital based)	388*	Inpatient rehabilitation facilities***	19,788***
Therapeutic communities	No information	No information	No information
Prisons	Approx. 47**	Secure psychiatric units	No information
Sociotherapeutic drug treatments	1,036**	Sociotherapeutic facilities	No information

(*Destatis, 2017; **IFT, 2017; *** DRV, 2017; Nauman & Bonn, 2018)

1.2.5 Further aspects of inpatient drug treatment provision and utilisation

Approximately 10 % of facilities which provide inpatient rehabilitation, have developed concepts to offer rehabilitation also to patients in substitution treatment. The requirements for this were created in Annex 4 of the Agreement on Addiction Disorders (between health insurance providers and pension insurance providers) (Vereinbarung Abhängigkeitserkrankungen) (Kuhlmann, 2015; Spitzenverbände der Krankenkassen and VDR, 2001).

1.2.6 Further aspects of inpatient drug treatment provision

Although demand for inpatient treatment remain high, the number of applications for rehabilitation treatments decreased further in 2016. In addition, the level of no-shows for withdrawal treatment increases the economic pressure on many inpatient facilities. It remains to be seen whether the simplification in 2016 of access to qualified withdrawal in rehabilitation will improve the situation. In central Germany (Saxony, Saxony-Anhalt, Thuringia), they have had positive experience with this (Ueberschär et al., 2017; see also Bartsch et al., 2017).

1.2.7 Ownership of outpatient drug treatment facilities

Outpatient counselling and treatment are predominantly run by charities in Germany. A smaller proportion is however in public ownership, mostly municipal facilities. Outpatient substitution treatment is generally carried out by doctors' practices, which are privately operated. The public health service is involved in the care of addicts through socio-psychiatric services and community psychiatric centres. They often care for patients with a psychiatric disorder as well as an addiction disorder. Data is not

⁴ The KDS was revised in 2017 and the data collection thus changed. The new KDS 3.0 groups different types of inpatient facility together (day care/whole-day, inpatient rehabilitation, transition), which means that only the aggregated data can be reported. The same applies in relation to sociotherapeutic facilities. Day care, whole-day outpatient and inpatient facilities are grouped into the same category. The data therefore cannot be compared with that of previous years.

collected nationally, but only at *Land* level, and where applicable even only at municipality level. Therefore, detailed statements on the number of services and cases is not possible.

Table 3 Proportion of types of ownership in outpatient treatment in percent (%)

	Public ownership	Charitable ownership	Private ownership	Other
Outpatient facilities (includes specialised counselling and treatment centres, low-threshold facilities, outpatient facilities within institutions)	8 %	89 %	2 %	1 %
Low-threshold facilities	No information	No information	No information	No information
Medical / psychotherapeutic practice (mainly outpatient substitution treatment*)	Minority	–	Majority	–
Socio-psychiatric services (Sozialpsychiatrische Dienste, SpDi) / Community psychiatric services)**	80 - 100 % depending on <i>Land</i> *	0 - 20 % depending on <i>Land</i> *	–	–
Prison facilities	No information	No information	No information	No information

* Substitution treatment in Germany is for the most part carried out in doctors' practices and outpatient substitution clinics, which are private businesses and SHI approved. The minority are under municipal, public ownership.

** Generally it can be assumed that every district (294) and every independent city (107) in Germany has socio-psychiatric services or a community psychiatric centre. In southern Germany in particular, the services are organised by charities. They often divide the region up, which means that several different socio-psychiatric services are present within an independent city or district. In total there are 478 socio-psychiatric services and community psychiatric centres.

(IFT, 2017; Netzwerk Sozialpsychiatrischer Dienste, 2018)

Complete information is also not available for inpatient treatment. Although facilities for day care sociotherapy are mainly charity run organisations, private ownership makes up a significant proportion of inpatient rehabilitation (c.f. Table 4).

Table 4 Proportion of types of ownership in inpatient treatment in percent (%)

	Public ownership	Charitable ownership	Private ownership	Other
Specialised psychiatric hospitals / specialist departments	No information	No information	No information	No information
Inpatient rehabilitation facilities	14	56	29	2
Therapeutic communities	No information	No information	No information	No information
Secure psychiatric units	No information	No information	No information	No information
Sociotherapy facilities (inpatient and day care)	Close to 0	81	4	15

(Specht et al., 2018; IFT, 2017)

1.3 Key data

1.3.1 Summary table of key treatment related data and proportion of treatment demands by primary drug

Outpatient Treatment

No new representative nationwide treatment data is available.

Inpatient treatment

For inpatient treatment there is currently only representative data from the German Statutory Pension Insurance Scheme (Deutsche Rentenversicherung, DRV, 2018) and German Hospital Statistics (Deutsche Krankenhausstatistik) (Destatis, 2017a).

Table 5 Patients treated on an inpatient basis following main diagnosis

	DRV Reporting year 2017			Destatis Reporting year 2016		
	Men	Women	Total	Men	Women	Total
F10 Alcohol	15,395	5,636	21,031	234,785	87,820	322,605
F11 Opioids	1,336	344	1,680			34,977
F12 Cannabinoids	2,119	430	2,459			17,495
F13 Sedatives / hypnotics	101	146	247			10,166
F14 Cocaine	517	56	573			3,247
F15 Stimulants	1,189	398	1,587			9,695
F16 Hallucinogens	8	2	10			724
F17 Tobacco	41	8	49			177
F18 Volatile substances	3	6	9			131
F19 Multiple substance use	2,275	436	2,711			33,810
Total addiction	22,984	7,462	30,446			433,030
F11-16, F18-19 Drugs total	7,548	1,818	9,366			110,248

(DRV, 2018; Destatis, 2017a)

1.3.2 Distribution of primary drug in the total population in treatment

Due to the limited data available, the percentage distribution of different substance dependencies in the population cannot be presented.

1.3.3 Further methodological comments on the key treatment-related data

No additional information is available on this.

1.3.4 Characteristics of clients in treatment

Outpatient Treatment

In an explorative study, Schneider (2016) investigated the patterns of use and negative impacts of 194 cannabis users who were being cared for or treated in outpatient counselling facilities. The focus was on the question of what characterised the "typical", highly impacted, cannabis client. The results support the assumption that cannabis users who seek out a counselling facility exhibit intensive patterns of use and suffer from many varied problems. In addition to addiction specific problems, there is a great need for social and legal support. Almost half of these users have already come to the attention of judicial authorities. The multi-layered need for counselling was also apparent from the type of counselling requested: the most frequent counselling objective was stated as "support in social and

legal matters". The absolute majority report having already experienced manifest effects of use. Symptoms such as panic and persecutory delusion are also often experienced. These symptoms correlate strongly with the negative effects in the social environment. In this context, there are differences with respect to age and use habits between "urban" and "rural" areas.

Inpatient treatment

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 in just a few pages in the form of brief reports. Of note here is the report on clients / patients from different living situations in outpatient and inpatient addiction treatment (Künzel et al., 2014). In that report, client / patient groups with different living situations prior to starting support / treatment, were observed in respect of their characteristics prior to the start of, during, and at the end of the support / treatment.

The DRV provides a comprehensive statistical report of their medical rehabilitation services, the type, duration and results of the service as well as an overview of the income and expenses and the number of beds in their own facilities.

In total, 9,366 people (7,548 men, 1,818 women) who have utilised the services of the statutory pension insurance providers received the diagnosis "mental and behavioural disorders due to medicinal drugs / illicit drugs". Of those, 914 were foreign nationals. On average, 93 days of care were utilised. The average age at the end of the treatment was 34.1 years old and is the lowest age in comparison to other rehabilitation services used (for the purposes of comparison, alcohol rehabilitation: 46.6 years old) (DRV, 2018).

1.3.5 Further top level treatment-related statistics

- DSHS, 2016
- Statistical Report on Rehabilitation from the DRV 2016
- Statistical Report on Hospital Diagnoses, 2016 and 2017
- Regional monitoring systems, such as BADO in Hamburg (Martens & Neumann-Runde, 2016)

Information on prevalence of use can be found in the Drugs workbook.

1.4 Treatment modalities

1.4.1 Outpatient drug treatment services

Counselling and / or treatment facilities, specialist walk-in clinics

The central task of these facilities is the counselling and treatment of persons with dependency disorders. The specialists encourage affected persons to accept help, they create support plans and refer patients into further services (social, occupational, medical rehabilitation). Addiction support and treatment facilities as well as specialist walk-in clinics often also deliver psychosocial support for substitution patients, support self-help projects and are specialist facilities for prevention. The legal basis are the municipal services of general interest according to Art. 20 (1) German Constitution.

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

Low-threshold facilities are a service which help patients into the support system. In addition to contact

and conversation services, they offer further support such as medical and hygienic basic care, street work, infection prophylaxis or legal advice. There are also consumption rooms in several major cities. The services are financed through voluntary public services and projects planned by the municipalities and also in part by the *Laender*. Further information can be found in the 2018 Harms and Harm Reduction workbook.

Practice-based doctors

Practice based doctors are frequently the first point of contact for people with an addiction problem. It is their task, in the scope of the diagnosis and treatment process, to raise the subject of a drug abuse or dependency problem and its consequences. They should encourage patients to use suitable support services and refer them to counselling centres. Across Germany, there are approx. 154,000 practice-based doctors (BÄK 2017) who have around 20 % patients with addiction disorders. The legal basis of this is SGB V. The outpatient medical treatment is planned by the associations of SHI-accredited doctors. Information on substitution can be found in sections 1.4.7 to 1.4.10.

Table 6 Availability of key interventions in outpatient drug facilities

	Specialised counselling and treatment centres	Low-threshold facilities	Medical practice / psychotherapeutic practice	Socio-psychiatric services (Sozialpsychiatrische Dienste, SpDi) / Community psychiatric centres
Psychosocial counselling and treatment	Always available	Counselling, on request; no treatment	No psychosocial counselling	Psychosocial counselling always available, treatment in community psychiatric centres
Screening and treatment for psychological disorders	Screening only, no treatment	Normally not available	Treatment by specialist doctors / psychotherapists	Treatment in psychiatric centres
Case management (CM)	Normally available	CM partially available (only counselling)	No information	Normally available
Substitution treatment	Partially available	Not available	Partially available with practice-based doctors (not in psychotherapeutic practices)	Normally not available
Other treatments	–	–	–	–

Estimates on the basis of expert opinion of the DHS.

External services for counselling / treatment in prisons

Correctional institutions cooperate on a regional level with outpatient addiction support facilities. External social workers advise and refer to therapy where applicable, according to Sec. 35 German Narcotic Drugs Act (Betäubungsmittelgesetz, BtMG) (suspending prosecution upon admission into therapy). In some prisons, substitution treatment is possible (see also section 1.2.2).

External addiction counsellors also play an important role before and after release, e.g. for referral into suitable residential and care facilities. The advisors are not part of the staff or the correctional institution and are thus bound by confidentiality obligations.

Psychiatric outpatient facilities within institutions

Outpatient facilities within institutions are generally located in psychiatric hospitals and sometimes also in psychiatric departments of general hospitals. They are characterised by the multi-professional composition of their team of staff. Their legal basis is SGB V while the service is planned by the health insurance providers and hospital operators.

Socio-psychiatric services

The municipalities also provide community psychiatric centres or socio-psychiatric services, on the basis of the ÖGDG, which are also responsible for persons suffering from dependence. They frequently care for chronically alcohol-dependent people, or those dependent on other psychotropic substances with psychiatric comorbidities. They counsel patients and refer them to suitable treatment or long-term care, such as specific residential accommodation.

Outpatient medical rehabilitation

Services in a variety of facilities are available to provide rehabilitation treatment in an outpatient rehabilitative setting: counselling and treatment facilities, specialist walk-in clinics, whole-day outpatient facilities or day clinics. The legal basis is primarily SGB VI as well as subordinately SGB V. The planning and quality assurance is the responsibility of the pension and health insurance providers, with the involvement of the respective service providers.

Outpatient assisted living

Outpatient assisted living enables drug dependent persons who have difficulty coping with everyday life to remain in their own, or shared, accommodation. They receive assistance from outpatient addiction support services, which offer intensive therapy. The costs can, upon request, be borne by the responsible social welfare provider (according to SGB XII).

Employment projects / qualification measures

Jobs and employment projects can provide the basis for a successful integration and stabilisation of the persons suffering from dependence disorders. The legal basis is in SGB II, SGB III, SGB VI and SGB XII. The employment agencies, the DRV, the social welfare providers and the service providers are responsible for the planning.

1.4.2 Further aspects of available outpatient treatment services

Outpatient psychotherapeutic treatment

Psychotherapy can, according to the German Psychotherapy Act (Psychotherapeutengesetz, PsychThG), be performed by practice based, licensed psychological psychotherapists. Specialist doctors for psychiatry and psychotherapy, specialist doctors for psychotherapeutic medicine and doctors with the additional designation "psychotherapy" are also qualified to carry out such treatment. Overall, there are 28,631 psychotherapists and 6,737 specialist doctors involved in the outpatient care of children, adolescents and adults with psychological disorders. Of the psychotherapists, 6,084 are medical psychotherapists and 22,547 are psychological psychotherapists (DGPPN, 2017). Data from the German Federal Health Monitoring reports (Gesundheitsberichtserstattung, GBE) reveals even higher numbers. According to that data, there are 32,309 psychological psychotherapists and child and youth therapists working in outpatient facilities. The number of therapists has continually increased since 2009⁵. The legal basis is SGB V. Planning is undertaken by the chambers of psychotherapists. It is not known how large the proportion of psychotherapists who treat addicts is.

1.4.3 Availability of core interventions in inpatient drug treatment services

Detoxification

Detoxification takes place as a rule in specialist psychiatric departments. If such departments are not available, detoxification treatments are also carried out in hospital internal medicine departments. Where a patient is being treated for other somatic disorders on an inpatient basis, detoxification can take place in the corresponding department. The legal basis is SGB V. The *Laender* and municipalities as well as the hospital operators are responsible for planning.

Qualified withdrawal facilities / specialist hospital departments

"Qualified withdrawal" treatment complements detoxification with motivational and psycho-social services and often prepares further rehabilitative measures. Qualified withdrawal treatments take place in special departments of specialist hospitals or special facilities where the psychophysical peculiarities of withdrawal from alcohol and psychotropic substances are taken into account appropriately. The legal basis is SGB V. The *Laender* and municipalities as well as the hospital operators are responsible for planning.

Inpatient facilities for medical rehabilitation

Medical rehabilitation is performed in specialist clinics and includes group therapy, individual therapy, family work in the form of couple and family sessions or seminars as well as non-verbal forms of therapy (design and music therapy). This is complemented by work and occupational therapy, sports and exercise therapy and other indicated treatment services. Social counselling and preparation for the subsequent support services (e.g. "after-care") always form a part of withdrawal treatment. The spectrum of medical rehabilitation services also includes employment related services. Medical rehabilitation has a time limit. The treatment time is set individually for the different forms of treatment.

⁵ http://www.gbe-bund.de/gbe10/pkg_isgbe5.prc_isgbe?p_uid=gast&p_aid=0&p_sprache=D
[Accessed: 26 Nov. 2018].

The legal basis is primarily SGB VI and subordinately SGB V. Planning and quality assurance are provided by the pension insurance providers and statutory health insurance providers. Outpatient and inpatient rehabilitation are, as far as possible, abstinence oriented (Weinbrenner & Köhler, 2015).

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

In the integration and after-care phase, a multi-layered range of services is offered comprising occupational support, residential projects and services for living in the community which are specifically geared to the needs of the addicted persons.

Table 7 Availability of key interventions in inpatient drug facilities

	Specialised psychiatric hospitals/specialist departments	Inpatient rehabilitation facilities	Therapeutic communities	Prison
Psychosocial counselling and treatment	Generally available, if required	Always available	No information	No information
Screening and treatment for psychiatric disorders	Always available	100 % screening, treatment only if possible in the scope of rehabilitation, otherwise transfer to psychiatric clinic or specialist department	No information	No information
Individual case management	No information	Normally available	No information	No information
Substitution treatment	Generally available, if required	Seldom available	No information	No information
Other	–	–	–	–

Estimates on the basis of DHS expert opinion.

Therapeutic communities (TCs)

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

Treatment in prisons

The secure psychiatric facilities are responsible for diagnosing, treating and ensuring the safety of patients detained there. This also applies in respect of drug addicts who have committed serious offences. These are admitted under Sec. 63 (admission to a psychiatric hospital) of the German Criminal Code (Strafgesetzbuch, StGB), Sec. 64 StGB (admission to a withdrawal institution) and Sec. 126a (preliminary admission) German Code of Criminal Procedure (Strafprozessordnung, StPO). Treatment in a forensic clinic represents an alternative to a prison sentence. The treatment objective generally consists of analysing and changing the individual factors relating to the offence for the criminal or the treatment of the underlying disease pivotal to the crimes involved, so that after release no further offences would be expected. Individual and group therapy measures are used as well as psycho-pharmacological treatments, complemented by accompanying ergo and physical therapy services.

Psychiatric clinics

The services available range from detoxification and "qualified" withdrawal treatment to crisis intervention and treatments for addicts with additional mental disorders. The legal basis is SGB V. The *Laender* are responsible for planning.

Transition facilities

Inpatient medical rehabilitation can, to the extent required, be followed by a so-called transition phase. This is also carried out in the inpatient setting. It is particularly intended for those patients who have a higher need for rehabilitation, such as addicts with psychiatric comorbidities (c.f. section 4.3). The legal bases are primarily SGB VI as well as, subordinately, SGB V. The pension insurance and health insurance providers are responsible for planning and quality assurance. A detailed description of the content and objectives of transition treatment can be found in a publication of the German Association for Inpatient Addict Support (Bundesverband für stationäre Suchtkrankenhilfe e.V., buss) (buss 2016).

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

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

Inpatient facilities within the social therapy system

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

1.4.4 Further aspects of available inpatient treatment services

No additional information is available on this.

1.4.5 Targeted interventions for specific drug-using groups

Recently arrived migrants / refugees

In recent years great efforts have been made to create appropriate counselling and treatment services for asylum seekers, because drug use and dependence – whether it originated abroad or here – was increasing. In order to determine the extent and type of substance use among young refugees, the

BMG funded the project "Extent of problem substance use in unaccompanied foreign minors" (Ausmaß des problematischen Substanzkonsums von unbegleiteten minderjährigen Ausländern, UMA). A further goal was to identify existing concepts and problems for specialists dealing with unaccompanied foreign minors who are using drugs, and to discover opportunities to better care for this target group. They are among the most vulnerable refugee groups. The need for protection is clearly reflected in studies on psychological stress suffered by this target group. The results of the studies showed that around half of them were exhibiting psychological problems and unaccompanied minor refugees had traumatic experiences significantly more frequently than accompanied Minors. The extent to which traumatic experiences lead to substance use is largely unknown. Overall, there is little information on the extent of substance use or on the type of substances used by unaccompanied foreign minors (Zurhold, 2017).

One of the newly created services for refugees is called "Guidance" and is located in Berlin at the emergency service for those at risk of addiction and addicts (Notdienst für Suchtmittelgefährdete und -abhängige Berlin e.V., DND). The employees have been trained in legal aspects, in particular asylum and social law, specific conversational methods (motivational conversation-based, culturally sensitive counselling) and prevention elements (the basics of early intervention). All necessary documents to carry out the counselling are translated (e.g. explanation of confidentiality obligations and data protection).

The service consists of, in addition to individual counselling sessions, firstly open consultations in Arabic and Persian, which on average are attended by 8 - 12 people, and secondly group events on early intervention. Ten of these events were held in 2017. The participants were predominantly 16 - 25 years old. They received interactive sessions, mainly on tobacco, alcohol, THC and party drugs. On average, 10 - 20 people took part in an early intervention course, all courses were led by language and cultural mediators.

In addition, coaching and training courses are carried out for employees in refugee support, youth welfare offices, youth support, assisted living and shared accommodation and hospitals. A total of 24 events took place in 2017, some in cooperation with the Special Unit for Addiction Prevention. 14 definite sessions have already been agreed for 2018.

The following describes some framework conditions under which the counselling is provided.

In order to make the treatment possible, substitution doctors are also brought on board. They receive support from language mediators from Guidance or the community interpreter service (Gemeindedolmetschdienst Berlin, GDD). Documents are translated for the doctors. The organisation of language mediation for admission interviews and important doctor consultations is carried out by Guidance. As with regular psychosocial care, one to one conversations as well as conversations between patients, doctors and counsellors take place. For referral to detoxification treatment (e. g. qualified withdrawal, detoxification from concomitant use), cooperations have been set up with 2 hospitals. In these cases also, admission and clarification of all necessary treatment requirements (funding, instruction, language mediation) is organised by the project.

37.9 % of those seeking advice were using heroin or other opiates. Many were not entitled to integration support services or were unable to assert their rights due to lack of language proficiency.

Results of individual counselling sessions:

In 2017 (1 Jan. 2017 - 31 Dec. 2017), a total of 371 affected persons or their relatives were offered advice in a one to one setting (in 2016 the number was 71). 126 of those were one-off contacts and

245 were treatments (>2 contacts). 98.1 % of those seeking advice were male. Of the 1.9 % women, 4 were affected directly, while 3 were relatives. Language mediation was required in 84.4 % of the counselling sessions. Language mediation was carried out by the mediators working for Guidance (Arabic, Persian, Uzbek) as well as mediators of the GDD which had to be paid for. 55.2 % of those affected lived in shared or emergency accommodation, 12.3 % in their own living space and 6.6 % were homeless. 25.9 % did not provide a response to this question. 20.6 % of those affected self-reported, 14 % were referred by those in their social environment – this shows that the service is accepted. Other referrals came from youth support (16.5 %), (substitution) doctors (12.8 %), accommodation (15.6 %), other addiction counselling facilities (5.3 %), psychotherapists (1.6 %), other counselling services (3.7 %), youth welfare offices (3.3 %) and police (2.5 %). 38.7 % of those affected had already had contact with addiction support, e. g. low-threshold projects, were resuming previous contact from 2016 or had had contact in their country of origin.

The majority of clients had an exceptional leave to remain ("Duldung") (54.7 %) or had no valid residence permit (5.3 %) – this had a particularly unfavourable effect on referral to an utilisation of support services as such persons were either not entitled to it, or the initiation of measures is very time consuming.

The main diagnoses in 2017 were once more dependence on opiates (37.9 % heroin, 9.5 % methadone, 1.6 % buprenorphine, 4.9 % other opiates). 5.8 % were injecting users, 61.3 % smoked the substance. The injecting users were predominantly advised on safer use and harm reduction and / or were referred to testing services at doctors' practices or low-threshold facilities. 8.9 % were referred to substitution treatment, 0.6 % (1 person) to psychosocial care.

10.7 % of those affected were dependent on alcohol, 27.2 % on cannabis and / or synthetic cannabinoids, 1.2 % on cocaine and 0.8 % on crack, amphetamine or XTC.

The majority of those seeking advice (82.7 %) was treated for up to 3 months. The number of contacts reflects the time-consuming effort involved: 36.3 % up to 6 contacts, 27.4 % up to 12 contacts, 36.3 % over 12 contacts. The latter refers in particular to people who have a high need but were unable to be referred on (not entitled, language barrier). Overall, only 45.2 % of clients were able to be referred to indicated measures. The need is substantially higher (also for those able to be referred), in particular for referrals to appropriate (therapeutic) housing services, youth support services and (addiction specific) therapeutic measures. 29.2 % were referred to inpatient withdrawal treatment, 8.9 % to substitution treatment. Only one person was able to be referred to inpatient rehabilitation, 1.8 % to psychotherapy, 3.6 % to acute treatment (psychiatry), 1.8 % to outpatient facilities within institutions, 0.6 % to regional addiction counselling. It is particularly noticeable that aside from referral to withdrawal and / or substitution treatment, almost no addiction specific referrals were possible. The causes of this are a lack of appropriate services, lack of entitlement to services and language barriers⁶.

Older drug addicts (40+)

Relevant data on older drug addicts in Germany, apart from those dependent on alcohol or medication, is mainly available on opiate addicts. Cannabis users are generally younger and their health is not damaged to the same degree as opioid addicts.

⁶ Notdienst für Suchtmittelgefährdete und -abhängige Berlin e.V., January 2018; see also Bartsch et al., 2017.

The basic message of the REITOX Report 2009, with the selected issue of "Treatment and care of older drug addicts", remains valid with respect to factors influencing the aging of drug addicts or their increased life expectancy, the social situation as well as physical and psychological health (Pfeiffer-Gerschel et al., 2009). Therefore, only current data will be reported on in this section, as well as developments in the area of the facilities.

Outpatient Treatment

The DSHS data (series of tables 2016) also shows in this respect that in outpatient addiction support facilities (counselling and treatment centres and specialist walk-in clinics) older opioid addicts (40+) accounted for 42.3 % of all opioid users receiving treatment. In 2007, the figure was just 21.8 %.

At 38.6 %, the age group of 40 to 44-year-olds was the most strongly represented among older (40+) opioid addicts in the data year 2016. The next largest groups were 45 to 49-year-olds, at 30.2 % and 50 to 54-year-olds, at 18.3 %. 12.8 % were 55 and over. The average age was 38.5 years old (m 38.7; f 37.1), versus 32.6 in 2007 and 29.2 in 2002.

From this, it is apparent that the trend which was first evident in 2009, is strengthening: opioid addicts cared for and treated in outpatient addiction support facilities are getting ever older.

Inpatient treatment (excluding sociotherapy and hospital treatment)

There is a similar picture for daycare and transition treatments: 47 % of those treated in such facilities were between 40 and 44 years of age. The next largest group was 45 to 49-year-olds, at 28.3 %, followed by 50 to 54-year-olds at 16 %. 2.2 % were 60 or over. The average age of opioid addicts treated in inpatient facilities was 36.4 (DSHS series of tables, 2016).

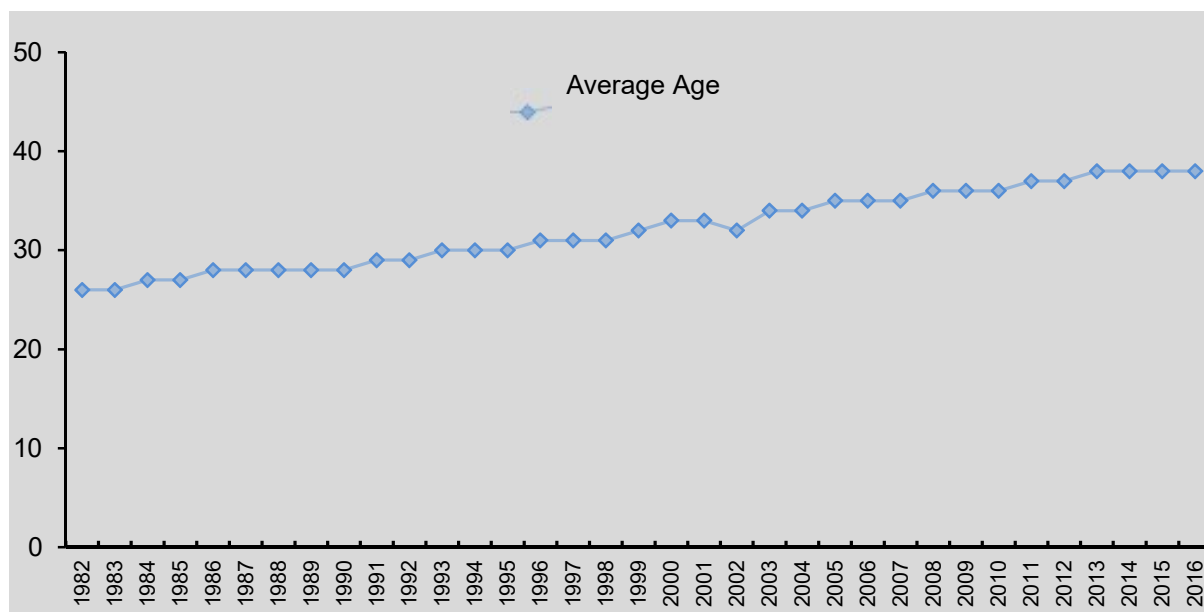
Hospital treatment

The diagnostic data from hospitals shows that the proportion of older opioid addicts is very high in this area also. 42.6 % of the 43,977 opioid addicts treated in hospital psychiatric facilities were over 40 years of age. In this context, the largest group of older (40+) opioid addicts is the 40 to 45-year-olds, at 37.5 %. This is followed by the age groups above in turn (5-year groupings) at 28.5 %, 16.5 % and 8.4 % respectively. At 9 %, the over 60s group should also not to be ignored (Destatis, 2017a).

Drug-related deaths

The 2018 Harms and Harm Reduction workbook (Dammer et al., 2018) provides detail on the issue of drug-related deaths. Therefore, only age-relevant information is reported here.

The average age at the time of the drug-related death rose continuously from 26 years old in 1982, to 38 years old in 2016. This shows that the increasing trend in the average age of persons in treatment is also seen in the case of drug-related deaths (Kraus & Seitz, 2018).



(Kraus & Seitz, 2018)

Figure 1 Drug-related deaths by average age, 1982 - 2016

Developments in care

Some providers took up the suggestions which emerged from the discussions presented on specialised age facilities for drug addicts presented in the REITOX Report 2009, and are putting them into practice in new facilities or services. For example, Condrops offers low-threshold and acceptance oriented support. This includes, as well as addiction counselling, the set up of an assisted living facility and an employment project.

The most well-known project for older drug addicts is LÜSA (Langzeit Übergangs- und Stützungsangebot, Long-term transition and support service). LÜSA offers over 30 of the most severely dependent and chronically drug-dependent persons 30 inpatient places in differently designed accommodations. The target of the up to two-year stay (in individual cases it can be longer) is reintegration into the community. Since the beginning of the project, the LÜSA target group has consisted of specific subgroups, who are permanently disabled due to their psychological and / or physical disorder and who will even in the long term not be in a position to live independently. In terms of total duration, 31 % of those admitted belong to this subgroup of permanently disabled people.

In the following, some data⁷ will be presented on this specific subgroup:

- Women make up 34.4 %, men 65.6 %;
- 69.8 % of residents are over 45 years old, 30.2 % are 35 - 45 years old;
- 52.2 % have been using drugs for over 25 years;
- In 30 % of cases, a psychological disorder is at the forefront of their illness, for 70 % it is a physical disorder;

⁷ LÜSA – Langzeit Übergangs- und Unterstützungsangebot. Geschichte – Zahlen – Fakten [Online]. <http://www.luesa.de/?site=fakten> [Accessed: 8 Jun. 2018].

- 94.89 % of residents are HCV positive;
- 34.8 % are recognised as being severely disabled;
- 24.9 % are under legal supervision;
- 78 % have had a previous stay at a correctional institution;
- 8.7 % died from the effects of an HIV / HCV infection;
- 17.4 % were discharged for disciplinary reasons or broke off their stay;
- 26.1 % were referred to other support facilities, 8.9 % to independent living (in some cases "outpatient assisted living").

In the scope of the care of HIV positive people, a number of residential and care projects were established, which also accept addicts who require care. Nationwide, there are now a total of 53 such facilities, including a hospice and seven care facilities (HIV Kompass). One such example would be the Berlin institution network "Zu Hause im Kiez GmbH". Services are offered at eleven locations that enable those affected to have a needs-based living arrangement. The goal is to enable all affected persons to live an independent and responsible life.

In addition, there were pilot projects funded by the BMG that should have effected a better interlinking of addiction support and support for the elderly and that represent examples of successful cooperation. However, they primarily reached people addicted to alcohol and medicinal drugs⁸.

New psychoactive substances (NPS) and methamphetamine

NPS are the most frequently used illicit substance in Germany after opioids and cannabis. Like methamphetamine, they pose major challenges to emergency medical care and addiction support. For this reason, a first study on the prevalence of use has been carried out in six *Laender* (Gomes de Matos et al., 2018). Regional patterns have been described for NPS and methamphetamine use in Germany on the basis of epidemiological data from Bavaria, Hamburg, Hesse, North Rhine-Westphalia, Saxony and Thuringia. The base of data is provided by the Epidemiological Survey of Substance Abuse (ESA) 2015, on the basis of a representative sample of the resident population, which was extended to additional numbers of cases in the *Laender* studied. The goal was to ascertain any regional differences in NPS and methamphetamine use.

No regional differences in NPS use were discerned. NPS use is equally widespread across the *Laender* studied. Methamphetamine is rarely used, although use in Saxony and Thuringia appears to be comparatively higher. The analysis of the risk factors must be interpreted with caution due to the sometimes low number of cases related to use (Gomes de Matos et al., 2018).

The lifetime prevalence of use of methamphetamine fluctuated between 0.3 % (North Rhine-Westphalia) and 2.0 % (Saxony). In comparison to the average, Thuringia and Saxony exhibited significantly increased values. The figures for NPS were between 2.2 % (Bavaria) and 3.9 % (Hamburg), while a multivariate analysis revealed no statistically significant differences between the *Laender*. Higher age and a higher level of education were associated with a reduced risk of NPS use

⁸ BMG – Bundesministerium für Gesundheit. Homepage. Forschungsbericht Analyse Sucht im Alter [Online]. https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Drogen_und_Sucht/Bericht_e/Forschungsbericht/Abschlussbericht_Analyse_Sucht_im_Alter.pdf [Accessed: 31 Oct. 2018].

and methamphetamine use and with a higher risk of use for tobacco and cannabis (Gomes de Matos et al., 2018; see also this year's Drugs workbook, Piontek et al., 2018).

Female-specific services

The significance of the topic "gender in addiction support" has been acknowledged in Germany for many years and has been covered in numerous publications, initially female specific, later male and gender specific. As far back as 2004, the DHS expert committee "gender specific addiction work" developed a position paper "Gender mainstreaming in addiction work: opportunities and necessities" (DHS, 2004). Further discussions and publications followed, e. g. "Quality features and recommendations for female-specific addiction work" by the working group "Women and Addicton" from the Freiburg and South Baden region (2006) or the women's addiction counselling service in Schleswig-Holstein with their service "Representation of interests and quality assurance"⁹.

Nevertheless, there is no systematic nationwide data collection on gender specific addiction support services in Germany. All projects and services fed data into the aforementioned databases, which are also for women or also for men. However, they do not necessarily have a gender specific treatment approach.

In outpatient addiction treatment there are, however, female-specific services in many cities and metropolitan areas, such as Berlin, Essen, Frankfurt, Hamburg, Munich and Nuremberg. They include both low-threshold services, such as drop-in centres, and regular addiction counselling centres for women.

Inpatient withdrawal clinics and therapeutic residential communities have also developed women specific rehabilitation concepts which they use, such as the Bernhard-Salzmann-Klinik in Gütersloh¹⁰ and the therapeutic housing group "The Onion" (PROWO e.V. – Projekt Wohnen / "Die Zwiebel") in Berlin, or Condrops e.V. in Munich. The institutions involved provide specific services for women in different situations, e. g. drop-in centres, addiction counselling facilities, and sociotherapeutic, clean and aftercare residential communities. Services for female addicts with an additional psychiatric disorder and for women who have been released from secure psychiatric facilities, further complement the range of services on offer. In this context, women with similar life experiences can live together in a free space without violence or addictive substances and try out new problem solving strategies.

In addition, the BMG funds target group specific pilot projects for female addicts:

One of the projects is GeSA "Association to support women in the cycle of violence and addiction" (Frauen helfen Frauen e.V.; Bundesmodellprojekt GeSA – Verbund zur Unterstützung von Frauen im Kreislauf von Gewalt und Sucht)¹¹. The goal of the project is to provide knowledge and skills in the areas of addiction, violence and trauma to experts in violence prevention and addiction support, and to establish a functioning network, in order to be able to ensure effective and sustainable care for women affected by violence and addiction. The regional cooperation model to improve care for women with

⁹ Frauen Sucht Gesundheit e.V. [Online]. <https://fsg-sh.de/interessenvertretung-und-qualitatssicherung/> [Accessed: 18 Jun. 2018].

¹⁰ Bernhard Salzmann Klinik. LWL–Rehabilitationszentrum Ostwestfalen. Konzept zur Behandlung von abhängigen Frauen [Online]. https://www.lwl.org/527-download/BSK/Konzepte/Behandlung_abhaengiger_Frauen.pdf [Accessed: 18 Jun. 2018].

¹¹ Frauen helfen Frauen e.V. [Online]. https://www.fhf-rostock.de/fileadmin/media/Dokumente_GeSA/GeSA.Handbuch.web.pdf [Accessed: 31 Oct. 2018].

addictive substance use affected by violence is located in the Rostock and Stralsund regions and has the objective of building a regional addiction and violence network. Regional cooperation teams (in Rostock and Stralsund) are responsible for this process. The teams consist of a maximum of five representatives of inpatient and outpatient facilities from both systems. Firstly, the point of the network is firstly to convey knowledge about the respective other system (basic seminars), to get to know the institutions involved in the care and treatment of persons affected as well as their working concepts and to acquire subject-specific knowledge on the topics of violence, trauma and addiction (specialist forums). A second essential aspect is the development and testing of individual cooperation models, which link together and meaningfully complement the resources available within the network. The aim is to create guidelines for action tailored to the specific regional conditions from the experience gained in the collaboration up to now across all cases. The experiences from GeSA are being made available nationwide (BMG, 2018).

Further funding is committed to women who use crystal meth. Around a third of all crystal meth users is female. In spite of this, there has been hardly any research on women and crystal meth to date. The research project "Crystal meth use by women" should fill this gap.

Comprehensive research on female-specific aspects of crystal meth use was conducted on a select group of crystal meth using women by means of a qualitative study on motives for use and comorbidities. The goal of the study was to collect data on the different motives for use, comorbidities, use practices and contexts of female crystal meth users as well as what they want from the support system. The intention was also to identify gender sensitive approaches to prevention and counselling practice. In the course of the study, aspects such as contemporary expectations of gender roles and the connection between experiencing sexual violence and later developing a dependence on crystal meth were investigated¹² (BMG, 2018).

The "Dresden crystal meth care pathway"¹³ (Dresdner Versorgungspfad Crystal) is a concept developed by the Dresden Technical University (Technische Universität Dresden, TU Dresden) and tested in practice which enables a sociomedical coordination of multi-professional and multidisciplinary care of pregnant women, families and children following prenatal methamphetamine use. The goal of the project is the evaluation of the "Dresden crystal meth care pathway" and the development of a concept for nationwide transfer (BMG, 2018).

Minors and adolescents

There is also no systematically prepared data for addiction specific services in the care of dependent children and adolescents. Databases similarly list normal addiction counselling and treatment centres that also care for children and adolescents.

However, in many cities and communities there are youth and addiction specific outpatient facilities. They are mostly utilised by cannabis users, or adolescent users who have drawn attention due to the use of other psychotropic substances. Often, these facilities offer evaluated programmes located in the crossover between prevention and treatment, such as "Early Intervention with Drug Users Coming to the Attention of Law Enforcement for the First Time" (FreD – Frühintervention bei erstaußälligem

¹² Tifs - Tübinger Institut für gender- und diversitätsbewusste Sozialforschung und Praxis e.V. Homepage. Projekte. Crystalkonsum von Frauen [Online]. <http://www.tifs.de/wir-ueber-uns/> [Accessed: 18 Jun. 2018].

¹³ Dresdner Versorgungspfad Crystal [Online]. <https://tu-dresden.de/med/mf/fph/forschung/forschungsprojekte> [Accessed: 31 Oct. 2018].

Drogenkonsum).

Another programme focussed on cannabis use is "Realize it", a counselling programme for adolescents and young adults who want to cease or significantly reduce their cannabis use.

In the area of inpatient rehabilitation, the DHS facility search database shows 62 records nationally on clinics and rehabilitation institutions which offer specialised treatment of children and adolescents who use illicit drugs.

Specifically in the area of children and young people, there are also internet-based programmes (c.f. section 1.4.6) which facilitate access to information and support.

In addition, the Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung, BMBF) funds "IMAC-MIND", a new research association, which operates where prevention meets treatment. It will research how addiction behaviour of children and adolescents can be prevented and therapeutic care improved. Specific research goals are: the development of approaches to child-appropriate care for psychological disorders, research into formative influences on health and the respective disorder as well as the development of risk-group related prevention approaches (UKE, 2017: see also Friedrich et al., 2018).

In addition, the BMG funded project "Crystal meth and family – analysing the living situation and support needs of affected children", ("Crystal Meth und Familie – Zur Analyse der Lebenssituation und des Hilfebedarfs betroffener Kinder") is intending to develop a group programme for parents dependent on methamphetamine who have children between 0 and 8 years old, in inpatient withdrawal facilities. The goal is to strengthen parenting skills and family resilience and promote the willingness to be abstinent and the further use of support (BMG, 2018).

1.4.6 E-health interventions for people seeking drug treatment and support online

To date, there is no systematic overview in Germany of e-health or online services for the counselling and treatment of drug addicts. The apparently best-known and oldest project is "drugcom"¹⁴, a project run by the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA). The internet portal provides information on legal and illegal drugs and offers those interested and seeking advice the opportunity to communicate with one another or make use of professional counselling in an uncomplicated way. The goal of the service is to encourage communication about drugs and addiction and promote a self-critical examination of addicts' own use behaviour.

There are various counselling options available to visitors to the website:

- counselling via email
- counselling via online chat
- locating an addiction counselling facility

In addition to online chat counselling, Drugcom.de has specific evaluated treatment programmes

¹⁴ BZgA Homepage [Online]. <https://www.drugcom.de/> [Accessed: 20 Jun. 2018].

available, e. g. "Quit the shit" (BZgA website drugcom.de). Another project is "kointer"¹⁵, a service provided by "JUGEND-HILFT-JUGEND" (jhj) in Hamburg. jhj Hamburg has existed since 1970 as an addiction and youth work provider and operates a socio-therapeutic based support system to provide care for substance dependent persons as well as support to youth and disabled persons. Since 1 December 2009, it has offered the "kointer" service, the first virtual counselling service in Hamburg in the area of addiction. The "kointer" team offers the following online services related to all questions and issues on the topic of drugs and addiction:

- Online chat
- Supported use journal
- Individual counselling
- Check up for those affected and relatives / friends

All counselling services are free of charge, strictly confidential and can take place anonymously if desired (jugendhilftjugend website).

The most recent service specialised in methamphetamine, is the "Breaking Meth"¹⁶ web portal. The objective of the project is to develop and scientifically support an online self-help service for methamphetamine users. The website is operated by the Drug Scouts project in cooperation with SZL Suchtzentrum GmbH in Leipzig.

The service is supported by BMG funding and is to be made available to other relevant groups also. The intention is to reach users who are starting to have an awareness of their problem and with no contact to the support system, people with existing contact to the support system as well as former patients following post-acute inpatient therapy in the sense of relapse prophylaxis.

Other platforms such as IRIS, a BMG-funded project of Tübingen University, offer counselling on tobacco and alcohol during pregnancy and provide tips on cessation¹⁷.

In addition, Merseburg University's "Checkpoint-C" app for methamphetamine users has been available since December 2014. The app is a navigation aid for day to day life involving crystal meth use. It offers the possibility for users to plan and estimate daily use and reflect on their own use behaviour. It contains lots of information for relatives as well as interested parties to educate themselves about use and substances. Within the app is a use journal which can help users to reflect on their individual pattern of use. In addition, one part of the app provides necessary first-aid basics in order to be able to react appropriately in a drug emergency.

The self-tests form the basis for a reflection on the user's own feelings of self-worth, self-control, self-realisation and view of reality, and help them to have a better picture of themselves.

Explanations on methamphetamine and the lexicon provide information on crystal meth, its effects, forms of and reasons for use and possible short and long term side effects, and provide many tips on safer use and dealing with risk factors (risk management). In addition, the app provides helpful advice

¹⁵ Jugendhilftjugend Homepage. Kointer [Online]. <https://de.jugend-hilft-jugend.de/Online-Angebot/> [Accessed: 20 Jun. 2018].

¹⁶ Zentrum für interdisziplinäre Suchtforschung, Hamburg. Breaking Meth [Online]. <https://breaking-meth.de/> [Accessed: 31 Oct. 2018].

¹⁷ IRIS-Plattform Homepage [Online]. <https://www.iris-plattform.de/> [Accessed: 20 Jun. 2018].

on controlling own use and supports a non-judgemental education of users and their relatives. The app was replaced by a Craving-Modul and a device for easy exit.

Alongside these national services, many addiction counselling facilities provide regional online counselling. Large providers such as the "Alternative youth and drug support, mudra" (Alternative Jugend- und Drogenhilfe, mudra) in Nuremberg, or the DND offer both email counselling and individual, group and expert online chats.

Inpatient rehabilitation facilities also use online tools, primarily for the purpose of making contact prior to treatment or providing support following discharge¹⁸.

1.4.7 Treatment outcomes and recovery from problem drug use

The data on treatment outcomes and success differs only marginally from that in the 2017 workbook. As in the previous year, treatments "finished as planned" is a criterion for assessing success. With respect to this indicator, there are differences both between the substance classes as well as between outpatient and inpatient care. Approximately 60 % of those treated on an outpatient basis finished the intervention as planned, versus 72 % treated on an inpatient basis. In inpatient treatment, the rate of treatments being finished as planned is higher across all substances than it is for the outpatient setting. This result is particularly pronounced in the treatment of alcohol dependence and pathological gambling (85 % vs. 69 % and 84 % vs. 58 % respectively). Opioid addicts are the group with the largest proportion of premature dropout: 48 % of persons treated on an outpatient basis and 42 % of those treated on an inpatient basis stopped treatment prematurely. This is followed by people with the main diagnosis of stimulant dependence (outpatient: 42 %, inpatient: 30 %), then cocaine dependence (outpatient: 39 %, inpatient: 32 %) and cannabis dependence (outpatient: 35 %, inpatient: 31 %). With respect to the assessment of success by addiction support professionals (Specht et al., 2018) it can be seen that finishing treatment as planned is associated with a higher treatment outcome across all addiction diagnoses. Accordingly, premature ending of treatment is associated with a lower degree of success.

At the beginning of 2018, the FVS published the catamnesis data from 7 of its member clinics that meet the standards of the German Society for Addiction Research and Addiction Treatment (Deutschen Gesellschaft für Suchtforschung und Suchttherapie, DG-Sucht) and take into account the various types of calculation method regarding treatment success¹⁹ (DG-Sucht, 2001; DG-Sucht, 1985). The most recent results of the sixth inter-facility drug catamnesis on the basis of the discharge year 2015 show similar success levels to the previous catamnyses. The catamnestic success rate is 75.4 % (DGSS1) (2014: 74.4 %; 2013: 78.2 %; 2012: 70.3 %) for consistently abstinent patients and for abstinent patients following a relapse over 30 days prior to the survey. The most conservative estimate is that 23.3 % of patients experience abstinence success one year after inpatient drug rehabilitation (DGSS 4) (2014: 23.8 %; 2013: 24.9 %; 2012: 21.2 %) (Fischer et al., 2018).

¹⁸ Checkpoint-C Homepage [Online]. <https://checkpoint-c.de/news/> [Accessed: 21 Jun. 2018].

¹⁹ The most favourable method of calculation, DGSS1, includes all catamnesis respondents who were discharged as planned. Under the KDS, a patient is classified as abstinent after a relapse, if they have been abstinent in the last 30 days of the survey period. The strictest method of calculation, DGSS4, includes all respondents and assesses non-responses and incomplete catamnesis data by definition as relapses (DG-Sucht, 2001; DG-Sucht, 1985). DGSS1 tends to produce an overestimation of rehabilitation success, DGSS4 tends to produce an underestimation.

In addition, the DRV collects data on the ability to work of those undergoing rehabilitation, as the goal of the DRV is to integrate addicts back into the employment market. According to that data, three quarters of patients in rehabilitation treatment in the last 12 months who were theoretically able to be part of the workforce were unfit for employment in the 12 months prior to treatment (women: 69 %, men: 70 %). As a result of the withdrawal treatment, 69 % of women and 74 % of men were able to be discharged as fit for work. The ability to work for the general labour market was reported as 6 hours or more for 87 % of women and 93 % for men (Naumann & Bonn, 2018).

1.4.8 Social integration services (employment / housing / education) for people in drug treatment and other relevant populations

The social integration and accompanying occupational integration is a central concern of addiction counselling and treatment in Germany, and is anchored in the goals of addiction support. Primarily the institutions responsible for rehabilitation, such as the pension insurance providers and health insurance providers, have, together with addiction support representatives, developed standards for social and occupational reintegration. Of particular note are the "Proposals for enhancing the employment related aspects of medical rehabilitation of persons with dependency disorders of 14 November 2014" drawn up by the "Joint working group on the focus on employment in medical rehabilitation – BORA" (Gemeinsame Arbeitsgruppe Berufliche Orientierung in der medizinischen Rehabilitation Abhängigkeitskranker (BORA)) (DRV, 2014). These proposals are intended to encourage facilities to support rehabilitation patients in an even more targeted manner according to their individual participation needs. The aim is to contribute to a further optimisation of the rehabilitation and integration process. This objective is viewed as a challenge common across interfaces. In this context, it is important that where required rehabilitation specialists are involved at an early stage as well as other contributing institutions (DRV, 2014). For this reasons, the DRV set up a research project (case management for participation services) which is intended to develop a case management concept within the scope of participation services on the basis of scientific expertise, that can be implemented by all pension insurance providers²⁰. The DRV participation services are documented and published on the DRV statistics website. In 2017, the DRV provided 175,950 services for participation in working life (DRV, 2018)

In addition, the "Act to Strengthen the Participation and Self-Determination of Persons with Disabilities" (Gesetz zur Stärkung der Teilhabe und Selbstbestimmung von Menschen mit Behinderungen, BTHG) came into force in January 2017. Its aim is to help people who, due to a substantial disability (this includes some dependent people), only have limited possibilities to participate in community life, out of the "welfare system" and help further develop the integration support system into a modern right to participate. The services should be based on personal need and determined on an individual basis according to a uniform nationwide process. Services should be provided in a person-centred manner and no longer institution-centred²¹.

²⁰ DRV – Deutsche Rentenversicherung. Homepage. Schwerpunktthema Qualitätssicherung. Peer Review-Verfahren - Experten bewerten den Reha-Prozess [Online]. http://www.deutsche-rentenversicherung.de/Allgemein/de/Navigation/3_Infos_fuer_Experten/01_Sozialmedizin_Forschung/02_reha_qualitaetssicherung/peer_review_node.html [Accessed: 25 Jun. 2018].

²¹ BMAS – Bundesministerium für Arbeit und Soziales. Homepage. Rehabilitation und Teilhabe [Online]. <https://www.bmas.de/DE/Themen/Teilhabe-Inklusion/Rehabilitation-und-Teilhabe/reha-und-teilhabe.html> [Accessed: 31 Oct. 2018].

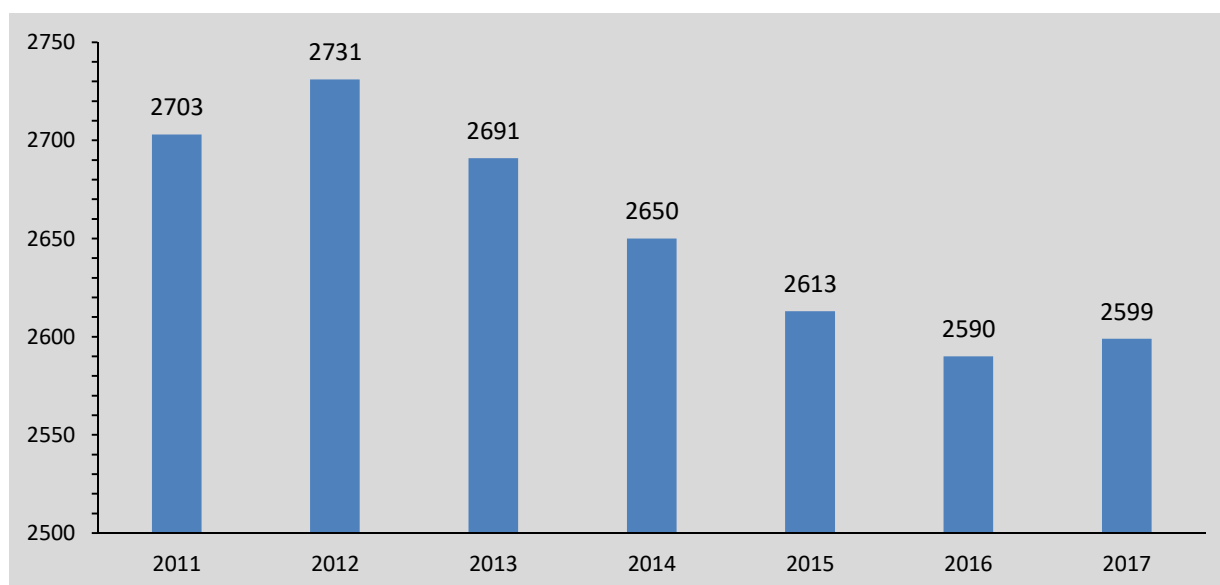
In addition to the state services, there are numerous projects and charitable facilities, mostly carried out in cooperation with the addiction support funding agencies (c.f. BORA). There is no central registration for these projects and services.

For the year 2016, the DSHS lists approx. 1,340 people working in low-threshold outpatient addiction support employment projects who thereby experience a meaningful daily structure and can practice social behaviour (DSHS, 2017).

Another area of social integration is represented by projects and facilities offering outpatient assisted living. Nationally, they are a fundamental element of outpatient addiction support. The DSHS lists approx. 2,632 treatment cases in this area for 2016 (DSHS, 2017).

1.4.9 Main providers / organisations providing opioid substitution treatment

In Germany, only doctors are allowed to carry out opioid supported treatment (substitution). Therefore they are the only providers, albeit in some cases not in their own practice but in facilities supplied by the public health service. Above all, large practices specialising in substitution treatment, work in close cooperation with psychosocial care (PSC) facilities, which are mostly funded by charitable organisations. A total of 2,599 doctors providing substitution treatment reported opioid addicts requiring treatment to the substitution register in 2017. The number of doctors providing substitution treatment has therefore not fallen for the first time since 2012, even if the increase is only very slight (c.f. Figure 2). In 2017, 548 doctors – namely approximately 21 % of substituting doctors – availed themselves of the colleague consultation rule: according to that rule, doctors without a qualification to medically treat addiction can treat up to ten substitution patients simultaneously (since 2 October 2017, previously it was up to three patients) if they involve a suitably qualified doctor as a consultant in the treatment. The doctors who availed themselves of the colleague consultation rule treated around 1 % of all substitution patients (BOPST, 2018).



(BOPST, 2018)

Figure 2 Number of substituting doctors 2011 - 2017

The nationwide average number of reported substitution patients per substitution doctor is 30,

however there are huge variations between the individual *Laender* (Hamburg: 47; Brandenburg: 7). Around 14 % of substitution doctors reported half of all substitution patients on the reference date. This suggests that many opioid addicts receive treatment in specialised practices. There are however also many practices (30 %) that only treat up to three substitution patients.

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 urban hinterland effect, than in the large-area states. Secondly, the proportion is significantly higher in the western *Laender* than in the eastern *Laender*.

The majority of patients receiving substitution treatment are treated on an outpatient basis by practice-based doctors or in specialised outpatient clinics. In an inpatient setting, substitution treatment is available in around 10 % of clinics offering medical rehabilitation for drug addicts (Kuhlmann, 2015).

1.4.10 Characteristics of clients in OST

On the reference date, 1 July 2017, the number of substitution patients was 78,800. This represented the highest figure for 10 years (c.f. Figure 1 in section 2.1). In 2017, around 91,200 registrations, de-registrations or changed registrations of patient codes were recorded in the substitution register. This high number is due, amongst other reasons, to the fact that the same people were registered and deregistered multiple times. (BOPST, 2018).

The proportions of substances used in substitution treatment have shifted in the past few years away from methadone (40.9 %) and towards levomethadone (34 %) as well as buprenorphine (23.3 %) (Table 7). The proportion of persons receiving substitution treatment with methadone or levomethadone has fallen since 2005 from 82 % to the current level of 74.9 %.

Table 8 Type and proportion (%) of substitution drugs reported to the substitution register (2005 - 2017)

	2005	2010	2015	2016	2017
Methadone	66.2	57.7	44	42.5	40.9
Levomethadone	15.8	23	31.8	33	34
Buprenorphine	17.2	18.6	23	23.1	23.3
Dihydrocodeine	0.7	0.3	0.2	0.2	0.1
Codeine	0.1	0.1	0.1	0.1	0.1
Diamorphine	–	0.3	0.8	0.8	1

(BOPST, 2018)

No new information is currently available on the characteristics of substituting patients. Data from the PREMOS study can be used as an information source (Wittchen et al., 2011 and 2011a).

1.4.11 Further aspects on organisation, access and availability of OST

With the 3rd BtMVVÄndV of 22 May 2017, the provisions on the substitution treatment of opioid

addicts were amended and have been fully applicable since publication of the "BÄK Guidelines on the implementation of substitution-based treatment for opioid addicts" in the German Federal Gazette on 2 October 2017. See also section 3.1 of the REITOX Report 2017 Legal Framework (Dammer et al., 2017).

According to the 3rd BtMVVÄndV, the following substances are approved for use in substitution treatment in Germany:

- a medicine approved for substitution treatment which does not contain the substance diamorphine,
- a levomethadone, methadone or buprenorphine preparation or
- in justified, exceptional cases, a preparation of codeine or dihydrocodeine.

Diamorphine-based substitution treatment has also been regulated under the law, in Sec. 5a BtMVV, since July 2009 (c.f. chapter 1.2.2 in the REITOX Report 2009; (Pfeiffer-Gerschel et al., 2009)).

Under the BtMVV, the BÄK sets out the generally accepted state of medical scientific knowledge in its guidelines for the provision of substitution treatment. Supplementary psychosocial care (PSC) is generally paid for by local social welfare providers or granted as individual support. The organisation, financing and provision of PSC by the *Laender* and municipalities varies. The addiction support system assumes a mix of biopsychosocial causes behind the development of an addiction disorder and concludes from that that the treatment of dependency disorders also has to be aligned with these three dimensions and that they have to be integrated within a coordinated treatment programme. Since the start of substitution treatment in Germany, PSC has been an integral part of the substitution based treatment of opiate addicts. Deimel and Stöver (2015) provide an inventory of the concepts, practices and lines of conflict in the psychosocial treatment of opiate addicts and draw from this proposals for the further development of psychosocial addiction work.

The provision of substitution treatment has been a cause for concern for some years, in particular in rural regions (c.f. Pfeiffer-Gerschel et al., 2014). Ever increasing numbers of older doctors are retiring with hardly any younger doctors coming through to take their place. As a result, the gap in the provision of care is growing, leading to many opioid dependent persons in small town or rural areas only being reached to a limited extent. In order, among other things, to address this problem, improve the situation of substitution doctors and to further develop the regulation of substitution treatment overall, medical therapeutic matters were transferred, in the 3rd BtMÄndVV, to the BÄK guideline competence. See also section 3.1 of the REITOX Report 2017 Legal Framework workbook (Dammer et al., 2017).

Furthermore, the support system is facing the challenge of providing care for long term substitution patients or aging drug addicts with accompanying health limitations up to and including nursing care (c.f. section 1.4.5).

1.4.12 Quality assurance in drug treatment

Guidelines and recommendations for action in treating drug dependence are constantly being developed in collaborations between various professional associations and experts (see also chapter 11 of the REITOX Report 2010). The overview is presented in reverse chronological order:

- Within the scope of the 3rd BtMÄndVV in 2017, the guidelines for substitution treatment were updated in line with the state of knowledge in medical science (BÄK, 2017a).

- The S3 guidelines on methamphetamine related disorders has been in force since September 2016 (Drogenbeauftragte der Bundesregierung et al., 2016).
- Furthermore, in 2016 the Joint Addiction Commission (Gemeinsame Suchtkommission) of the Professional Society of Child and Youth Psychiatrists and the specialist associations presented a position paper on the requirements on qualified withdrawal treatment for children and young persons (Thomasius et al., 2016).
- The proposals for enhancing the employment related aspects of medical rehabilitation of persons with dependency disorders came into force on 1 March 2015. They were drawn up by the joint working group "Focus on employment in the medical rehabilitation of persons suffering from dependence" (Berufliche Orientierung in der medizinischen Rehabilitation, BORA) (Müller-Simon and Weissinger, 2015).
- At the beginning of 2014, the DGS approved the final version of the guidelines, "Therapy for opiate dependence – Part 1: substitution treatment" (Backmund et al., 2014).
- Also in 2014, the German Pain Society (Deutsche Schmerzgesellschaft), in collaboration with other specialist medical organisations developed an S3-Guideline on "Long term use of opioids for non-tumour related pain" (Langzeitanwendung von Opioiden bei nicht tumorbedingten Schmerzen - "LONTS") (Deutsche Schmerzgesellschaft, 2014).
- The revised version of the 2004 S3-Guideline on "Prophylaxis, diagnostics and treatment of the hepatitis C virus (HCV) infection, AWMF-Register No. 021/012" from the German Society for Digestion and Metabolic Diseases (Deutsche Gesellschaft für Verdauungs- und Stoffwechselkrankheiten e.V., DGVS) was published in 2010 (Sarrazin et al., 2010).
- In 2006, the Association of the Scientific Medical Societies (Arbeitsgemeinschaft der medizinisch-wissenschaftlichen Fachgesellschaften, AWMF) published the AWMF-guidelines on diagnostics and treatment of substance-related disorders under the title "Evidence-based addiction medicine – treatment guidelines for substance-related disorders" ("Evidenzbasierte Suchtmedizin – Behandlungsleitlinie substanzbezogene Störungen") (Lutz et al., 2006).
- Also in 2006, at a consensus conference, the guidelines of the DGS for the treatment of chronic hepatitis C in injecting drug users were approved (Backmund et al., 2006).
- The AWMF guidelines on cannabis related disorders was published in 2004 (Bonnet et al., 2004) as well as
- the guidelines on mental and behavioural disorders due to cocaine, amphetamine, ecstasy and hallucinogens (DG-Sucht & DGPPN, 2004).

In addition to the treatment guidelines, the funding agencies also have other quality assurance instruments at their disposal. The DRV Bund carries out annual evaluations of medical rehabilitation of persons with dependence disorders: to this end, the facilities supported by the DRV are examined in a peer review process and the quality of the rehabilitation process is recorded. Anonymised medical discharge reports as well as rehabilitation clients' treatment plans are selected at random by experienced and specially trained rehabilitation doctors from the relevant specialist area. The assessment is based on an indication-specific checklist of quality-relevant characteristics of

rehabilitation and on a handbook. Both inpatient and outpatient withdrawal rehabilitation services are included in the process and assessed according to the same criteria (DRV website²²). In addition, the persons undergoing rehabilitation treatment are surveyed about the subjective success of the treatment and their satisfaction with the treatment overall as well as with the different treatment modules / elements (Naumann & Bonn, 2018).

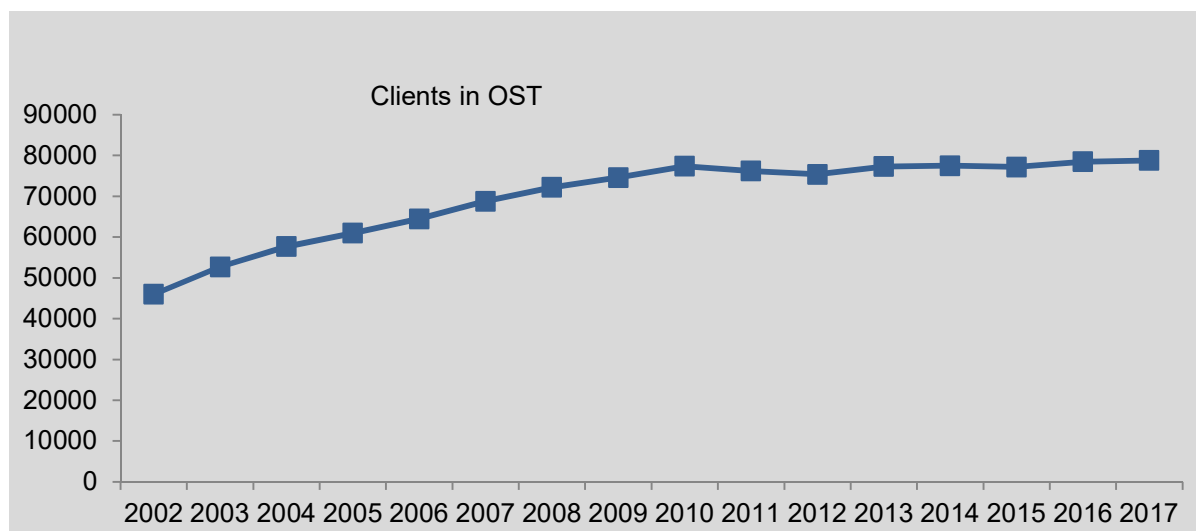
Furthermore, the medical rehabilitation of people with dependence disorders may only be provided by specialist staff with the relevant further training. In this context, the DRV has produced guidelines for the further training of specialist staff working in individual and group therapy within the framework of the medical rehabilitation of drug addicts, in which further training courses can receive a "recommendation for recognition". Cooperation between different professional groups from social work, psychology, psychiatry and other medical fields forms an essential part of the treatment standards in the case of drug dependence. As for outpatient options (in particular counselling centres), quality assurance and professional supervision are mainly in the hands of the organisations that provide these facilities, or the *Laender* and municipalities. The responsibility for detoxification and rehabilitation, however, lies with the respective funding agency (statutory health insurance providers (Gesetzliche Krankenversicherung, GKV) and pension insurance providers (Rentenversicherung, RV)) (c.f. also Pfeiffer-Gerschel et al., 2012).

2 TRENDS

2.1 Long-term trends in the number of clients entering treatment and in OST

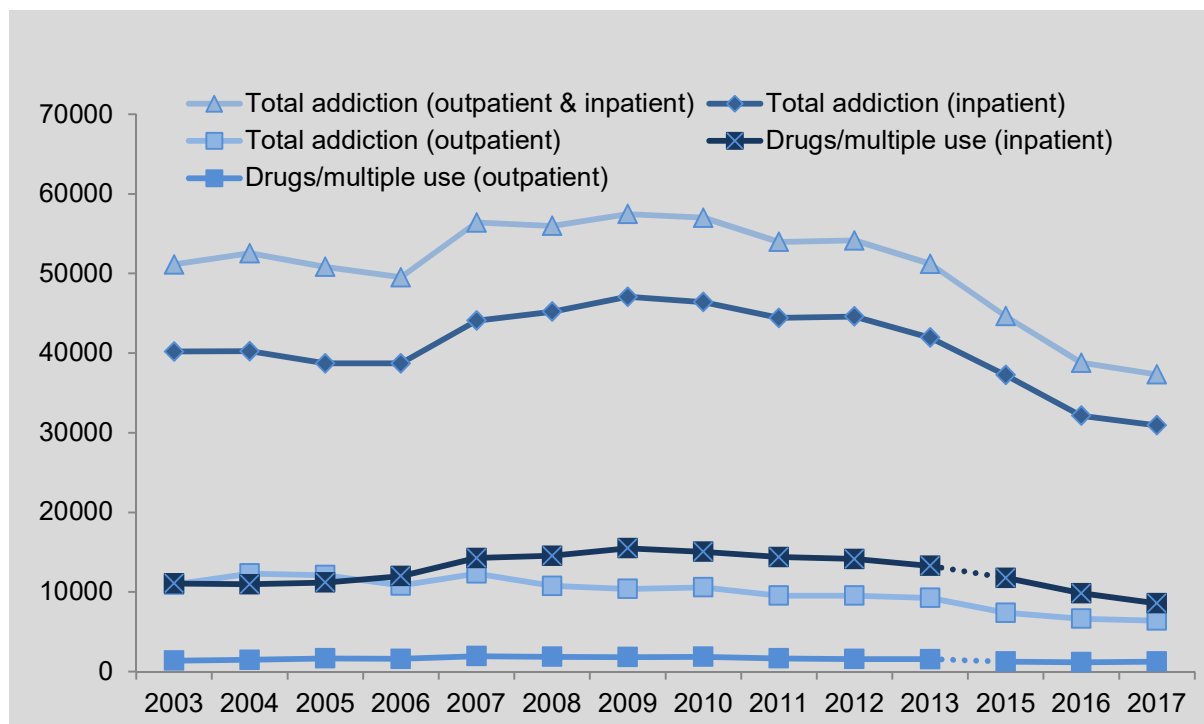
From 2002, when reporting became obligatory, the number of substitution patients reported continuously increased until 2010. After a stable trend in recent years, the number of substitution patents broadly remained the same in the last year, increasing by only 0.4 %. On the reporting date (1 July 2017), the number was 78,800 (see Figure 3). There are still considerable regional differences regarding the supply of and demand for substitution treatments.

²² Deutsche Rentenversicherung – DRV. Homepage. [Online]. www.deutsche-rentenversicherung.de [Accessed: 31 Oct. 2018].



(BOPST, 2018)

Figure 3 Number of reported substitution patients in Germany (reference date 1 July)



Note: No data available for 2014.

(DRV, 2018)

Figure 4 Changes in outpatient and inpatient rehabilitation treatments

The total number of rehabilitation services funded by the RV in the area of addiction rose by over 10 % between 2003 (51,123) and 2009 (57,456) and has since then been continually decreasing (2010: 56,997; 2017: 31,900) (Figure 4). Part of this decrease is due to a change in the method of data collection since the 2015 reporting year. The majority of rehabilitation services (69 %) is provided for alcohol related disorders. Disorders due to the use of illicit drugs and multiple drug use together comprise around 25.3 % of the treatments provided (medicinal drugs: 0.8 %). There has been little

change in this distribution since 2015.

The same applies to the relationship between inpatient and outpatient rehabilitation treatment. Between 2003 and 2009 (according to the data of the DRV), the numbers of rehabilitation cases for drug patients (drugs / multiple use) in inpatient treatment continuously increased before falling 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 4).

Since the reporting year 2015, the available statistics from the DRV for day care treatments have been listed separately. This new breakdown, as well as the omission of after care cases, means that the data can no longer be compared to previous years and now seem to be lower (Figure 4).

Table 9 Change to the breakdown of DRV treatment data

	2015			2016			2017		
	Inpat.	Day care	Outpat.	Inpat.	Day care	Outpat.	Inpat.	Day care	Outpat.
Alcohol	25,047	1,916	6,072	21,848	1,762	5,401	21,896	1,746	5,060
Drugs	11,764	412	1,258	9,824	355	1,181	9,583	371	1,271
Medicines	423	21	58	441	22	63	438	22	71
Multiple	15			19		3	3		
Total	37,249	2,349	7,388	32,132	2,139	6,648	31,920	2,139	6,402

* all day outpatient
(DRV, 2017)

The total number of acute addiction treatments in hospital has, with some fluctuations, slightly decreased since 2011, while drug treatments overall have increased in the same period. In the last year, however, the number has once again slightly fallen (Destatis, 2017a). The largest increase was recorded for cocaine in 2016 (+33 %). This is followed by treatments due to the use of cannabinoids (+2 %). The treatment of opioid dependence fell slightly in 2016 (2016: -0.2 %). Although treatments for stimulant dependence decreased in the last year, the number of treatments in comparison to 2011 has significantly increased (+150 %).

Overall, alongside the treatment of alcohol dependence, the number of treatments for opioid, cannabinoid, stimulant and cocaine dependence remains at a high level (Table 10).

Table 10 Inpatient treatment of drug problems in hospitals

Year							Changes	
Primary diagnosis substance	2011	2012	2013	2014	2015	2016	2015-2016	2011-2016
Alcohol	338,355	345,034	338,204	340,500	326,971	322,608	-1.3 %	-4.6 %
Opioids	28,956	26,512	27,962	33,686	34,916	34,977	0.2 %	20.7 %
Cannabinoids	9,094	10,142	11,708	15,153	17,148	17,495	2 %	92 %
Sedatives/Hypnotics	10,241	9,999	9,707	10,082	10,134	10,166	0.3 %	-0.7 %
Cocaine	1,222	1,417	1,702	2,200	2,435	3,247	33 %	166 %
Stimulants	3,878	4,519	5,810	8,627	10,216	9,695	-5 %	150 %
Hallucinogens	574	472	526	610	789	724	-8.2 %	26.1 %
Tobacco	269	225	238	190	213	177	-16 %	-31 %
Volatile substances	198	155	135	159	153	131	-14 %	-76.7 %
Multiple use/other substances	41,777	43,063	43,826	35,798	35,731	33,810	-5.4 %	-19 %
Total addiction	434,564	441,538	439,818	447,005	438,706	433,030	-1.3 %	-0.3 %
Total drugs	95,940	96,279	101,376	106,315	111,522	110,245	-1.5 %	15 %

(Destatis, 2017a)

2.2 Additional trends in drug treatment

No additional information is currently available on this topic.

3 NEW DEVELOPMENTS

3.1 New developments

Improvement in the access routes to treatment

See section 1.2.7.

The prescription of medicinal drugs containing opioids

The prescription of medicinal drugs with dependency potential has significantly increased in recent years. This gave the BMBF occasion to fund a research project (ProMeKa) of the ZIS at the University of Hamburg to investigate the "Extent and trends of the problem medicating with benzodiazepines, Z-substances, opioid analgesics and anti-depressants among statutory health insurance patients" in six north German *Laender*. The primary objective of the project is to obtain new, comprehensive and representative findings on the prevalence of and trends in long-term prescriptions as well as, where

relevant, prescribing behaviour, not in accordance with the guidelines, for medicinal drugs with addictive potential as well as anti-depressants among patients insured by the GKV. It also aims to identify at-risk groups with conspicuous and high-risk prescribing patterns for these substances. As the research project will only be concluded in 2019, no data is available yet.

A publication from 2016 had already shown that prescribing medications containing opioids to patients with chronic, non-tumour related pain, has significantly increased in recent years. In Germany, patients with chronic, non-tumour related pain received, according to data from the Barmer GEK in 2010, around three quarters of all prescribed opioids, in some cases despite existing contraindications (Just et al., 2016). In Germany, the proportion of those covered by statutory health insurance with at least one opioid prescription per year increased from 3.3 % to 4.5 % between 2000 and 2010, which corresponds to an increase of 37 % (Schubert et al., 2013).

Glaeske (2018) also found that the prescription of opioids had significantly increased in 2016 compared to 2015: oxycodone (+44 %), tapentadol (+39 %), fentanyl (patch) (+6 %) and hydromorphone (+5 %). The already high prescription rate for the combination of oxycodone and naloxone (994,000 packs) increased by another 5 %. High-strength painkillers containing opioids are mainly prescribed for tumour-related pain; however, after the experiences witnessed in the USA with a liberal regulation of such medicinal drugs and the subsequent dramatic increase in abuse and dependent use, the prescription of these medicinal drugs in Germany must continue to be monitored.

Cannabis as medicine

In Germany in recent years only a few hundred patients (2014: 382 persons) have received a licence for the legal use of cannabis as a painkiller. In 2016, the number of licences granted for the acquisition of cannabis and its use for the purposes of medically-assisted self-therapy increased to 1,061 (see also the 2017 workbook Treatment, Bartsch et al., 2017).

With the German Act Amending Narcotics and Other Provisions, which came into force on 10 March 2017, possibilities for prescribing cannabis-based pharmaceuticals were expanded. Just two major health insurance providers (Allgemeine Ortskrankenkassen – AOK and Techniker Krankenkasse – TK) have received 13,000 applications to assume costs for cannabis treatment in the first ten months since the Act came into force (RPonline, 10 January 2018).

Which overall changes will result from the new Act will be apparent from 2018 onwards from the health insurance providers' data, as well as from 2022 onwards in the results of the accompanying data collection set out in the Act.

4 ADDITIONAL INFORMATION

4.1 Additional sources of information

No additional sources of information are currently available on this.

4.2 Further aspects of drug treatment

No additional information is available on this.

4.3 Psychiatric comorbidity

No new information is available on this. The topic was described in detail in the 2017 Treatment workbook (Bartsch et al., 2017).

5 SOURCES AND METHODOLOGY

The sources are assigned to the respective information and can be found in the bibliography under 5.1.

The main sources for the Treatment workbook are:

- Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS) (Base: German Core Data Set, Deutscher Kerndatensatz)
- Statistical Report on Hospital Diagnoses (Krankenhausdiagnosestatistik)
- German Hospital Directory (Deutsches Krankenhausverzeichnis)
- Statistical Report of the German Pension Insurance Scheme (Statistik der Deutschen Rentenversicherung)
- Statistical Report of the Statutory Health Insurance Providers (Statistik der Gesetzlichen Krankenversicherungen)
- Regional monitoring systems
- Substitution register
- Addiction Yearbook 2018 from the DHS

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5.2 Methodology

Outpatient Treatment

The DSHS provides extensive data, based on the KDS, on clients treated on an outpatient basis for the majority of outpatient facilities funded by the *Laender* and municipalities (Braun et al., 2017a, b). Most of the addiction support facilities in Germany use the revised KDS 3.0 (DHS, 2016). Due to these revisions, the comparability of data from different time periods will always be limited.

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

Inpatient care

Many larger facilities, in particular psychiatric clinics, which also offer addiction-specific treatments, are not represented in the DSHS. In order to close this gap as far as possible, data has also been drawn from other sources for the purposes of the REITOX Report.

The Statistical Report on Hospital Diagnoses, produced by the German Federal Statistical Office, documents the diagnoses on discharge of all patients leaving inpatient facilities as well as the main diagnoses, age and gender. The Statistical Report on Hospital Diagnoses is complete but not specifically for addiction and thus offers little detailed information in this area. It does, however, allow a differentiation in the number of cases in line with the ICD-diagnoses (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 and 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 to transfer this information to the standard of the KDS.

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

The breakdown of those two statistical reports according to primary diagnosis is broadly the same, if one takes into account the substantially higher proportion of undifferentiated diagnoses by F19 (multiple substance use and consumption of other psychotropic substances) in the data recorded by

the DRV.

Data from regional monitoring systems serves as a valuable addition to national statistics.

Substitution treatment

Since 1 July 2002, data on substitution treatment in Germany has been recorded by the substitution register which was set up with the purpose of avoiding double prescriptions of substitution drugs as well as of monitoring quality standards on the treatment side. The short-term use of substitution drugs for the purpose of detoxification is not recorded in this register, provided the detoxification treatment lasts no longer than four weeks and the patients no longer require substitution drugs immediately upon completion of the treatment. Since 2010, this data source has provided findings on the number of clients treated and on the substitution drugs used, complete with a list of names of the doctors in charge of treatment. Since a change to the psychotherapy guidelines in 2011, patients receiving substitution treatment have a right to psychotherapy even if they have not achieved abstinence after more than 10 treatment sessions (G-BA 2013).

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