



European Monitoring Centre
for Drugs and Drug Addiction



Treatment

GERMANY

2019 Report of the national
REITOX Focal Point to the EMCDDA
(Data year 2018 / 2019)

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Gefördert durch:



aufgrund eines Beschlusses
des Deutschen Bundestages

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0 SUMMARY (T0)

The treatment system for people with drug-related problems and their relatives in Germany ranges from counselling and 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 primary 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.

44% of outpatient clients who visit treatment facilities due to a drug problem are cannabis users (63.1% of first time clients). One quarter of outpatients are treated for harmful opioid use (26.5%). 14% of all patients submit themselves to outpatient treatment due to stimulant use. Patients with a cannabinoid-related disorder also account for the largest group undergoing inpatient treatment (34%). Other frequent diagnoses are ICD-10 F15 stimulants (22.7%) and F19 other psychotropic substances/polytoxicomania (16.4%).

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 reference date (1 July 2018), the number was 79,400. A total of 2,585 doctors providing substitution treatment reported opioid addicts to the substitution register in 2018.

The percentage share 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 Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS)¹ 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 and amphetamine/methamphetamine, 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 use 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

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 German Core Data Set (Deutschen Kerndatensatz, KDS). The KDS is a data gathering tool specifically for addiction support, which is widely used in both outpatient and inpatient addiction support.

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, possibilities for prescribing cannabis-based pharmaceuticals were expanded. In 2017, according to the National Association of Statutory Health Insurance Funds, around 200,000 applications were registered with health insurance providers, of which 60% were approved. In May 2019, the final licences were awarded for the cultivation of medicinal cannabis in Germany. It amounts to a total of 10.4 tonnes-worth awarded over a four-year period. The first harvests are expected in 2020.

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

1 NATIONAL PROFILE (T1)

1.1 Policies and coordination (T1.1)

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

The drug strategy published in 2012 remains valid for Germany (Drogenbeauftragte der Bundesregierung 2012, see 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 areas of emphasis in the area of treatment, i.a. through promoting projects and research contracts, as they did in 2017 (see 1.4.5 and 1.4.6).

The areas of focus of the Federal Government Commissioner on Narcotic Drugs (Drogenbeauftragte der Bundesregierung), Marlene Mortler, with regards to supporting the further development of diagnostics and treatment, continues to be children from families impacted by addiction, amphetamine, in particular crystal meth, and excessive media use. After five and a half years in office, Mrs. Mortler moved to the European Parliament on 2 July 2019. Her successor, Daniela Ludwig, was appointed in September 2019. She is yet to determine her area of focus for support. Her will become clear as she gains more experience in the position.

The Third Amending Regulation of the German Regulation on the Prescription of Narcotic Drugs (Dritte Verordnung zur Änderung der Betäubungsmittelverschreibungsverordnung, 3.BtMVVÄndV) (BMG, 2017), passed by the German Federal Government in 2017, regulates the statutory requirements for implementing substitution treatment for opioid addicts. The development of evidence-based guidelines for the provision of substitution therapy was transferred to the guideline competence of the German Medical Association (Bundesärztekammer, BÄK). The new guidelines have been in use since 2 October 2017. They have great importance in terms of improving and securing substitution in medical practice. Above all, they represent an amendment to take account of new scientific evidence (see Dammer et al., 2017). In December 2018 a decision by the Federal Joint Committee (Gemeinsamen Bundesausschuss) came into force, with which the previously predominant abstinence-oriented treatment approaches were replaced with a more broadly defined objective. It is becoming clearer that opioid dependence is a serious chronic illness which generally requires life-long treatment and in which physical, psychological and social aspects all have to be taken into account equally (G-BA, 2018).

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

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, perform 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 funding acute treatment (i.a. detoxification), pension insurance providers are primarily responsible for funding 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 are responsible for processing and updating the guidelines for substitution-based treatment in the scope of the German Regulation 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 the *Laender*. The funding for PSC is dealt with in varying ways by the *Laender*, however funding usually comes from the municipalities, either as 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, Volume 12 (SGB XII)).

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

No new information is available on this.

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

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 are anchored constitutionally 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 legislation.

In 2017, the revised KDS (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 institutes in the new category "outpatient facilities". Due to the new method of documentation, the data from 2017 onwards is only comparable to a limited extent with data from previous years, and does not correspond to standard table 24 (ST 24), which has been completed from 2017 according to the categories valid at that time (see Table 1).²

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. At the heart of the addiction support system are (in addition to family doctors) the approximately 1,614 outpatient addiction counselling and treatment centres, low-threshold facilities and specialist and outpatient facilities within institutions. Furthermore, treatment and care are provided in 379 inpatient rehabilitation facilities (incl. day care rehabilitation facilities and transition), as well as 1,013 sociotherapy facilities (for example outpatient assisted living, employment and occupational projects and inpatient social therapy facilities) (IFT, 2018). The 407 specialist psychiatric departments (92 of which are exclusively for the treatment of addiction disorders), with a total of 4,348 beds for addicts, play a key role: they are not only responsible for detoxification, but also for crisis intervention and treating psychiatric comorbidities (Destatis, 2018a).

The majority of outpatient addiction support facilities (91.1%) are funded by independent, charitable bodies, in particular the Freie Wohlfahrtspflege (Braun et al., 2019a). In inpatient treatment, independent charitable institutions provide 54.7% of the support facilities (Braun et al., 2019b). In addition, public and private entities are also active in outpatient (6% and 0.9% respectively) and inpatient (12.4% and 29.9% respectively) addiction treatment. The number of other involved parties is small. They account for 2% of outpatient and 2.9% of inpatient facilities (Braun et al., 2019a & b).

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, offer a variety of services for drug addicts, from low-threshold services, to counselling and treatment, psychosocial care of

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

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). In this context, a differentiation is made between written contracts, common concepts and other agreements. For example, 19.7% of outpatient facilities reported having written contracts with facilities or services in the area of addiction treatment, 13.1% with work, qualification and employment promotion facilities or services. 59.9% of facilities made other agreements with self-help associations (Braun et al., 2019a).

1.2.1 Outpatient drug treatment system – main providers and client utilization (T1.2.1)

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. Current data is therefore no longer comparable with data prior to 2017. It remains the case, however, that outpatient addiction support facilities make up the largest proportion of counselling, motivation enhancement and outpatient treatment (1,614 facilities) (IFT, 2018). They are the first port of call for clients with addiction problems, when 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 outpatient facilities' costs is borne by the providers themselves. With the exception of outpatient medical rehabilitation, outpatient addiction support is, in varying degrees, funded by voluntary contributions from the *Laender* and municipalities on the basis of municipal services of general interest. This is anchored constitutionally 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 prescribing substitute drugs (see section 1.4.9). Medical treatment is usually accompanied by 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 also responsible for addicts, in addition to many other things. They are generally publicly funded. 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 facilities | Type of facility National definition | Number of persons treated |
|---|----------------------------|--|---------------------------|
| Specialised drug treatment centres | 1,614 | Outpatient facilities, includes: - specialised counselling and treatment centres: - low-threshold facilities - specialist and outpatient facilities within institutions | No information |
| Low-threshold agencies | No information | Low-threshold facilities | No information |
| General primary health care (e.g. GPs) | >2,585** | Medical practice/psychotherapeutic practice (mainly outpatient substitution treatment) | >79,400** |
| General mental health care | No information | Socio-psychiatric services/community psychiatric services | No information |
| Prisons (in-reach or transferred) | 71 | Facilities in prisons (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.

** There is currently no data available on the number of medical or psychotherapeutic practices that treat or have treated addicts, nor on the number of patients treated for addiction in medical or psychotherapeutic practices. The numbers illustrated here refer exclusively to the number of substituting doctors and substitution patients on the reference date in 2018. Since medical practices are the first port of call, a significantly higher number can be assumed in both cases (BOPST, 2019).

(IFT, 2018; Bundesopiumstelle [BOPST], 2019)

1.2.2 Further aspects on the availability of outpatient treatment provision (T1.2.2)

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 increased methamphetamine use in some *Laender*, the counselling and treatment competence and capacities in relation to (meth) amphetamine have been well-developed. 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, 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

- to estimate the availability and type of medication for the treatment of the specified illnesses among prisoners in Germany and
- 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 serving sentences 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 in relation to medication to treat opioid dependence, TB, HIV and HCV in prisons and prison hospitals in selected *Laender* 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).

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

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 as far as OST and HCV therapy are concerned.

The wide range in the prevalence rates for OST (0% in Saarland to 7.9% in Bremen) suggests very different approaches to treatment possibilities. The northern *Laender* in particular exhibited high OST rates, which underlines their liberal and harm reduction-oriented policy, whereas in 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 in the prison setting (Schulte et al., 2009; Reimer et al., 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 health care 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 (see this year's Prison workbook, Schneider et al., 2018).

1.2.3 Further aspects of outpatient drug treatment provision and utilisation (T1.2.3)

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

1.2.4 Inpatient drug treatment system – main providers and client utilisation (T1.2.4)

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 106,000⁴ addiction treatments in total which are not related to alcohol or tobacco dependence (Destatis, 2018b). 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. With the Flexirentengesetz (Flexible Pension Act) which came into force in 2017, child rehabilitation (including on an outpatient basis) became a mandatory service covered by the statutory pension insurance providers. Health insurance providers have a subordinate responsibility.

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 those with psychiatric comorbidity (see 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)⁵

| Type of facility EMCDDA term | Total number of facilities | Type of facility National definition | Number of persons treated |
|--|-------------------------------|---|---------------------------------|
| Hospital-based residential drug treatment | 224** | Specialised psychiatric hospitals/specialist departments | 106,194* |
| Residential drug treatment (non-hospital based) | 379** | Inpatient rehabilitation facilities | 28,778*** |
| Therapeutic communities | No information | No information | No information |
| Prisons | Approx. 71** | Secure psychiatric units | No information |
| Sociotherapeutic drug treatments | 1,013** | Sociotherapeutic facilities | No information |

(*Destatis, 2018b; **IFT, 2018; *** DRV, 2019c)

⁴ This number is calculated using the very detailed diagnosis data of hospital patients from the Federal Statistical Office (Destatis) (2018). It includes all treatments with the primary diagnosis ICD-10-GM-2017 F11 to F16 as well as F18 and F19 (Destatis, 2018b).

⁵ 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.

1.2.5 Further aspects of inpatient drug treatment provision (T1.2.5)

Around 10% of facilities which provide inpatient withdrawal treatment, have developed concepts to also offer withdrawal 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 and utilisation (T1.2.6)

Although demand for inpatient treatment remains high, the number of applications for rehabilitation treatments decreased by a further 2.2% to 77,116 applications in 2018 (DRV, 2019a). In addition, the level of no-shows for withdrawal treatment increases the economic pressure on many inpatient facilities. For the “Seamless process for qualified withdrawal/addiction rehabilitation” (“Nahtlosverfahren Qualifizierter Entzug/Suchtrehabilitation”), which came into force in 2017, the German Statutory Pension Insurance Scheme (deutsche Rentenversicherung, DRV), the statutory health insurance providers (gesetzliche Krankenversicherung, GKV) and the German Hospital Federation (Deutsche Krankenhausgesellschaft, DKG), make recommendations for action which are intended to improve access to medical rehabilitation following qualified withdrawal. In that context, seamless transition to rehabilitation is requested, at the latest seven days prior to the end of the withdrawal treatment, by the hospital and attending doctor and with the consent of the patient. This can be an inpatient or all-day outpatient rehabilitation, or a combination treatment. A list is made available to hospitals by rehabilitation agency contact partners. Rehabilitation agencies should process decisions within five working days. In addition, patients from qualified withdrawal treatment should be prioritised when allocating places. It remains to be seen to what extent the simplification of access to rehabilitation from qualified withdrawal treatment will improve the situation (DRV, GKV & DKG, 2017; Ueberschär et al., 2017).

1.2.7 Ownership of inpatient drug treatment facilities (T1.2.7)

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

Table 3 Proportions of types of ownership in outpatient treatment in per cent (%)

| | Public ownership | Charitable ownership | Private ownership | Other |
|---|------------------|----------------------|-------------------|----------------|
| Outpatient facilities (includes specialised counselling and treatment centres, low-threshold facilities, outpatient facilities within institutions) | 6.0% | 91.1% | 0.9% | 2.0% |
| Low-threshold facilities | No information | No information | No information | No information |
| Medical practice/psychotherapeutic practice (mainly outpatient substitution treatment*) | Minority | - | Majority | - |
| Socio-psychiatric services/Community psychiatric services)** | No information | No information | No information | No information |
| Facilities in prisons | 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.

(Braun et al., 2019a)

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

Table 4 Proportions of types of ownership in inpatient treatment in per cent (%)

| | Public ownership | Charitable ownership | Private ownership | Other |
|--|------------------|----------------------|-------------------|----------------|
| Specialised psychiatric hospitals/specialist departments | No information | No information | No information | No information |
| Inpatient rehabilitation facilities | 12.4% | 54.7% | 29.9% | 2.9% |
| Therapeutic communities | No information | No information | No information | No information |
| Secure psychiatric units | No information | No information | No information | No information |
| Sociotherapeutic facilities (inpatient and day care) | Close to 0 | 81 | 4 | 15 |

(Braun et al., 2019b)

1.3 Key data (T1.3)

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

Table 5 People treated for the first time and repeat patients by primary diagnosis (in %)

| Primary Diagnosis | Repeat Admission (%) | | Persons treated for the first time (%) | |
|--|----------------------|------------|--|------------|
| | Inpatient | Outpatient | Inpatient | Outpatient |
| F11 Opioids | 17.2% | 35.9% | 9.9% | 10.4% |
| F12 Cannabinoids | 33.2% | 31.4% | 43.1% | 63.1% |
| F13 Sedatives/Hypnotics | 2.8% | 1.7% | 2.0% | 1.6% |
| F14 Cocaine | 7.8% | 7.7% | 9.7% | 7.2% |
| F15 Stimulants | 22.9% | 14.8% | 35.2% | 13.4% |
| F16 Hallucinogens | 0.1% | 0.1% | 0.1% | 0.2% |
| F18 Volatile Substances | 0.03% | 0.02% | | 0.03% |
| F19 Multiple substance use/use of other substances | 16.0% | 8.5% | 0.005% | 4.1% |
| Total (100 %) | 6,963 | 32,899 | 694 | 22,778 |

Source: Braun et al., 2019a & b, T2.02

Outpatient Treatment

In 2018 data from a total of 325,052 treatments (not including one-off contacts) carried out in 861 outpatient facilities was collected within the framework of the DSHS. However, these figures also include treatments for tobacco and alcohol. For the following remarks, only those clients who were primarily treated for illicit substance use (including sedatives/hypnotics and volatile solvents) were taken into account (clients who were treated primarily for a disorder primarily related to alcohol consumption made up 48.5% of all primary diagnoses in outpatient addiction care in 2018). For 2018, the DSHS contains data on the primary diagnoses from a total of 65,225 treatments from 861 facilities that were started or completed in outpatient psychosocial addiction support counselling centres due to problems with illicit drugs (Braun, Dauber, Künzel & Specht, 2019a).

Today, only 26.5% of cases of treatment/counselling with a primary diagnosis in the area of illicit drugs concern clients who have primarily entered counselling or treatment due to a dependence or harmful use of opioids. Almost half of all cases (44.0%) concern clients with a mental behavioural disorder due to cannabinoids (see Table 8). Amongst persons who were in addiction specific treatment due to illicit substances for the first time, cannabinoids were also in first place here, at 63.1%. The second largest group, with a considerable margin, is first-time clients with the primary diagnosis of stimulants (13.4%), ahead of first-time clients with opioid-related disorders (10.4%) (Braun et al., 2019a). Repeat-clients were predominantly those with opioid and cannabinoid related disorders (35.9% and 31.4% respectively, see Table 5).

Inpatient treatment

In general, inpatient treatment in Germany is carried out under drug-free conditions. Since documentation standards are determined by the respective source of funding and not by the type of treatment, all inpatient treatments carried out for persons with primary diagnoses F11-F16 and F18-F19 are presented in the following with a differentiation by acute hospital treatment (Statistical Report on Hospital Diagnoses, Krankenhausdiagnosestatistik), and rehabilitation therapy (Statistical Report of the German Statutory Pension Insurance Scheme, Statistik der Deutschen Rentenversicherung). Furthermore, the DSHS provides data for a selection of specialist clinics and facilities in accordance with the German Core Data Set on Documentation in the area of Addict Support (Deutscher Kerndatensatz zur Dokumentation im Bereich der Suchtkrankenhilfe, KDS; see also section 5.2). Out of the total of 31,188 inpatient treatments for substance-related disorders in 137 facilities documented by the DSHS in 2018, 9,398 were related to illicit substances (including sedatives/hypnotics and volatile solvents) (Braun et al. 2019b). Of the treatments with primary drug problems recorded by the DSHS, the proportion of those with a primary diagnosis based on dependence or harmful use of cannabinoids is 34.0%, the proportion of treatments on the grounds of opioids is 15.6%. In relation to all primary diagnoses recorded in the area of addiction, 10.7% of treatments are due to cannabinoids which is the largest diagnosis group in inpatient treatment, after treatments due to alcohol at 64.3%. The proportion of treatments

due to stimulant use (22.7% of all inpatient treatments due to illicit drugs, 7.1% of all inpatient addiction treatments overall) has continuously increased in previous years, overtaking in 2015 the proportion for opioid treatments (Braun et al., 2019b).

Table 6 Patients treated on an inpatient basis by primary diagnosis

| | | DSHS | | | | |
|--|--------------------------|--|--------------|--------------|--------------|--------------|
| ICD-10 GM | Hospital Statistics 2017 | DRV** | 2018*** | | | |
| | | 2018 | 2017*** | Males | Females | Total |
| | Total | Total | Total | | | Total |
| F11 Opioids | 29.6% | 96.1% (drugs) 3.9% (medicinal drugs) | 16.40% | 15.6% | 15.7% | 15.6% |
| F12 Cannabinoids | 17.6% | | 31.6% | 35.2% | 29.2% | 34.0% |
| F13 Sedatives/hypnotics | 9.0% | | 3.1% | 1.5% | 8.0% | 2.8% |
| F14 Cocaine | 3.7% | | 6.8% | 9.4% | 4.3% | 8.4% |
| F15 Stimulants | 9.4% | | 22.6% | 21.8% | 25.9% | 22.7% |
| F16 Hallucinogens | 0.6% | | 0.1% | 0.1% | 0.2% | 0.1% |
| F18 Volatile substances | 0.2% | | 0.1% | 0.01% | 0.1% | 0.03% |
| F19 Other psychotropic substances & multiple substance use | 30.0% | | 19.3% | 16.3% | 16.5% | 16.4% |
| Total | 31,828 | | 9,550 | 9,159 | 7,462 | 1,936 |

Source: * Destatis, 2018b; ** DRV 2019b; DRV 2019c; *** Braun et al., 2018, ****Braun et al., 2019b

Table 7 Summary table - Clients in treatment

* The available data sets should not be seen as cumulative, rather they overlap in part with the same groups of persons within

| Number of clients | |
|----------------------------|--|
| Total clients in treatment | According to the DSHS with primary diagnosis illicit drugs |
| | outpatient: 65,225 |
| | inpatient: 9,398 |
| Total OST clients | 79,400 |
| Total | No information |

outpatient and/or inpatient care. Therefore, it is impossible to derive overall estimates from the routine data, in particular when one takes into account care from family doctors.

Source: Braun et al., 2019a, b; BOPST, 2019.

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

Table 8 Primary drug of clients in per cent in outpatient and inpatient settings

| Primary Diagnosis | Inpatients | Outpatients |
|---|--------------|---------------|
| F11 Opioids | 15.6% | 26.5% |
| F12 Cannabinoids | 34.0% | 44.0% |
| F13 Sedatives/hypnotics | 2.8% | 1.6% |
| F14 Cocaine | 8.4% | 7.5% |
| F15 Stimulants | 22.7% | 14.0% |
| F16 Hallucinogens | 0.1% | 0.1% |
| F18 Volatile substances | 0.03% | 0.0% |
| F19 Other Psychotr. subst./polytoxicomania | 16.4% | 6.3% |
| Total (100%) | 9,398 | 65,225 |

Source: Braun et al., 2019a & b, T3.01

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

In addition to the data used here on illicit drugs, the DSHS also collects data on legal drugs such as alcohol and tobacco, as well as non-substance-related addictions. During the preparation of this workbook, therefore, some of the existing data was used to exclude legal drugs or non-substance-related addictions for the respective presentation.

1.3.4 Characteristics of clients in treatment (T1.3.4)

Outpatient Treatment

The collection of the KDS by the DSHS incorporates a variety of information on socio-demographic data of clients and treatments, which will be presented below.

Overall, the three most frequent primary diagnoses for both men and women (in descending order) are F12 - cannabinoids, F11 - opioids and F15 - stimulants.

Table 9 Patients treated on an outpatient basis, by primary diagnosis and gender

| Primary diagnosis | Outpatient | | |
|--|---------------|---------------|-----------|
| | Male | Female | Undefined |
| F11 Opioids | 25.8% | 29.4% | 8.3% |
| F12 Cannabinoids | 46.4% | 34.7% | 75.0% |
| F13 Sedatives/hypnotics | 0.9% | 4.4% | |
| F14 Cocaine | 8.1% | 5.0% | |
| F15 Stimulants | 12.3% | 20.3% | |
| F16 Hallucinogens | 0.1% | 0.2% | |
| F18 Volatile substances | 0.02% | 0.0% | |
| F19 Other Psychotr. subst./polytoxicomania | 6.3% | 6.0% | 16.7% |
| Total (100%) | 51,974 | 13,227 | 24 |

Source: Braun et al., 2019a & b, T3.01

The clients are significantly more frequently male in almost all primary diagnosis groups. Only in the group of patients treated for sedatives/hypnotics was there a higher proportion of women than men (54.0% vs. 45.1%) treated on an outpatient basis.

The average age for the illicit drugs diagnosis groups was 32.2; for female clients it was somewhat lower, at 31.5, than for male clients, at 32.5. Those with the primary diagnosis F13 - sedatives/hypnotics are the oldest diagnosis group on average at 44 years old; F18 - volatile substances, at 23.5 years old, and cannabinoids, at 25.1 years old, are the youngest (see Fig. 1). If one differentiates the data by gender, male clients with the primary diagnosis F18 - volatile substances (24.2 years old) are the youngest and F13 - sedatives/hypnotics (41.1 years old) the oldest; among female clients, the lowest average age group is also in the diagnosis group F18 - volatile substances (22.3 years old) and the highest is F13 - sedatives/hypnotics (46.4 years old).

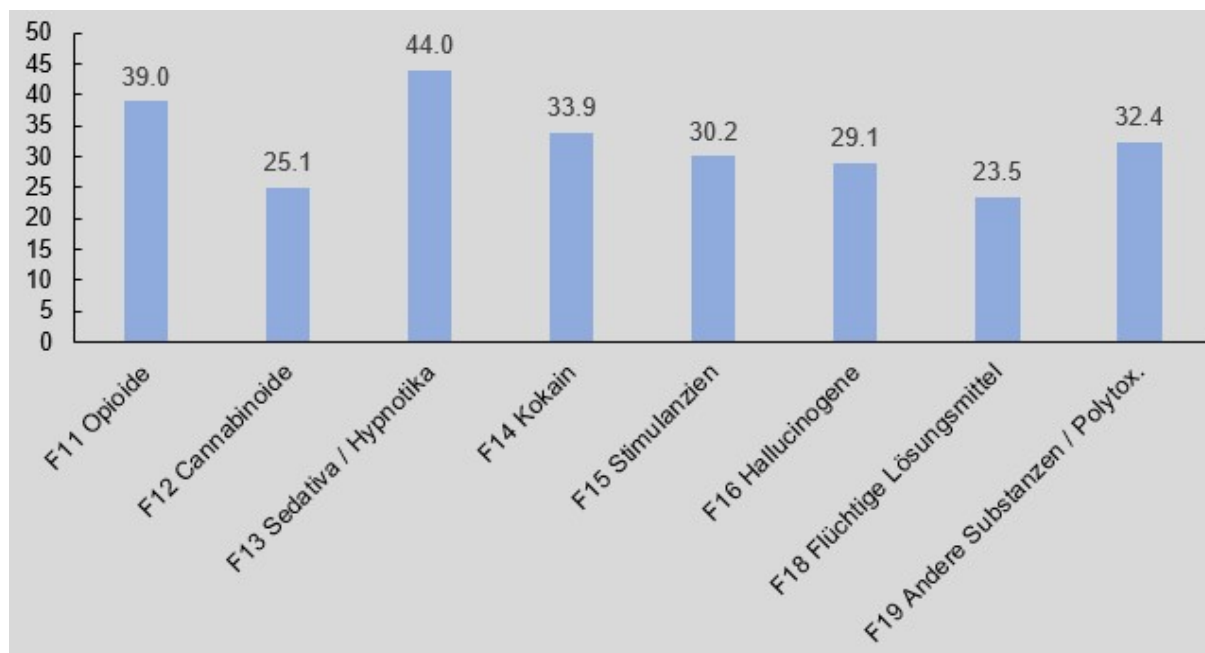


Figure 1 Average age of patients treated on an outpatient basis at the start of treatment, by primary diagnosis

Source: Braun et al., 2019a, T3.02

Between 21.4% and 51.0% of all clients treated on an outpatient basis have a partner, between 20% and 60.4% live with their partner in the same household (see Table 10). On average, the women undergoing treatment have 1.46 children, which more or less corresponds to the national average of 1.57 children (Max Planck Institute for Demographic Research & Vienna Institute of Demography, 2019; Braun et al., 2019a).

Table 10 Living situation of patients treated on an outpatient basis, by primary diagnosis

| Primary diagnosis | Living together with | | | | | |
|--|----------------------|---------|------------|-----------|-------------------|-----------------|
| | Living alone | Partner | Child(ren) | Parent(s) | Other relative(s) | Other person(s) |
| F11 Opioids | 46.0% | 45.7% | 24.5% | 18.5% | 8.3% | 26.7% |
| F12 Cannabinoids | 30.0% | 21.2% | 12.3% | 54.4% | 14.8% | 17.5% |
| F13 Sedatives/hypnotics | 41.8% | 60.4% | 33.0% | 19.1% | 3.9% | 9.0% |
| F14 Cocaine | 37.2% | 47.7% | 26.9% | 19.6% | 7.5% | 24.6% |
| F15 Stimulants | 39.4% | 39.6% | 28.5% | 28.0% | 9.6% | 20.0% |
| F16 Hallucinogens | 38.8% | 25.0% | 7.5% | 42.5% | 10.0% | 30.0% |
| F18 Volatile substances | 28.6% | 20.0% | 10.0% | 60.0% | 10.0% | 10.0% |
| F19 Other Psychotr. subst./polytoxicomania | 43.5% | 36.1% | 19.3% | 30.0% | 12.0% | 26.0% |

Source: Braun et al., 2019a, T3.04

Between 10.2% and 42.3% of all clients treated on an outpatient basis have a migration background. A distinction is made between those who migrated themselves, those who migrated with parents and third generation migrants (see Table 11). A closer analysis of gender does not reveal any large differences.

The primary diagnoses with the largest proportion of people with a migration background are F14 - cocaine, F11 - opioids, and F12 - cannabinoids (see Table 11). 33.4% of cocaine addicts with a migration background are originally from Turkey. Among people with the primary diagnosis F11 opioids, 21.1% of those with a migration background are from Russia, and 15.1% from Kazakhstan. The largest proportion of migrants with the primary diagnosis F12 - cannabinoids are from Turkey (23.6%).

Table 11 Migration background of patients treated on an outpatient basis, by primary diagnosis

| Primary diagnosis | Migration background | | | |
|---|-------------------------|---------------------|---------------------------|--|
| | No migration background | Migrated themselves | Born as child of migrants | Exclusively 3 rd generation migrant |
| F11 Opioids | 62.6% | 28.1% | 9.2% | 0.2% |
| F12 Cannabinoids | 77.6% | 9.6% | 12.2% | 0.5% |
| F13 Sedatives/ hypnotics | 84.6% | 10.1% | 4.9% | 0.4% |
| F14 Cocaine | 57.9% | 22.0% | 19.7% | 0.4% |
| F15 Stimulants | 89.3% | 6.0% | 4.6% | 0.2% |
| F16 Hallucinogens | 91.8% | 4.9% | 3.3% | |
| F18 Volatile substances | 81.8% | 9.1% | 9.1% | |
| F19 Other Psychotr. subst./polytoxicomania | 79.8% | 10.6% | 9.2% | 0.4% |

Source: Braun et al., 2019a, T3.12

When analysing this data, however, it should be taken into account that it only covers clients who have actually entered the addiction support system. It must not be confused with actual need. Since it can also be seen from the DSHS that the counselling takes place in a language other than German in on average only approx. 5.5% of cases, one can assume that for people with insufficient knowledge of German, access to the addiction support system has a significantly higher threshold and is significantly less frequent.

Table 12 Highest level of education in patients treated on an outpatient basis, by primary diagnosis

| Primary diagnosis | Highest level of education | | | | | | |
|--|----------------------------|---|--|----------------------------|----------------------------------|-----------------|--------------------------------|
| | Non started yet | Currently in higher or vocational education | Not completed higher or vocational education | Professional qualification | Master craftsperson / Technician | Academic degree | Other vocational qualification |
| F11 Opioids | 15.5% | 1.9% | 39.2% | 38.3% | 0.9% | 2.0% | 2.3% |
| F12 Cannabinoids | 32.9% | 15.9% | 21.2% | 26.2% | 0.8% | 1.6% | 1.4% |
| F13 Sedatives/hypnotics | 9.8% | 4.3% | 14.9% | 53.8% | 2.1% | 11.6% | 3.5% |
| F14 Cocaine | 13.4% | 4.7% | 29.3% | 43.0% | 1.8% | 5.2% | 2.5% |
| F15 Stimulants | 17.7% | 6.3% | 28.5% | 42.8% | 1.2% | 1.7% | 1.9% |
| F16 Hallucinogens | 28.8% | 11.9% | 10.2% | 33.9% | 1.7% | 8.5% | 5.1% |
| F18 Volatile substances | 58.3% | 16.7% | | 16.7% | | 8.3% | |
| F19 Other Psychotr. subst./polytoxicomania | 20.1% | 4.7% | 33.0% | 37.6% | 1.0% | 1.9% | 1.7% |

Source: Braun et al., 2019a, T3.16

The proportion of clients who had not started vocational training was under 20% in about half of the primary diagnoses (Table 12). Three relatively higher proportions can be found for the primary diagnoses cannabinoids (32.9%), hallucinogens (28.8%) and volatile substances (58.3%), which when compared to other groups however, have a significantly higher percentage among clients who are currently in higher or vocational education. Since these are also the three youngest diagnosis groups on average (see Fig. 1) a connection seems likely.

Approximately 11.4% of male and 10.6% of female clients in the outpatient treatment system have left school without any school-leaving qualifications. The rates are highest among those treated with the primary diagnoses (in descending order) opioids (16.5%), other psychotropic substances/polytoxicomania (14.4%) and cocaine (13.8%) (Braun et al., 2019a, T3.15).

Table 13 Employment situation of patients treated on an outpatient basis on the day before the start of their care, by primary diagnosis (in %)

| Primary diagnosis | Employment situation on the day before the start of care | | | | | | | | | |
|---------------------------------------|--|--|----------------------------|-----------------------------|--|--------------------------|-------------------------|---------------|--------------------|-------------------|
| | Trainee | Blue/white collar worker/civil servant | Selfemployment/ freelancer | Invocational rehabilitation | On parental leave/ on (long-term) sickness | Unemployed under SGB III | Unemployed under SGB II | Pupil/student | Housewife/-husband | Pensioner/retired |
| F11 Opioids | 0.9% | 18.5% | 1.1% | 0.2% | 1.0% | 4.5% | 50.7% | 1.0% | 0.6% | 4.5% |
| F12 Cannabinoids | 11.6% | 22.5% | 1.2% | 0.4% | 1.3% | 4.0% | 24.6% | 21.5% | 0.3% | 0.8% |
| F13 Sedatives/hypnotics | 2.4% | 29.2% | 3.5% | 0.4% | 5.4% | 3.5% | 23.0% | 3.6% | 3.4% | 19.2% |
| F14 Cocaine | 2.8% | 36.6% | 6.1% | 0.4% | 1.6% | 5.8% | 23.9% | 2.4% | 0.5% | 0.9% |
| F15 Stimulant | 4.7% | 27.8% | 1.3% | 0.5% | 2.2% | 6.1% | 38.1% | 5.0% | 0.5% | 1.6% |
| F16 Hallucinogens | 8.6% | 27.6% | 10.3% | | | 3.4% | 20.7% | 15.5% | 3.4% | |
| F18 Volatile substances | 13.3% | 13.3% | | | 13.3% | | 13.3% | 46.7% | | |
| F19 Other Psychotr. subst./polytoxic. | 3.3% | 16.7% | 1.1% | 0.4% | 1.8% | 5.8% | 44.2% | 4.7% | 0.4% | 2.7% |

Source: Braun et al., 2019a, T3.18 (sample)

All diagnosis groups include a large proportion of unemployed clients. They make up approximately one third of those patients with the primary diagnoses cannabinoids, sedatives/hypnotics and cocaine, nearly half of those with primary diagnosis psychotropic substances/polytoxicomania and for opioids it is even more than half (see Table 13). The group containing the least unemployed people was that using volatile substances. However, the average age of the diagnosis groups should be taken into account when looking at this data. For example it is the lowest for volatile substances, at 23.5 years old (see Fig. 1) - accordingly, the proportions of pupils/students (46.7%) and trainees/apprentices (13.3%) are higher (Table 13).

Inpatient treatment

Table 14 Primary diagnosis by gender

| Primary diagnosis | Inpatient | | |
|---|-----------|--------|-----------|
| | Male | Female | Undefined |
| F11 Opioids | 15.6% | 15.7% | |
| F12 Cannabinoids | 35.2% | 29.2% | |
| F13 Sedatives/ hypnotics | 1.5% | 8.0% | |
| F14 Cocaine | 9.4% | 4.3% | |
| F15 Stimulants | 21.8% | 25.9% | |
| F16 Hallucinogens | 0.1% | 0.2% | |
| F18 Volatile substances | 0.01% | 0.1% | |
| F19 Other Psychotr. subst./polytoxicomania | 16.3% | 16.5% | |
| Total | 7,462 | 1,936 | |

The largest proportion of people treated on an inpatient basis in the diagnosis group “illicit drugs” for both male and female patients is that with the primary diagnosis cannabinoids (35.2% and 29.2% respectively). The next most frequent diagnosis is, also for both genders, ICD-10 F15 (stimulants). The lowest proportion of treatments in this area was for volatile substances (0.01% and 0.1% respectively) (see Table 14). Looking at the gender distribution by diagnosis group, it is noticeable that significantly more men than women were affected in most primary diagnosis groups. Exceptions are the diagnoses F13 sedatives (41.9% males treated v. 58.1% females) and F18 volatile substances (33.3% males v. 66.7% females).

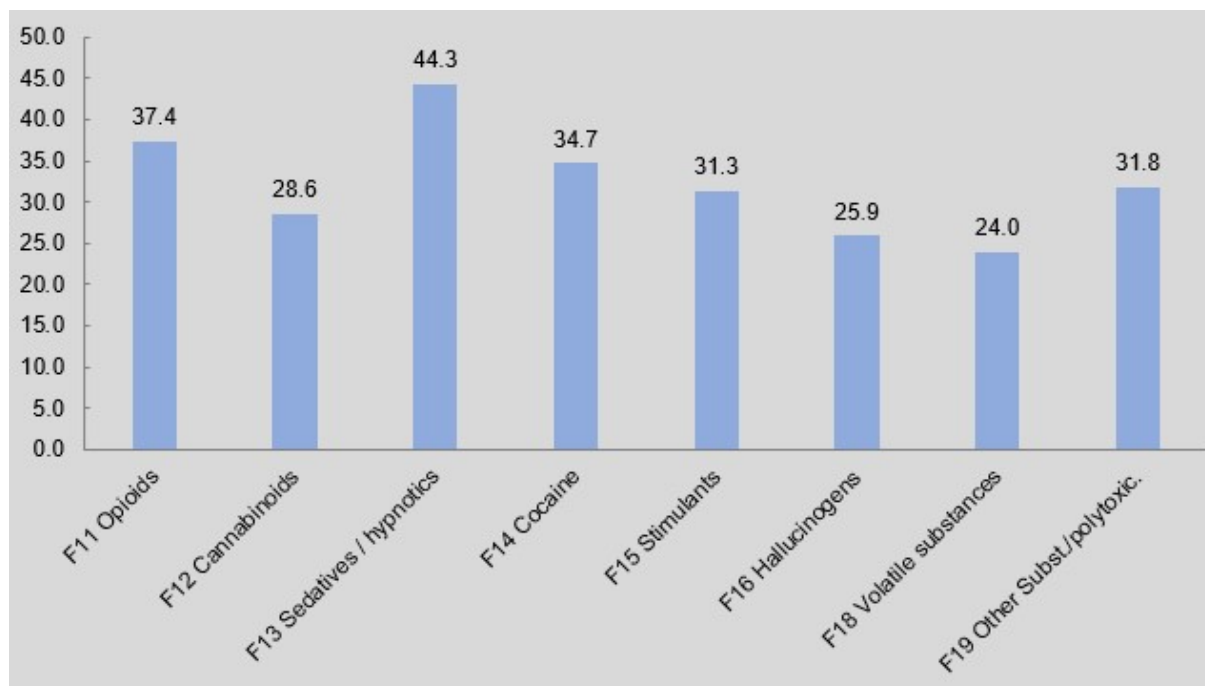


Figure 2 Average age of patients at the start of treatment, by primary diagnosis

Source: Braun et al., 2019b, T3.02

The average age in four out of the eight main diagnoses is between 31 and 38 years old. The oldest patients on average are treated for the use of sedatives/hypnotics (44.3 years old), the youngest for volatile substances (see Figure 3).

Table 15 Living situation of patients treated on an inpatient basis, by primary diagnosis (in %)

| Primary diagnosis | Living together with | | | | | |
|---|----------------------|---------|------------|-----------|-------------------|-----------------|
| | Living alone | Partner | Child(ren) | Parent(s) | Other relative(s) | Other person(s) |
| F11 Opioids | 60.2% | 54.2% | 23.4% | 30.0% | 12.5% | 17.4% |
| F12 Cannabinoids | 52.2% | 31.4% | 13.1% | 52.9% | 19.6% | 21.4% |
| F13 Sedatives/ hypnotics | 46.6% | 63.5% | 26.2% | 15.9% | 13.5% | 10.3% |
| F14 Cocaine | 52.5% | 56.7% | 25.9% | 37.5% | 20.3% | 22.4% |
| F15 Stimulants | 58.4% | 41.0% | 21.7% | 36.6% | 15.6% | 19.3% |
| F16 Hallucinogens | 55.6% | | | 100.0% | 25.0% | |
| F18 Volatile substances | 33.3% | | 50.0% | | 50.0% | 50.0% |
| F19 Other Psychotr. subst./polytoxicomania | 56.1% | 38.4% | 12.0% | 46.8% | 20.3% | 29.2% |

Source: Braun et al., 2019b, T3.04

Excluding those treated for volatile substances (F18) and sedatives/hypnotics (F13), more than half of those treated for all primary diagnoses live alone.

Table 16 Migration background of those treated on an inpatient basis, by primary diagnosis (in %)

| Primary diagnosis | Migration background | | | |
|---|-------------------------|---------------------|---------------------------|--|
| | No migration background | Migrated themselves | Born as child of migrants | Exclusively 3 rd generation migrant |
| F11 Opioids | 66.0% | 22.7% | 10.6% | 0.8% |
| F12 Cannabinoids | 78.1% | 9.1% | 12.4% | 0.4% |
| F13 Sedatives/ hypnotics | 86.4% | 9.5% | 4.1% | |
| F14 Cocaine | 60.4% | 17.2% | 21.2% | 1.2% |
| F15 Stimulants | 89.3% | 5.5% | 4.5% | 0.6% |
| F16 Hallucinogens | 100.0% | | | |
| F18 Volatile substances | 100.0% | | | |
| F19 Other Psychotr. subst./polytoxicomania | 81.0% | 8.6% | 9.7% | 0.7% |

Braun et al., 2019b, T3.12

Most of those treated on an inpatient basis have no migration background. The two diagnosis groups with the highest proportion of migrants are F14 cocaine and F11 opioids (see Table 16). The greatest proportion of migrants with a disorder due to the use of cocaine come from Turkey (34%). 20.1% of migrants who were treated on the basis of opioids came from Kazakhstan and 19.8% from Russia (Braun et al., 2019b).

Table 17 Highest level of education of those treated on an inpatient basis, by primary diagnosis (in %)

| Primary diagnosis | Highest level of education | | | | | | |
|--|----------------------------|---|--|----------------------------|----------------------------------|-----------------|--------------------------------|
| | Non started yet | Currently in higher or vocational education | Not completed higher or vocational education | Professional qualification | Master craftsperson / Technician | Academic degree | Other vocational qualification |
| F11 Opioids | 12.3% | 1.1% | 35.5% | 43.8% | 1.4% | 2.5% | 3.4% |
| F12 Cannabinoids | 21.7% | 4.3% | 35.1% | 34.1% | 1.2% | 1.0% | 2.6% |
| F13 Sedatives/hypnotics | 8.4% | 0.8% | 13.4% | 56.3% | 3.4% | 10.5% | 7.1% |
| F14 Cocaine | 13.6% | 2.0% | 28.1% | 48.3% | 1.9% | 2.9% | 3.2% |
| F15 Stimulants | 15.4% | 2.1% | 31.6% | 45.1% | 1.4% | 2.1% | 2.4% |
| F16 Hallucinogens | | | 40.0% | 20.0% | 10.0% | 10.0% | 20.0% |
| F18 Volatile substances | | 33.3% | | 66.7% | | | |
| F19 Other Psychotr. subst./polytoxicomania | 15.5% | 2.7% | 33.6% | 44.0% | 1.2% | 1.4% | 1.6% |

Source: Braun et al., 2019b, T3.16

The proportion of clients who had not started vocational training, with the exception of those treated for cannabinoids, was under 20% for all of those treated. Overall, most patients have an occupational qualification. An equally large proportion has started higher or vocational education but not finished it (see Table 17).

Approximately 7.8% of male and 9.5% of female clients in the inpatient treatment system have left school without school-leaving qualifications. The rates are highest among those treated with the primary diagnoses (in descending order) stimulants (13.3%), cannabinoids (12.4%) and cocaine (11.7%) (Braun et al., 2019a, T3.15).

Table 18 Employment situation on the day before the start of care, by primary diagnosis (in %)

| Primary diagnosis | Employment situation on the day before the start of care | | | | | | | | | |
|---------------------------------------|--|--|----------------------------|-----------------------------|--|--------------------------|-------------------------|---------------|--------------------|-------------------|
| | Trainee | Blue/white collar worker/civil servant | Selfemployment/ freelancer | Invocational rehabilitation | On parental leave/ on (long-term) sickness | Unemployed under SGB III | Unemployed under SGB II | Pupil/student | Housewife/-husband | Pensioner/retired |
| F11 Opioids | 0.7% | 11.9% | 0.4% | 0.6% | 2.3% | 9.9% | 56.3% | 0.4% | 0.4% | 3.1% |
| F12 Cannabinoids | 3.1% | 13.0% | 0.3% | 0.9% | 2.0% | 15.1% | 48.5% | 3.0% | 0.3% | 1.1% |
| F13 Sedatives/ hypnotics | 0.4% | 29.4% | 0.4% | 1.2% | 2.8% | 15.9% | 23.0% | 1.2% | 1.6% | 18.7% |
| F14 Cocaine | 1.6% | 19.6% | 1.3% | 1.3% | 2.8% | 13.2% | 46.4% | 0.8% | 0.3% | 1.2% |
| F15 Stimulant | 1.2% | 12.9% | 0.6% | 0.8% | 2.2% | 12.3% | 59.0% | 0.3% | 0.1% | 1.1% |
| F16 Hallucinogens | | 10.0% | | | 10.0% | 20.0% | 50.0% | | | |
| F18 Volatile substances | 33.3% | 66.7% | | | | | | | | |
| F19 Other Psychotr. subst./polytoxic. | 1.6% | 14.0% | 0.5% | 0.4% | 1.7% | 16.1% | 48.9% | 1.0% | 0.2% | 3.0% |

Source: Braun et al., 2019b, T3.18

All diagnosis groups include a large proportion of unemployed clients. With the exception of the diagnosis sedatives/hypnotics, they make up significantly more than half in all diagnosis groups (see Table 18).

Children and adolescents

A not insignificant proportion of patients treated are children (under 14 years old) and adolescents (15-17 years old). Due to their physical and psychological development, they are, in light of the health impacts of drug use, a particularly vulnerable group.

Treatment data from the DSHS shows that both in an outpatient setting and in inpatient treatment, both children and adolescents are treated most frequently for cannabinoids (see Table 19). All other primary diagnoses are significantly lower than 10%.

The distribution of hospital treatments is similar. In that context, adolescents are most frequently treated for (in descending order) cannabinoids (52.6%), other psychotropic

substances/polytoxicomania (29.2%) and stimulants (11.2%). Children are most frequently treated for volatile substances (6.59%), cannabinoids (2.23%) and stimulants (1.34%).

Table 19 Distribution of primary diagnoses among children and adolescents

| Primary diagnosis | DSHS | | | | Statistical Report on Hospital Diagnoses | |
|---|------------|-------|-----------|-------|--|-------|
| | Outpatient | | Inpatient | | -14 | 15-17 |
| | -14 | 15-17 | -14 | 15-17 | -14 | 15-17 |
| F11 Opioids | 0.9% | 1.5% | | 1.1% | 1.8% | 2.5% |
| F12 Cannabinoids | 87.8% | 88.1% | | 85.9% | 50.2% | 52.6% |
| F13 Sedatives/ hypnotics | 0.3% | 0.2% | | 1.1% | 3.5% | 1.9% |
| F14 Cocaine | 1.2% | 1.0% | | | 0.2% | 0.7% |
| F15 Stimulants | 7.6% | 6.7% | | 5.4% | 16.0% | 11.2% |
| F16 Hallucinogens | | 0.2% | | | 1.0% | 1.6% |
| F18 Volatile substances | 0.5% | 0.1% | | | 1.3% | 0.3% |
| F19 Other Psychotr. subst./polytoxicomania | 1.7% | 2.3% | | 6.5% | 26.0% | 29.2% |

Overall, almost a fifth (17.2%) of all patients treated an on outpatient basis with a primary diagnosis of F12 (cannabinoids) were children and adolescents. For volatile substances, the proportion is even over a quarter (29.7%). The substance group with the lowest proportion of outpatient treatments of children and adolescents is opioids (0.2%). Based on the Statistical Report on Hospital Diagnoses, 14% of patients treated for cannabinoids are children and adolescent; for volatile substances it is even higher at 15%. The proportion of children and adolescents treated for opioids is particularly low (0.4%) (see Table 20).

Table 20 Proportion of children and adolescents in all cases of treatment, by primary diagnosis

| | DSHS | | | | Statistical Report on Hospital Diagnoses | |
|---|------------|-------|-----------|-------|--|-------|
| | Outpatient | | Inpatient | | | |
| Primary diagnosis | -14 | 15-17 | -14 | 15-17 | -14 | 15-17 |
| F11 Opioids | 0.0% | 0.2% | | 0.1% | 0.1% | 0.3% |
| F12 Cannabinoids | 1.8% | 15.4% | | 2.5% | 2.0% | 12.0% |
| F13 Sedatives/ hypnotics | 0.2% | 0.7% | | 0.4% | 0.3% | 0.8% |
| F14 Cocaine | 0.1% | 1.1% | | | 0.1% | 0.8% |
| F15 Stimulants | 0.4% | 3.2% | | 0.2% | 1.3% | 4.7% |
| F16 Hallucinogens | | 11.8% | | | 1.3% | 10.8% |
| F18 Volatile substances | 13.5% | 16.2% | | | 6.6% | 8.4% |
| F19 Other Psychotr. subst./polytoxicomania | 0.2% | 2.2% | | 0.4% | 0.7% | 3.8% |

Addiction self-help

The majority of self-help participants are over 40 years old (89%). Of those, the 41 to 69-year-old group is the most represented, at 47%. Only 10% of the participants are between 22 and 40 years old. Under 21s account for just 1% (Naundorff, Kornwald, Bosch, Hansen & Janßen, 2018). The age structure can, for example, be explained by the often late contact between dependents and the addiction support system: for example, it can be seen from the FVS catamnesis data that patients in inpatient rehabilitation were on average dependent for thirteen years before undergoing treatment (Muhl et al., 2019).

3,185 people visited a self-help group for a dependence on illicit drugs, 2,959 for a dependence on medicinal drugs.

Roughly every fifth participant reported having been in acute treatment (detoxification/physical withdrawal) before visiting the group. 36% were treated prior to their admission to an inpatient rehabilitation facility. 10% were treated on an outpatient basis, 11% has so far only undergone counselling (e.g. in an addiction counselling facility). The self-help group was the first contact to addiction support for 19% of participants (Naundorff et al., 2018).

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

- Deutsche Suchthilfestatistik 2019 (Braun et al., 2019a, b & c)
- DRV Statistical Report on Rehabilitation 2019
- 2017 Basic Hospital Data (Statistisches Bundesamt, 2018a).
- Detailed diagnosis data on patients in hospital (Destatis, 2018b)
- Regional monitoring systems, such as BADO in Hamburg (Neumann-Runde & Martens, 2018)

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

1.4 Treatment modalities (T1.4)

1.4.1 Outpatient drug treatment services (T1.4.1)

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, they support self-help projects and are also 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, outreach 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 around 157,300 practice-based or employed doctors (outpatient) who may be the first point of contact for patients with addiction disorders (BÄK 2018). The legal basis for 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 21 Availability of key interventions in outpatient drug support facilities

| | Specialised counselling and treatment centres | Low-threshold facilities | Medical practice/ psycho-therapeutic practice | Socio-psychiatric services/ community psychiatric centres |
|---|---|--|--|---|
| Psychosocial counselling and treatment | 100% | 100% Counselling, on request, no treatment | 0 | 100% |
| Screening and treatment for psychological disorders | Only screening, no treatment | 0 | Treatment only by specialist doctors | 100% |
| Case management (CM) | 95% | CM only for those who request counselling | No information, CM is not generally used for dependence. | 100% |
| Substitution treatment | 20% | 0 | 2.1 | 0 |
| Other treatments | - | - | - | - |

(Expert estimate)

External service for counselling/treatment in prisons

Correctional institutions cooperate on a regional level with outpatient addiction support facilities. External social workers advise and refer patients 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 counsellors 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 the psychiatric departments of general hospitals. They are characterised by the multi-professional composition of their team of staff. Their legal basis is the 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, which are also responsible for persons suffering from dependence, on the basis of the German Public Health Service Act (Gesetz über den öffentlichen Gesundheitsdienst, ÖGDG). 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 withdrawal 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, SGB IX and SGB XII. The employment agencies and "jobcentres", the German Pension Fund (Deutsche Rentenversicherung, DRV), the social welfare providers and the service providers are responsible for the planning.

1.4.2 Further aspects of available outpatient treatment services (T1.4.2)

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 25,873 psychotherapists and 5,877 specialist doctors involved in the outpatient care of children, adolescents and adults with psychological disorders. Of the psychotherapists, 6,121 are medical psychotherapists and 19,752 are psychological psychotherapists (Federal Health Monitoring, 2017; DGPPN, 2019). 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.

Addiction self-help

Also important for the care of addicts is the addiction self-help system, the services of which complement the professional services of the health care system in a variety of ways. The legal basis is Sec. 20h SGB V. The public health insurance providers and the DRV have promoted and supported the activities of health-related self-help for many years.

Self-help groups are made up of at least six, but on average between fifteen and twenty members. The service is based on voluntary cooperation. A characteristic element of the self-help principle is the regular and self-determined exchange by participants with the aim of improving individual quality of life. Generally, both those directly affected (those dependent on addiction self-help) and relatives take part.

In 2017, the five addiction self-help and abstinence associations in Germany⁶ carried out a joint data collection on different aspects of their addiction self-help groups.

According to the data collection, around 70,000 people were reached in 2017, 30,000 women and 40,000 men. 74% of the people reached are addicts, 19% are relatives and 7% take part in the services as so-called “interested parties”.

Of the 4,110 self-help groups in total, the vast majority (81%) are mixed groups for addicts and relatives. In addition, addiction self-help groups only for women (6%), only for addicts (5%) and only for relatives (4%) as well as groups for children and adolescents are among the more common services. 5% of the groups comprise services only for men, migrants and gambling or medicinal drug addicts.

Most participants in addiction self-help groups are dependent on alcohol (46,268). 3,185 people reported taking part in the meetings due to illicit drugs, 2,959 due to medicinal drug dependence (Naundorff et al., 2018).

1.4.3 Inpatient drug treatment services (T1.4.3)

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 the SGB V. The *Laender* and municipalities as well as the hospital operators are responsible for planning.

⁶ The five addiction self-help and abstinence associations are: Blaues Kreuz in Deutschland e.V., Blaues Kreuz in der Evangelischen Kirche – Bundesverband e.V., Freundeskreise für Suchtkrankenhilfe – Bundesverband e.V., Guttempler in Deutschland e.V. und Kreuzbund e.V. – Selbsthilfe- und Helfergemeinschaft für Suchtkranke und Angehörige.

Qualified withdrawal facilities/specialist hospital departments

"Qualified withdrawal" treatment complements detoxification with motivational and psychosocial 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 the 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 also includes social advice, social law advice and career guidance. Medical rehabilitation has a time limit. The treatment time is set individually for the different forms of treatment. The legal basis is primarily the SGB VI and subordinately the 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.

Aftercare services

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

Table 22 Availability of key interventions in inpatient drug facilities

| | Specialised psychiatric hospitals/specialist departments | Inpatient rehabilitation facilities | Therapeutic communities | Secure psychiatric units |
|---|--|--|-------------------------|--------------------------|
| Psychosocial counselling and treatment | Where required | 100% | No information | No information |
| Screening and treatment for psychiatric disorders | 100% | 100% screening, treatment only if possible in the scope of rehabilitation, otherwise transfer to psychiatric clinic or specialist department | No information | 100% |
| Individual case management | No information | 100% | No information | No information |
| Substitution treatment | Generally 100%, if required | 10% | No information | No information |
| Other | - | - | - | - |

(Expert estimate)

Therapeutic communities (TCs)

There are only a few therapeutic communities (TCs) 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 of the criminals or of 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 psychopharmacological treatments, complemented by accompanying ergo and physical therapy.

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 the SGB VI as well as, subordinately, the 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, 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 the 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 (T1.4.4)

No additional information is available on this.

1.4.5 Targeted interventions (T1.4.5)

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 or during the journey - represents a relevant topic for care. 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 refugee 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. Their results show that around half of them were exhibiting psychological problems and unaccompanied refugee minors had traumatic experiences significantly more frequently than accompanied minors. The risk of a psychological disorder, including an addiction disorder, also increases with the number of negative or traumatic life experiences. Consequently, a correspondingly high incidence of addiction disorders is to be expected for refugees (see Roberts, Felix Ocaka, Browne, Oyok, Sondorp, 2011; Ezard, 2012; Roberts et al., 2014). Overall, however, there is little information on the extent of substance use or on the type of substances used by unaccompanied foreign minors (Zurhold, 2017). Since the consumption of illicit drugs for refugees in Germany may, under certain circumstances, be associated with consequences under the law relating to foreign persons, it is assumed that many will not present themselves to the addiction support system at all out of mistrust in the system and fear of deportation, and consequently information on prevalence is not possible (Leidgens, 2015; Hügel, 2016).

One of the newly created services for refugees is called "Guidance"⁷ and is located in Berlin at the "Emergency Service Berlin" (Notdienst Berlin e.V.). The employees have been trained in legal aspects, in particular asylum and social law, specific conversational methods (motivational conversation, culturally sensitive counselling) and prevention elements (the basics of early intervention). All necessary documents to carry out the counselling have been 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, and secondly group early intervention events. All sessions are accompanied by language and culture 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 detailed description of the project can be found in the REITOX report 2018 (Bartsch et al, 2018, section 1.4.5).

Older drug addicts (40+)

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

Hospital diagnosis data shows that the proportion of older opioid addicts is very high. 44% of the 31,385 opioid addicts treated in hospitals were over 40 years of age. In this context, the largest group of older (40+) opioid addicts is the 40 to 44-year-olds, at 37.1%. This is followed by the age groups above in turn (5-year groupings) at 27.0%, 18.4% and 8.1%

⁷ Notdienst Berlin e.V., Guidance [online] www.guidance-berlin.de [accessed: 30.10.2019].

respectively. At 9.3%, the over 60s group represents a not insignificant proportion (Destatis, 2018a).

Data from the Federal Criminal Police Office (Bundeskriminalamt, BKA) also shows that the average age of drug-related deaths has increased further. In 1982, it was still 26 years old, since then it has almost continually increased. In 2017 the average age at the time of drug-related deaths was 38.9 years old (BKA, 2018; Kraus & Seitz, 2018). On the basis of a change to the BKA database, for 2018 no data is available in relation to the average age of drug-related deaths. Further information on the problem of cases of drug-related deaths can be found in the 2019 Harms and Harm Reduction workbook (Dammer et al., 2019, section 1.1).

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.

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, Condrops⁸ 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 accommodation facilities. The target of the up to two-year stay (in individual cases it can be longer) is reintegration into society. 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 data will be presented on this specific subgroup:

- Females make up 34.4%, males 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;

⁸ Condrops e.V. [Online:] www.condrops.de [accessed: 30.10.2019].

- In 30% of cases, a psychological disorder is at the forefront of their illness, for 70% it is a physical disorder;
- 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"). (LÜSA, no date).

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. There are now several facilities nationally, including eight residential projects and one residential care project (Deutsche Aidshilfe, no date). One such example would be the Berlin institution network "Zu Hause im Kiez gGmbH⁹". Services are offered at twelve 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 are pilot projects funded by the BMG that effect a better interlinking of addiction support and support for the elderly and that represent examples of successful cooperation. However, they primarily reach alcohol and medicinal drug addicts (Reimer et al., 2014).

New psychoactive substances (NPS) and methamphetamine

After cannabis and the group of amphetamines/methamphetamines, NPS are the most frequently consumed illegal substances in Germany (Gomes de Matos et al., 2016). Like methamphetamine, they pose major challenges for 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 include additional numbers of cases in the *Laender* studied. The goal was to ascertain any regional differences in NPS and methamphetamine use.

⁹ Zuhause im Kiez gGmbH [online] www.zik-ggmbh.de

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). Compared 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 and methamphetamine use and with a higher risk of use for tobacco and cannabis (Gomes de Matos et al., 2018; Piontek et al., 2018).

Treatment recommendations for the treatment of methamphetamine addicts can be found in the "S3 guidelines on methamphetamine related disorders" ("S3-Leitlinie Methamphetaminbezogene Störung") (Drogenbeauftragte der Bundesregierung, BMG, BÄK & Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde (German Society for Psychiatry, Psychotherapy and Neuropsychiatry, DGPPN), 2016).

For the purpose of evaluating inpatient withdrawal treatment, the BMG is funding the "Crystal study" ("Crystal-Studie"), a pilot project in the Hochstadt District Hospital and the Mecklenburg MEDIAN Clinic. The focus of the research is the collection of data on psychiatric comorbidities of crystal meth-dependent patients, neurocognitive deficits, gender aspects and therapy prognoses. The aim of the study is to improve the treatment of crystal meth-dependent patients with the help of the evaluated therapy manual (Kampf et al., 2017). Another research project is currently building on this study, dealing with the specifics of crystal meth-dependent patients. Thematic points of focus of the project are, among other things, the question as to the differences in relation to sociodemographic, psychosocial, clinical and cognitive characteristics of crystal meth users on admission and discharge from the withdrawal treatment compared to users of other drugs. The data collection will run until about September 2019. The hope is that it will be possible, on the basis of the results, to develop specific therapy concepts for patients addicted to methamphetamine (Schacht-Jablonowsky et al., 2019).

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 more female specific, later also 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" ("Gender mainstreaming in der Suchtarbeit: Chancen und Notwendigkeiten") (DHS, 2004). Further discussions and publications followed, e.g. "Quality features and recommendations for female-specific

addiction work" ("Qualitätsmerkmale und Empfehlungen für eine frauenspezifische Suchtarbeit") by the working group "Women and Addicton" ("Frauen und Sucht") (2006) from the Freiburg and South Baden region or the women's addiction counselling service in Schleswig-Holstein with their service "Representation of interests and quality assurance" ("Interessenvertretung und Qualitätssicherung")¹⁰.

Nevertheless, there is no systematic nationwide data collection on gender specific addiction support services in Germany. All projects and services, which are also for women or also for men, feed data into the aforementioned databases. 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-Salzman-Klinik in Gütersloh¹¹, the therapeutic housing group "The Onion"¹² ("Die Zwiebel") in Berlin, or Condrops 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 shared accomodation. 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 which ran from 2015 to the end of 2018 is "GeSA (Violence - Addiction - Way out) - Association to support women in the cycle of violence and addiction" ("GeSA (Gewalt - Sucht - Ausweg) - Verbund zur Unterstützung von Frauen im Kreislauf von Gewalt und Sucht")¹³. The goal of the project was 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

¹⁰ Frauen Sucht Gesundheit e.V. [online]. <https://fsg-sh.de/interessenvertretung-und-qualitaetssicherung/> [accessed: 2 Sep. 2019].

¹¹ Bernhard Salzman Klinik. LWL-Rehabilitationszentrum Ostwestfalen. Konzept zur Behandlung von abhängigen Frauen [online]. https://www.lwl.org/527-download/BSK/Konzepte/Behandlung_abhaengiger_Frauen.pdf [accessed: 12 Aug. 2019].

¹² Die Zwiebel, therapeutischer Wohnverbund für Frauen. [online] <https://www.prowoberlin.de/Angebot3/die-zwiebel-therapeutischer-wohnverbund-fuer-abh%C3%A4ngigkeitserkrankte-frauen.html> [accessed: 2 Sep. 2019].

¹³ Frauen helfen Frauen e.V. Rostock, Modellprojekt GeSA [online] www.fhf-rostock.de/einrichtungen/gesa/ueber-gesa.html [accessed: 30. Oct. 2019].

care for women affected by violence and addiction. The regional cooperation model to improve care for women with addictive substance use affected by violence was located in the Rostock and Stralsund regions and had the objective of building a regional addiction and violence network. Regional cooperation teams (in Rostock and Stralsund) were responsible for this process. The teams consisted of a maximum of five representatives of inpatient and outpatient facilities from both systems. Firstly, the point of the network was 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 was the development and testing of individual cooperation models, which linked together and meaningfully complemented the resources available within the network (Frauen helfen Frauen e. V. Rostock, 2017).

Finally, the aim was to create guidelines for action tailored to the specific regional conditions from the experience gained in the three-year collaboration across all cases. The collaboration between the regional associations in Rostock and Stralsund, created as part of the project, will also be maintained after the end of the project. Further project findings will be used within the framework of establishing a group for affected women in Rostock, which will be complemented by a cooperation of female colleagues in addiction support and violence protection, as well as a possible cooperation with the DRV (Frauen helfen Frauen e. V. Rostock, 2019).

Further funding is committed to women who use crystal meth. Around a third of all crystal meth users is female (Roche et al., 2015). 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" was conceived to fill that 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 comorbidities, motives for use, use practices and use 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 investigated (Staudenmeyer et al., 2018).

The "Dresden crystal meth care pathway" ("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 (Haarig & Mathiebe, no date).

Minors and adolescents

There is also no systematically prepared data for addiction specific services in the care of dependent children and adolescents¹⁴. 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 young cannabis 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"¹⁵ (FreD - Frühintervention bei erstaußälligem Drogenkonsum).

Another programme focussed on cannabis use is "Realize it"¹⁶, 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 more than 77 records nationally on clinics and rehabilitation institutions which offer a specialised treatment of children and adolescents who use illicit drugs (DHS, 2019).

Specifically in the area of children and adolescents, 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"¹⁷, a new research association, which operates where prevention meets treatment. It researches 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 (Pressestelle des Universitätsklinikums Hamburg-Eppendorf (UKE), 2017; Friedrich et al., 2018).

Figures on treatment data for children and adolescents can be found in section 1.3.4. Access to both low and higher threshold services mostly takes place in this age group through engaging with parents/guardians (where conspicuous behaviour/complications at home or in school/vocational education become apparent) or through court orders.

¹⁴ The term "children" designates people under 14 years old, "adolescents" those between 15 and 17 years old. Definitions may differ depending on the circumstances of the study.

¹⁵ FreD - Frühintervention bei erstaußälligem Drogenkonsum. [Online:] <https://www.lwl-fred.de/de/> [accessed: 30. Oct. 2019].

¹⁶ Realize it! Beratung bei Drogenkonsum. [Online:] <https://www.realize-it.org/> [accessed: 30. Oct. 2019].

¹⁷ IMAC-Mind [online] <https://www.imac-mind.de/> [accessed: 17 Jul. 2019].

1.4.6 E-health services for drug addicts looking for online counselling and treatment (T1.4.6)

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.de"¹⁸, 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 available, e. G. "Quit the shit"¹⁹, in which an online diary of consumption forms the core element and is supplemented by anonymous online counselling services. The online addiction counselling project "KOiNTER"²⁰, a service from jhj Hamburg e.V., is set up in a similar way, however without a set duration. Since 1 December 2009, "KOiNTER" has provided the first virtual counselling service in Hamburg in the area of addiction; in 2014 the site was completely redesigned and extra features were added. KOiNTER currently offers the following online services related to all questions and issues on the topic of drugs and addiction:

- Online chat
- Supported consumption 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.

The most recent service specialised in methamphetamine is the "Breaking Meth"²¹ web portal. It is operated by the Drug Scouts project in Leipzig and the Centre for Interdisciplinary Addiction Research (Zentrum für Interdisziplinäre Suchtforschung, ZIS) in Hamburg, and is

¹⁸ Drugcom [online] www.drugcom.de [accessed: 17 Jul. 2019].

¹⁹ "Quit the Shit" [online] <https://www.quit-the-shit.net/qts/> [accessed: 17 Jul. 2019].

²⁰ Online Suchtberatung KOiNTER [online] <https://kointer.de> [accessed: 17 Jul. 2019].

²¹ Breaking Meth [online] <https://breaking-meth.de> [accessed: 17 Jul. 2019].

aimed at current and former users. “Breaking Meth” offers users the possibility to communicate with one another anonymously on use-related topics. The key areas are, for example, safer use and use reflection. Due to the support care by specialist staff, there is also the possibility of particularly low-threshold contact with the support system. In addition, abstinent users who possibly cannot or will not take the option of a self-help group, are offered a possibility to communicate via “be clean” (“clean sein”) and “stay clean” (“clean bleiben”). Users have, thanks to a cooperation with the author, the additional option of reading the German version of the book *Quitting Crystal Meth*²² (Breaking Meth, no date).

Alongside these national services, many addiction counselling facilities offer regional online counselling via email or even single and group chats.

1.4.7 Treatment outcomes and recovery (T1.4.7)

As in the previous year, a treatment being “finished as planned” is a criterion for assessing success. A differentiation is made between release on

- regular or
- therapeutic grounds
- premature finish with therapist consent or
- a planned change to a different facility.

With respect to the aspect of “finished as planned” as a success indicator, there are differences both between the substance classes as well as between outpatient and inpatient care. On average, approximately 61% (Braun et al., 2019a, T6.04) of those treated on an outpatient basis finish the intervention as planned, compared to 69% (Braun et al., 2019b, T6.04) in the inpatient area. In inpatient treatment, the rate of treatments being finished as planned is higher than it is for the outpatient setting across all primary diagnoses in the area of illicit drugs. Opioid addicts are the group with the largest proportion of premature dropout: 47,6% of persons treated on an outpatient basis and 36,7% of those treated on an inpatient basis stopped treatment prematurely. In outpatient treatment, the next highest proportions of premature dropout are found in patients with the primary diagnoses of other psychotropic substances/polytoxicomania (41.6%) and stimulants (39.5%); in inpatient treatment it is cannabinoids (30.9%) and cocaine (30.7%) (Braun et al., 2019a & b).

At the beginning of 2019, the FVS published the catamnesis data from six 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 success²³ (DG-

²² Joseph Sharp (2018). *Quitting Crystal Meth: What to expect & What to do*. Createspace Independent Publishing Platform, Scotts Valley.

²³ 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

Sucht, 2001; DG-Sucht, 1985). The most recent results of the seventh inter-facility drug catamnesis on the basis of the discharge year 2016 show slightly reduced success levels compared to the previous catamneses. The catamnestic success rate is 67.7% (DGSS1) (2015: 75.4%; 2014: 74.4%; 2013: 78.2%) for consistently abstinent patients and for abstinent patients following a relapse over 30 days prior to the survey. The most conservative estimate is that 20.7% of patients are still successfully abstinent one year after inpatient drug rehabilitation (DGSS 4) (2015: 23.3%; 2014: 23.8%; 2013: 24.9%). According to primary diagnoses, the catamnestic success of cocaine and stimulant addicts (27.8% and 24.2%) as well as of polytoxicomaniac patients (21.6%) was higher than the success of the overall sample (DGSS 4). Less successful were cannabis addicts (20.1%) and above all opioid addicts (8.8%) (Muhl et al., 2019).

The provisions for the catamnesis data have also changed with the third revised version of the KDS, which came into force in 2017. Therefore, a revised version of the questionnaire has been used for the survey since 2018. It can thus be assumed that future data will only be comparable with that of previous years to a limited degree.

Further results on treatment outcomes are collected by the DRV regarding the ability to work of those undergoing rehabilitation. The goal of the DRV is to integrate addicts back into the employment market. According to its statistics, in 2016 three quarters of patients in rehabilitation treatment who are 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). In the scope of quality assurance, the DRV also carries out surveys on the satisfaction of those undergoing rehabilitation. The data from a survey from 2016/17 shows that 69% of respondents see themselves remaining abstinent in the long term, 72% consider the treatment successful in relation to their general state of health and performance at work, in their freetime and daily life. 82% report an improvement with regard to their psychosomatic issues (Osthold-Corsten & Kley, 2019). It is important to note however that this information is merely subjective, on feelings that were made in the period from eight to twelve weeks after the end of rehabilitation and is not necessarily an indication on the long-term success of the rehabilitation.

The addiction self-help and abstinence associations also collect data with regards to the relapse rates of their group participants. According to surveys, in 2017 13% of the self-help group members relapsed. However, 77% of these were able to find their way back to abstinence (Naundorff et al., 2018).

abstinent in the last 30 days of the survey period. The strictest method of calculation, DGSS4, includes all those treated and assesses non-responses and incomplete catamnesis responses by definition as relapses (DG-Sucht, 2001; DG-Sucht, 1985). DGSS1 tends rather to produce an overestimation of rehabilitation success, DGSS4 tends to produce an underestimation.

1.4.8 Social integration (T1.4.8)

Both social integration and occupational integration are a central concern of addiction counselling and treatment in Germany, and are anchored in the goals of addiction support. Parties such as the pension insurance funds and health insurance providers therefore work together with representatives from addiction support, employment agencies and job centres to optimise and further develop the standards for social and occupational reintegration, usually directly following medical rehabilitation.

Of particular note are, for example, the "Proposals for enhancing the employment related aspects of medical rehabilitation of persons with dependency disorders of 14 November 2014" ("Empfehlungen zur Stärkung des Erwerbsbezugs in der medizinischen Rehabilitation Abhängigkeitskranker vom 14. November 2014") drawn up by the "Joint working group on the focus on employment in medical rehabilitation - BPRA" (Gemeinsamen Arbeitsgruppe Berufliche Orientierung in der medizinischen Rehabilitation, BORA) (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 that is 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. In order to facilitate the return to work, the German Statutory Pension Insurance Scheme, represented by the DRV, the German Federal Employment Agency (Bundesagentur für Arbeit), the German Association of District Councils (Deutscher Landkreistag) and the Association of German Cities (Deutscher Städtetag), also issued a recommendation on 1 June 2018 to cooperate in the support of addicted people seeking work. The aim of this is to optimise administrative processes before, during and after medical rehabilitation of addicts (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) was passed in December 2016. It will gradually come into force in four stages of reform between 2017 and 2023. 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, to leave the "welfare system" as well as 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-centred (Bundesgesetzblatt, 2016). In support of the Act, in May 2018 the Federal Ministry of Labour and Social Affairs (Bundesministerium für Arbeit und Soziales, BMAS) launched the programme "Innovative ways to participate in working life - rehapro" ("Innovative Wege zur Teilhabe am Arbeitsleben – rehapro"). As part of the programme, job centres and agencies of statutory pension insurance providers receive funds in a targeted manner, which they can provide to pilot projects testing innovative ideas and approaches (BMAS, 2018).

In addition to the state services, there are numerous projects and welfare facilities and other charitable facilities, mostly carried out in cooperation with the addiction support funding agencies (see BORA). There is no central data collection on these projects and services.

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

1.4.9 Main providers/organisations providing opioid substitution treatment (T1.4.9)

In Germany, only doctors may prescribe opioid supported treatment (substitution). Since the Third Amending Regulation of the German Regulation on the Prescription of Narcotic Drugs (see Dammer et al., 2017, section 3.1), the group of people authorised to dispense substitution drugs has been expanded (BMG, 2017). It now includes for example, in addition to substituting doctors and their specialist staff, also

- Medical, pharmaceutical or care staff in an inpatient facility for medical rehabilitation, a public health authority, a nursing home/care home or a hospice²⁴,
- Medical or care staff, who work for an outpatient care service or specialised outpatient palliative care facility²⁵,
- Pharmacists or pharmaceutical staff in a pharmacy²⁶,
- Medical or specialist care staff in a hospital²⁷ and
- Staff employed in state-approved addiction support facilities who have been trained accordingly²⁸.

Nevertheless, doctors are the only direct providers of the treatment form, even if sometimes not in their own practices but in facilities provided 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 2,585 doctors providing substitution treatment reported opioid addicts requiring treatment to the substitution register in 2018. The number of doctors providing substitution treatment has thus slightly fallen again, following an increase in 2017 (see Figure 3 5). In 2018, 548 doctors - namely approximately 21% of substituting doctors - availed themselves of the colleague consultation rule: according to that rule, doctors without a qualification to

²⁴ To the extent the substituting doctor themselves does not work in the respective facility and has made an agreement with the facility.

²⁵ To the extent the substituting doctor does not themselves work for that care service or facility and has made an agreement with the respective service or facility.

²⁶ To the extent the substituting doctor has made an agreement with the respective pharmacist.

²⁷ To the extent the substituting doctor does not themselves work for the hospital and has made an agreement with the hospital.

²⁸ To the extent the substituting doctor themselves does not work for that facility and has made an agreement with the facility.

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, 2019).

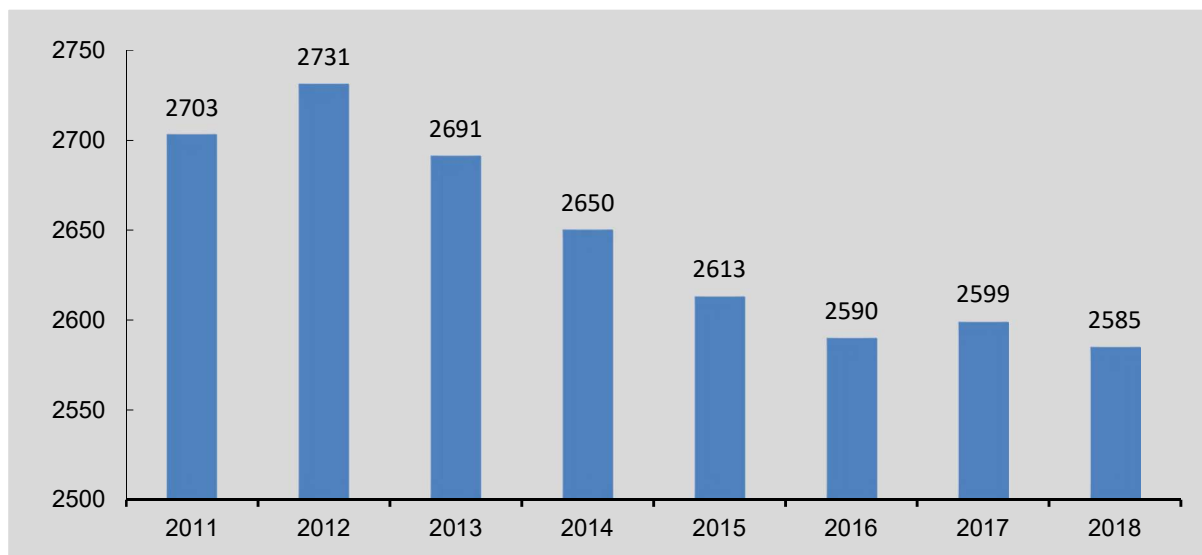


Figure 3 Number of substituting doctors 2011-2018

Source: BOPST (2019)

The nationwide average number of reported substitution patients per substitution doctor is 29.5, however there are huge variations between the individual *Laender* (Hamburg: 44; Brandenburg: 7). Around 14% of substitution doctors reported half of all substitution patients on the stated reference date. This suggests that many opioid addicts receive treatment in specialised practices. There are however also many practices (28%) that only treat up to three substitution patients (BOPST, 2019).

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* (see Figure 4 Figure 6 and Figure 5

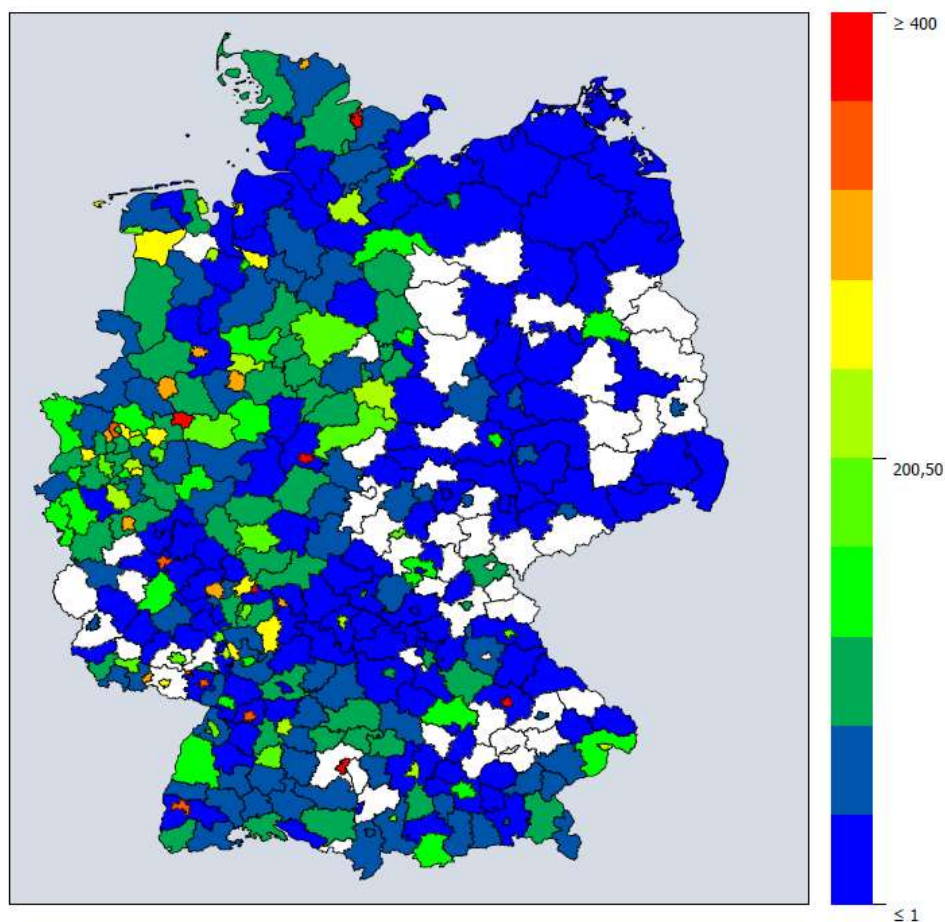


Figure 4 Figure 6 Number of substitution patients reported per 100,000 population per district or independent city on the reference date 1 January 2018

Presentation: Bundesopiumstelle (BOPST) (2019), Report on the Substitution Register, p. 9.

Source: Bundesinstitut für Arzneimittel und Medizinprodukte/BOPST (2019).

Note: No substitution patients are registered in districts and independent cities coloured white.

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 (T1.4.10)

On the reference date, 1 July 2018, the number of substitution patients was 79,400. This represented the highest figure for 10 years (see Figure 5). In 2018, around 89,600 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, 2019).

The proportions of substances used in substitution treatment have shifted in the past few years away from methadone (39.4%) and towards levomethadone (35.2%) as well as buprenorphine (23.1%) (Table 2224). The proportion of persons receiving substitution

treatment with methadone or levomethadone has fallen since 2005 from 82% to the current level of 74.6% (see Figure 7) (BOPST, 2019).

Table 23 Type and proportion (%) of substitution drugs reported to the substitution register (2005-2018)

| | 2005 | 2010 | 2015 | 2016 | 2017 | 2018 |
|----------------|------|------|------|------|------|------|
| Methadone | 66.2 | 57.7 | 44 | 42.5 | 40.9 | 39.4 |
| Levomethadone | 15.8 | 23 | 31.8 | 33 | 34 | 35.2 |
| Buprenorphine | 17.2 | 18.6 | 23 | 23.1 | 23.3 | 23.1 |
| Dihydrocodeine | 0.7 | 0.3 | 0.2 | 0.2 | 0.1 | 0.1 |
| Codeine | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| Diamorphine | - | 0.3 | 0,8 | 0,8 | 1 | 1 |
| Morphine | - | - | - | - | - | 1 |

Source: BOPST (2019)

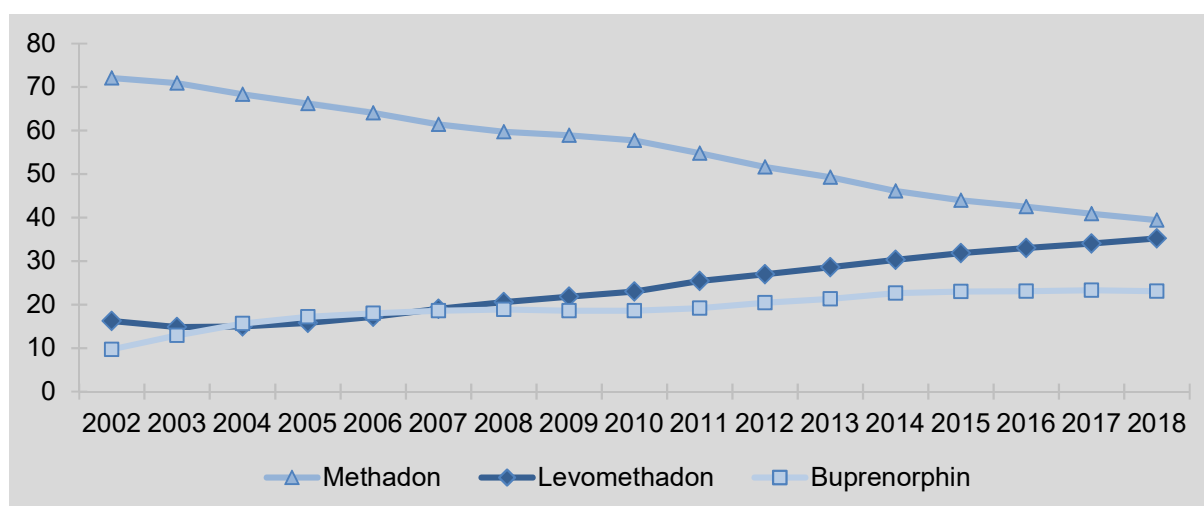


Figure 5 Trend in the frequency of reported substitution drugs 2002-2018

Source: BOPST (2019)

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., 2011a & 2011b).

1.4.11 Further aspects on organisation, access and availability of OST (T1.4.11)

According to the 3rd Regulation Amending the German Regulation on the Prescription of Narcotic Drugs (3. Verordnung zur Änderung der Betäubungsmittel-Verschreibungsverordnung, 3.BtMÄndVV), 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 German Regulation on the Prescription of Narcotic Drugs (Betäubungsmittel-Verschreibungsverordnung, BtMVV), since July 2009 (see Pfeiffer-Gerschel et al., 2009, chapter 1.2.2). After ten years, there are now ten outpatient clinics nationwide, in which it is possible to treat severely ill opioid addicts with the substance diamorphine (Ärzteblatt, 2019a).

In accordance with the BtMVV, the BÄK sets out the generally accepted state of medical scientific knowledge in its guidelines for the provision of substitution treatment. Accompanying 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. From this it can be seen that the treatment of addiction disorders also has to be based on 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 proposals from this 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 (see Pfeiffer-Gerschel et al., 2014). Only a few doctors are responsible for large districts and sometimes difficult for patients to reach (see Figure 8). In addition, 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 3.BtMÄndVV, to the guideline competence of the BÄK (see section 1.4.9). See also section 3.1 of the REITOX Report 2017, Legal Framework workbook (Dammer et al., 2017).

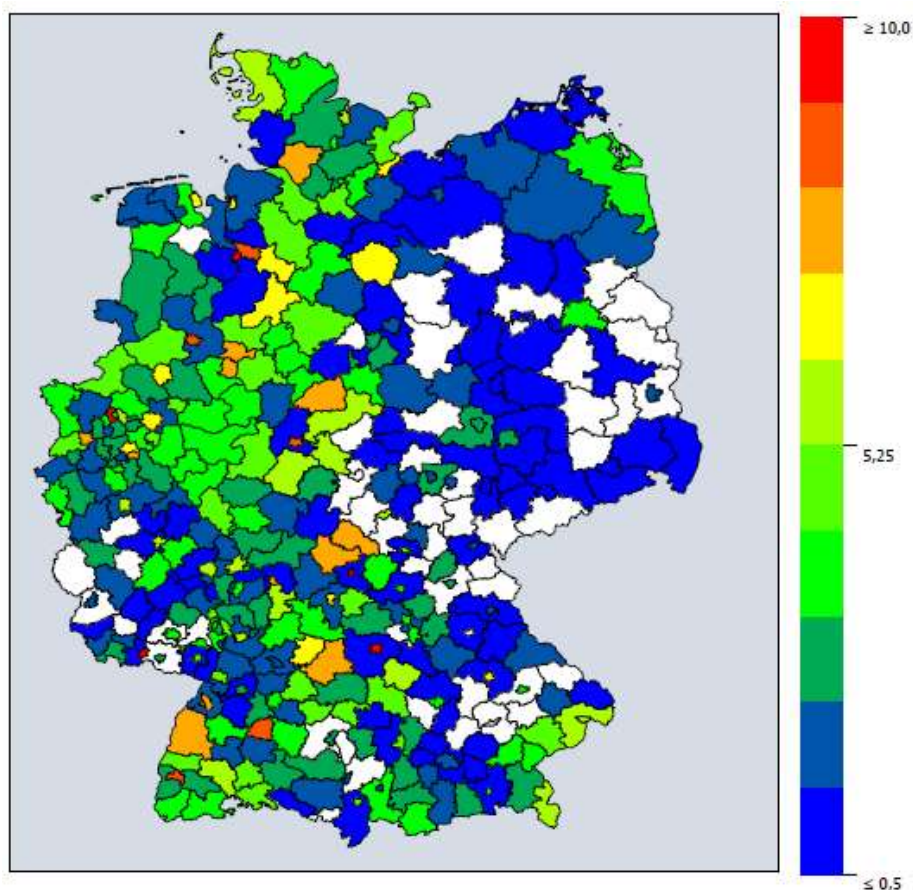


Figure 6 Number of substituting doctors per 100,000 population per district or independent city reporting figures in the first six months of 2018

Presentation: Bundesopiumstelle (BOPST) (2019), Report on the Substitution Register, p. 8.

Source: Bundesinstitut für Arzneimittel und Medizinprodukte/BOPST (2019).

Note: No substitution doctors are registered in districts and independent cities coloured white.

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).

Results from a cross-sectional study with 2,176 substitution patients show that the health-related quality of life is significantly below the population norm. The mental health-related quality of life in particular is negative. The outcome of the study is recommendations for integrated approaches on patients' health care in substitution treatment. These should include, for example, psychosocial support services, psychotherapy and case management but also aspects of medical care (Strada et al., 2019).

1.4.12 Quality assurance in drug treatment (T1.5)

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:

- By way of an order of 6 September 2018, the Federal Joint Committee (Gemeinsame Bundesausschuss, G-BA) revised the regulations under which opioid addicts are able to receive substitution supported therapy under statutory health insurance. The previously predominant abstinence-oriented treatment approach has been replaced with a therapeutic approach with a more broadly defined objective, which, for example, enshrines the survival and abstinence from unlawfully purchased and acquired opioids as treatment goals. The order came into effect on 7 December (G-BA, 2018).
- At the end of 2017, work aids were introduced by the BÄK to agree the key points for providing substitution drugs for immediate use in the scope of opioid substitution (BÄK, 2017a).
- 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, 2017b).
- The S3 guidelines on methamphetamine related disorders have 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 adolescents (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 & Weissinger, 2015).
- At the beginning of 2014, the DGS approved the final version of the guidelines, "Therapy for opiate dependence - Part 1: substitution treatment" "Therapie der Opiatabhängigkeit – Teil 1: Substitutionsbehandlung" (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" ("Prophylaxe, Diagnostik und Therapie der Hepatitis-C-Virus (HCV)-Infektion, AWMF-Register-Nr. 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. 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 withdrawal, however, lies with the respective funding agency (statutory health insurance providers (Gesetzliche Krankenversicherung, GKV) and pension insurance providers (Rentenversicherung, RV)) (see also Pfeiffer-Gerschel et al., 2012).

2 TRENDS (T2)

2.1 Long-term trends in the number of people entering treatment and OST (T2.1)

Rehabilitation

The total number of rehabilitation services funded by the DRV in the area of addiction rose by over 10% between 2003 (51,123) and 2009 (57,456) and has since then been decreasing (Figure 8) (DRV, 2019b). 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 (59.3%) is provided for alcohol related disorders. Disorders due to the use of illicit drugs comprise around 25.1% of the services provided, disorders due to the use of medicinal drugs comprise 1%. 14.5% of rehabilitation services result from mixed case withdrawal treatment. There has been little change in this distribution since 2015 (Ostholt-Corsten & Kley, 2019) (see Figure 9).

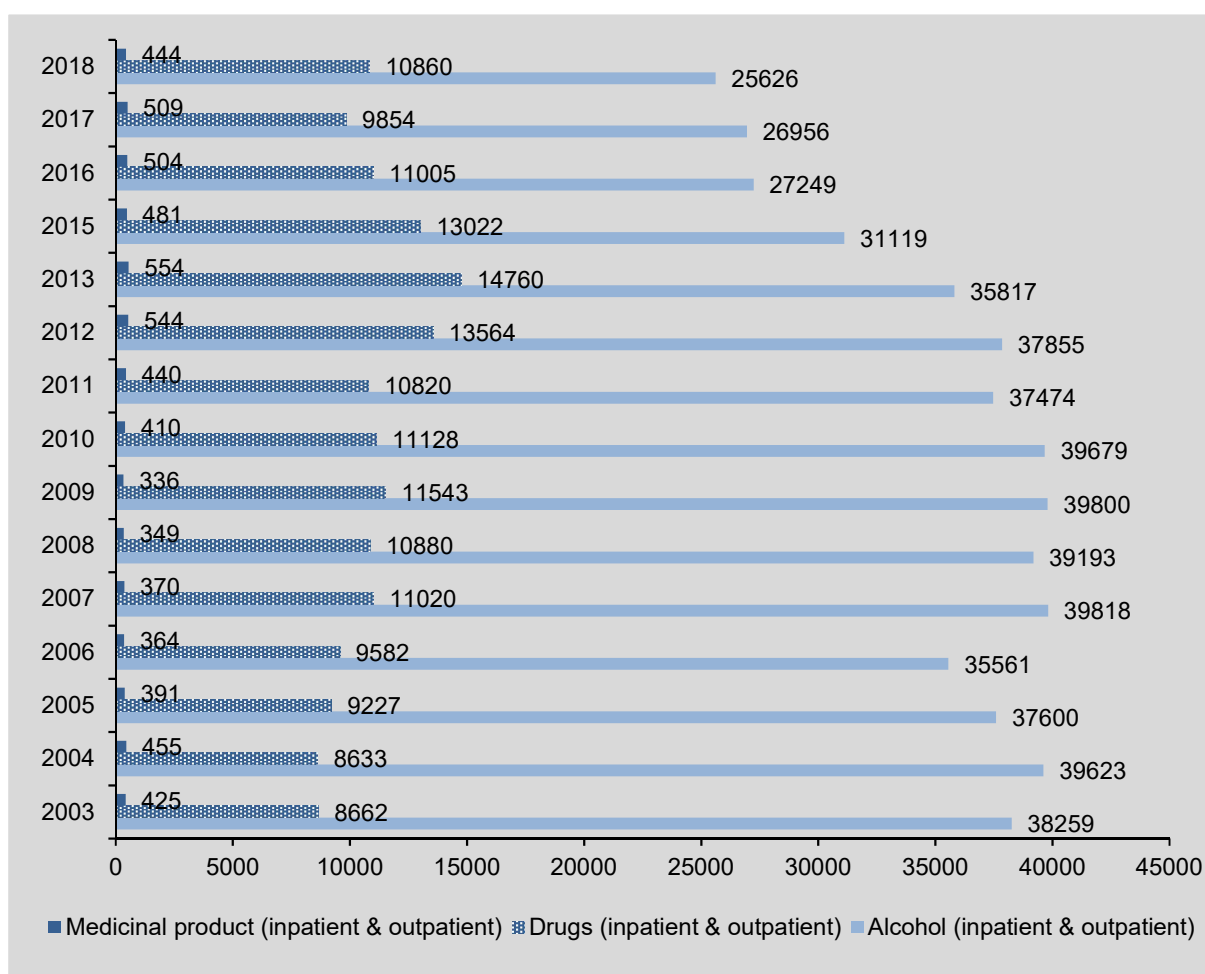


Figure 7 DRV treatment data by year and primary diagnosis

Note: No data available for 2014.

Source: DRV (2019)

The same applies to the relationship between inpatient and outpatient rehabilitation treatment. The numbers of rehabilitation cases for drug patients (according to the DRV data) in inpatient treatment increased up to 2013, and then fell again up to 2017. In the past year (2018) they then slightly increased again. In the area of outpatient treatment, the respective numbers of cases increased between 2003 and 2006, then remained broadly stable until 2017 (with the exception of a high number of cases in 2013), before rising again in 2018 (Figure 810).

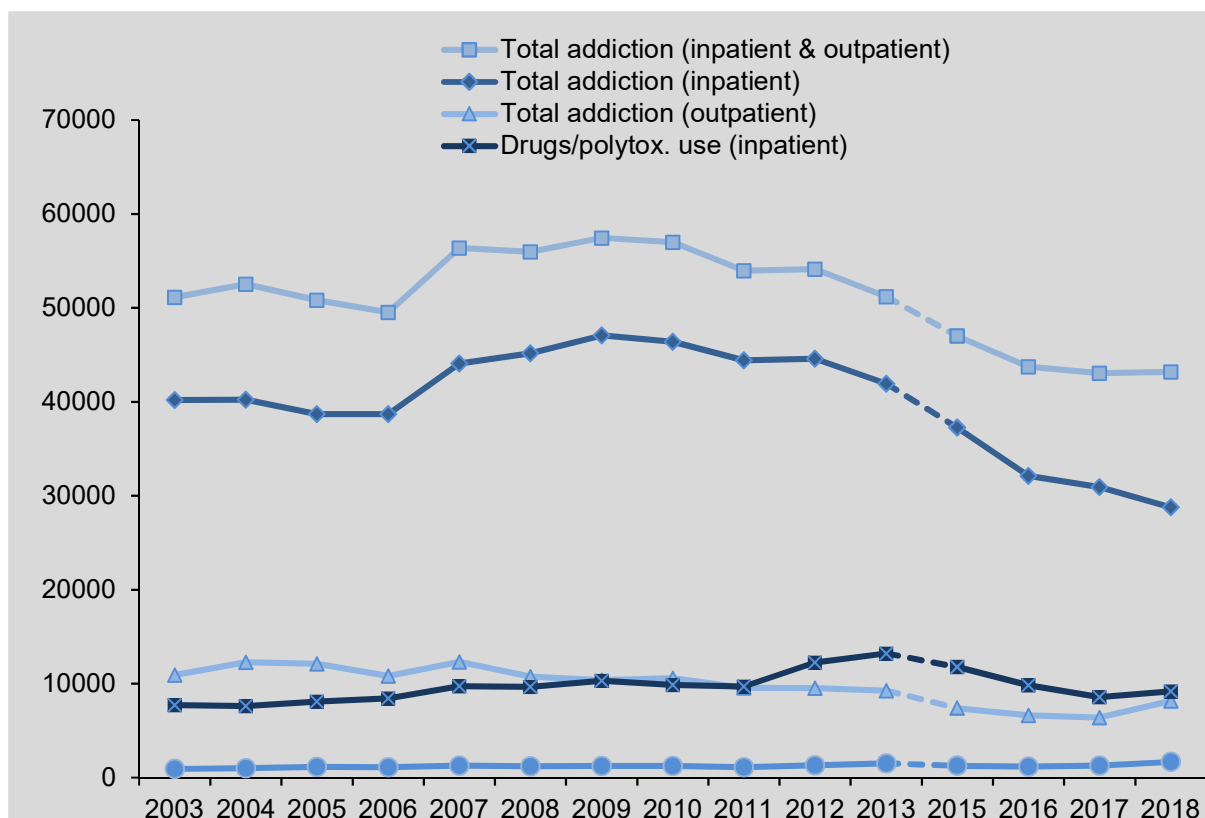


Figure 8 Changes in outpatient and inpatient rehabilitation treatments

Note: No data available for 2014.

This trend cannot be explained in terms of applications and approvals for addiction rehabilitation services from the DRV. Both have decreased since 2010 (see Figure 11).

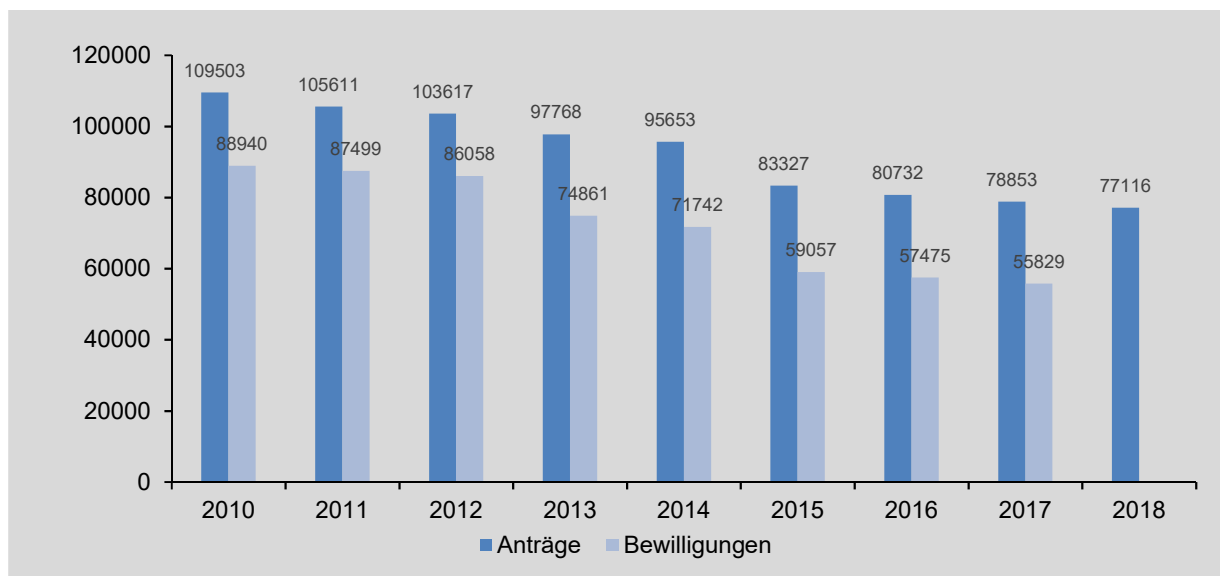


Figure 9 Addiction rehabilitation – applications and approvals (DRV)

Source: Ostholt-Corsten & Kley, 2019.

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, with figures now seeming lower (see the hatched line in Figure 4).

(DRV, 2019)

Hospital treatments

The total number of acute addiction treatments in hospital has, with some fluctuations, slightly increased since 2011. In the last year, however, the number has once again slightly fallen (Destatis, 2018b). The largest increase in 2017 was recorded for volatile substances (+27.4%). This is followed by treatments due to the use of cocaine (+21.2%). Compared to 2011, the increase for addiction treatments due to cocaine dependency is the most extreme, at +220%. The treatment for opioid dependency in hospital significantly decreased in 2017 (-10.3%) (see Table 24).

Table 24 Inpatient treatment of drug problems in hospitals 2011-2017

| Primary diagnosis substances | Year | | | | | | | Changes | |
|--------------------------------|---------------|---------------|----------------|----------------|----------------|----------------|----------------|--------------|--------------|
| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2016 - 2017 | 2011 - 2017 |
| Opioids | 28,956 | 26,512 | 27,962 | 33,686 | 34,916 | 34,977 | 31,385 | -10.3% | 8.3% |
| Cannabinoids | 9,094 | 10,142 | 11,708 | 15,153 | 17,148 | 17,495 | 18,710 | 6.9% | 105.7% |
| Sedatives/ Hypnotics | 10,241 | 9,999 | 9,707 | 10,082 | 10,134 | 10,166 | 9,585 | -5.7% | -6.4% |
| Cocaine | 1,222 | 1,417 | 1,702 | 2,200 | 2,435 | 3,247 | 3,936 | 21.2% | 220.0% |
| Stimulants | 3,878 | 4,519 | 5,810 | 8,627 | 10,216 | 9,695 | 9,961 | 2.7% | 156.8% |
| Hallucinogens | 574 | 472 | 526 | 610 | 789 | 724 | 623 | -13.9% | 8.5% |
| Volatile substances | 198 | 155 | 135 | 159 | 153 | 131 | 16 | 27.4% | -15.6% |
| Multiple use/ other substances | 41,777 | 43,063 | 43,826 | 35,798 | 35,731 | 33,810 | 31,827 | -5.8% | -23.8% |
| Total | 95,940 | 96,279 | 101,376 | 106,315 | 111,522 | 110,245 | 106,194 | -3.6% | 10.6% |

Source: Destatis (2017); Destatis (2018b).

Substitution treatment

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 0.8%. On the reference date (1 July 2018), the number was 79,400 (see Figure 1012). There are still considerable regional differences regarding the supply of and demand for substitution treatments.

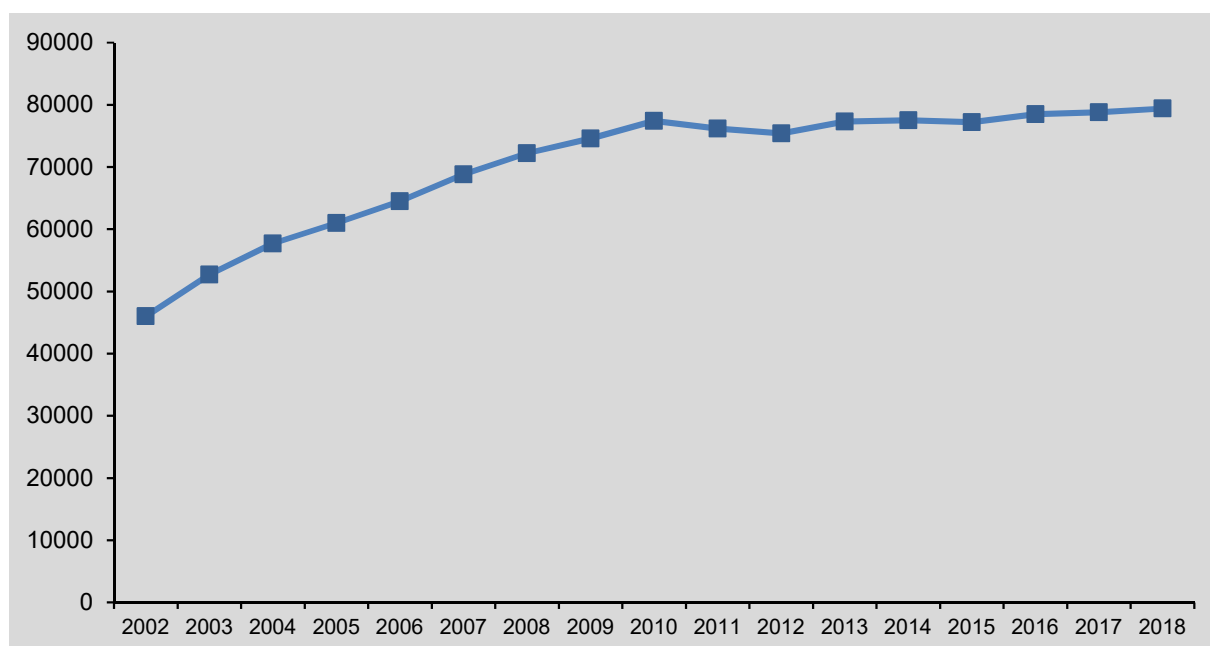


Figure 10 Number of reported substitution patients in Germany, 2002-2018 (reference date 1 July)

Source: BOPST (2019)

2.2 Additional trends in drug treatment (T2.2)

No additional information is available on this.

3 NEW DEVELOPMENTS (T3)

3.1 New developments (T3.1)

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 ZIS research project (ProMeKa) 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, in part, 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

With the German Act Amending Narcotics and Other Provisions²⁹, which came into force on 10 March 2017, possibilities for prescribing cannabis-based pharmaceuticals for the care of seriously ill patients were expanded. In 2017, according to the National Association of Statutory Health Insurance Funds, around 200,000 applications were registered with health insurance providers, of which 60% were approved. There is no data as yet in this regard for 2018 and 2019 (Deutscher Bundestag, 2019).

To date, Germany has imported cannabis from Canada, the Netherlands and Israel. The first crops from German cultivation are expected to be harvested from 2020 (Ärzteblatt, 2019b; Deutscher Bundestag, 2019). For this purpose, in May 2019, the final licences were awarded by the German Federal Institute for Drugs and Medical Devices (Bundesinstitut für Arzneimittel und Medizinprodukte, BfArM) for the cultivation of medicinal cannabis in Germany. It amounts to a total licensed quantity of 10.4 tonnes over a four-year period, which will be distributed annually in 13 lots of 200 kg each (Ärzteblatt, 2019c; BfArM, 2019).

In order to tax and control the cultivation in Germany, the Cannabis Agency (Cannabisagentur) was set up as a new specialist area at the BfArM, in the “Special Therapy Facilities” (“Besondere Therapieeinrichtungen”) department. Further responsibilities, such as imports of cannabis, are covered by BOPST. As soon as a crop has been harvested, the Cannabis Agency will be responsible for buying it up and selling it on to the manufacturers of cannabis-based pharmaceuticals, wholesalers or pharmacies. The BfArM is not allowed to make any profit from this, or have any surpluses (BfArM, 2017).

The indications for the prescription of medicinal cannabis are as yet rather unclear, since the legislative text does not define in any more detail the “serious diseases” for which a prescription could be considered. Clarity should be provided in this respect on the legal conditions for accompanying research and on the evaluation of the diagnoses stated in

²⁹ Schedule III BtMG, Sec. 31 SGB V.

applications. Any doctor who prescribes cannabis is obliged to take part in this accompanying research. The data which will be collected exclusively for scientific reasons must be forwarded to the BfArM (Müller-Vahl & Grotenhermen, 2017).

Which overall changes will result from the new Act will be apparent from 2022 onwards from the results of the accompanying data collection provided for in the Act. In the cannabis report published in 2018, a cooperation between Bremen University and the TK, initial analysis of the prescription statistics of the Techniker Krankenkasse (TK) will be presented³⁰. Between July 2017 and the end of February 2018, 1,731 applications were made to the TK for reimbursement of costs for cannabis preparations. 67% of these applications were approved, of which 61% were on the basis of the indication “pain”. Other indications which often appear are “tumour” (7%), “other neurology” (7%) and “specialised outpatient palliative care” (7%). 65% of applications were rejected due to therapeutic alternatives³¹, 13% were incomplete and in 4% of cases no prospect of therapeutic success was seen.

Overall, 53% of all cannabis prescriptions are issued for male insured patients. In terms of age, people in the age group 50-59 years old received the most prescriptions (31.14%), with significantly more women (39.08%) than men (24.05%) receiving a prescription. The proportion of women who received a prescription for medicinal cannabis was larger than the proportion of men in the 60-69 year-old age group (15.02% v. 12.75%), the 70 to 79-year-old age group (7.14% v. 6.47%) and the 80 to 80-year-old age group (1.66% v. 1.22%). In contrast, among those under 50, the proportion of male insured patients who received a prescription was higher: 23.62% (v. 19.74%) of 40 to 49-year-olds, 19.28% (v. 13.0%) of 30 to 39-year-olds, 5.54% (v. 3.4%) over 20 to 29-year-olds and 3.73% (v. 2.58%) of those under 20 years old. Prescriptions were predominantly (39%) issued by neurologists, psychiatrists and psychotherapists. These are followed by family doctors (21%) and anaesthetists (8%).

Regional differences could also be established in relation to prescription prevalence: for example, prescriptions were most frequently issued in Saarland (208.89 applications per 100,000 insured persons), Bavaria (155.85/100,000) and Baden-Württemberg (151.77/100,000), while it was considerably lower in the new *Laender*, Hesse and Rhineland-Palatinate (between 52.18 and 95.54 prescriptions per 100,000 persons insured by the TK). On average, the national prescription prevalence amounted to 123.43 per 100,000 persons insured by the TK (Glaeske & Sauer, 2018).

³⁰ In 2018, approximately 10.3 million people in Germany were insured by the TK.

³¹ It should not be forgotten at this point that cannabis as medicine, in comparison to other therapy options, has a rather low efficacy (see Maier, 2017; Wurglics & Ude, 2017). The therapy is also more expensive, for example in relation to opiate therapy. Whether medicinal cannabis represents a suitable therapy option must therefore be clarified with the attending doctor individually (Glaeske & Sauer, 2018).

Depot injection for substitution therapy

Since April 2019, the substitute buprenorphine has been available in substitution therapy as the depot injection “Buvidal”. Depending on dosage, it can be injected once a week or monthly. Previously, patients without a take-home prescription had to collect their substitution drug from their doctor or pharmacy on a daily basis and administer it on-site. Buvidal is supposed to help enable a more self-determined life for those affected, and improve reintegration into society.

Buvidal can be a good alternative for people in rural areas in particular, who have to travel a long way to their doctors’ practice, but also in the case of travel and longer periods of absence. The same applies in relation to prison (see Schneider et al., 2019, Prison workbook) (European Medicines Agency [EMA], 2018; Deutsche Aidshilfe e. V., 2019; Deutsche Apotheker-Zeitung [DAZ.online], 2019).

4 ADDITIONAL INFORMATION (T4)

4.1 Additional sources of information (T4.1)

No additional sources of information are currently available on this.

4.2 Further aspects of drug treatment (T4.2)

No additional information is available on this.

4.3 Psychiatric comorbidity (T4.3)

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 (T5)

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, KDS)
- 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 2019 from the DHS

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5.2 Methodology (T5.2)

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 Länder and municipalities (Braun et al., 2018a, b). Most of the addiction support facilities in Germany use the KDS, which has been available in a newly revised version (KDS 3.0) since 2017. Due to the change in the KDS, the data up to 2017 and from 2017 onwards can only be compared to a limited degree. Differences will be discussed at the respective point in the text.

Since 2010, unlike in previous years up to and including 2009, no facility has been excluded from the data in the DSHS reported here on the grounds of their missing rate being too high (>33%), in order to avoid an overestimation of the missing figures and to achieve a maximum facility sample for each table. Therefore, caution needs to be exercised when comparing the data from 2010 onwards with that of 2007 to 2009.

The EMCDDA's "Treatment Demand Indicator (TDI)" has been integrated into the KDS. However, there is still a certain fuzziness 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

In the area of inpatient treatment, 137 facilities participated in the federal analysis of the DSHS in 2018 (in 2017 it was 152 facilities) (Braun et al. 2018).

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 KDS, produced by the German Federal Statistical Office, documents the diagnosis on discharge of all patients leaving inpatient facilities as well as the primary diagnoses, age and gender. The Statistical Report on Hospital Diagnoses is complete but not specific in the area of 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 for 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, where 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 the number of attending doctors. Information on the regional availability of substitution therapy was published for the first time in 2019, as well as on the regional distribution of available doctors (BOPST, 2019).

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