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Charlotte Tönsmeise[1], Maria Friedrich[2], Franziska Schneider[3], Esther Neumeier[3], Krystallia Karachaliou[3] & Tim Pfeiffer-Gerschel[3]

[1]German Centre for Addiction Issues (DHS); [2] Federal Centre for Health Education (BZgA);
[3] Institute for Therapy Research (IFT)

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0 SUMMARY (T0)

The treatment system for people with drug-related problems and their relatives in Germany ranges from counselling to acute treatment and rehabilitation right up 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 vary widely within the framework of complex cooperations. The overarching goal 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.

45.2% of outpatient clients who visit treatment facilities due to a drug problem are cannabis users (64.7% of first time clients). Nearly one quarter of outpatients are treated for harmful opioid use (23.1%). 14.5% of all outpatients submit themselves to treatment due to stimulant use. Patients with a cannabinoid-related disorder also account for the largest proportion of those undergoing inpatient treatment (30.6%). Other frequent diagnoses are ICD-10 F19 Other psychotropic substances/multiple substance use (24.3%) and F15 Stimulants (19.9%).

From 2002, when reporting became obligatory, the number of substitution patients reported continuously increased until 2010 and has remained largely stable in recent years. On the reference date (1 July 2019), the number was 79,700. A total of 2,607 doctors providing substitution treatment reported opioid addicts to the substitution register in 2019.

Data on gender-specific treatment as well as on the treatment of children and adolescents is not systematically prepared or evaluable. It should be noted, however, 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.

Long term trends in outpatient and inpatient addiction treatment show that for the first time in 2019 the number of people treated overall and for the first time due to cannabinoids did not continue to increase.

The corona pandemic has also affected the addiction support system in Germany. Even though no representative data is available on the situation in the addiction support system, surveys have shown that restrictions on contacts, legal and distancing regulations led to counselling and treatment services only being available on a reduced or restricted basis and some facilities having to pause their services temporarily. The practice of dispensing substitution drugs, in particular, has been considerably complicated and restricted by the effects of the corona pandemic. As a result, the SARS-CoV-2-Arzneimittelversorgungsverordnung (SARS-CoV-2 Medicinal Product Supply Ordinance) came into force at the end of April, defining possible exceptions to the German Regulation on the Prescription of Narcotic Drugs (Betäubungsmittel-Verschreibungsverordnung, BtMVV). For example, it permits substituting doctors to treat more patients than previously, and to prescribe medicinal drugs for a period of seven days or, in individual cases, up to 30 days (take home).

Furthermore, the Krankenhausentlastungsgesetz (German Hospital Relief Act) is intended to cover gaps in the area of statutory health insurance (gesetzliche Krankenversicherung, GKV) and use compensation payments to support addiction rehabilitation facilities.

Various efforts have also been made in the areas of addiction treatment and counselling, in order to adapt or supplement services in spite of the pandemic, in order that they can be continued or resumed.

In recent years, municipal financing, which accounts for the majority of all financing for addiction counselling facilities, has stagnated. This situation has now become even more acute as a result of the coronavirus pandemic. In order to draw attention to the counselling centres' precarious situation, the *Aktionstag Suchtberatung: Kommunal wertvoll!* (approx.: Action day on addiction counselling: local, valuable!) will take place for the first time on 4 November, under the auspices of the Federal Government Commissioner on Narcotic Drugs, Daniela Ludwig. The goal is to bring addiction counselling facilities and policymakers in the municipalities into a dialogue with each other and draw attention to the urgency of (continued) financing of addiction counselling facilities as well as to secure their future.

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., 2018; 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 powers, set specific areas of emphasis in the area of treatment, i.a. through promoting projects and awarding research contracts, as they did in 2019 (see sections 1.4.4 and 1.4.5).

The Third Amending Regulation of the German Regulation on the Prescription of Narcotic Drugs (Dritte Verordnung zur Änderung der Betäubungsmittel-Verschreibungsverordnung, 3.BtMVVÄndV) (BMG, 2017), passed by the German Federal Government in 2017, regulates the statutory requirements for implementing substitution treatment for opioid addicts. The medical-therapeutic matters were transferred to the guideline competence of the German Medical Association (Bundesärztekammer, BÄK). The amendments have been in use since 2nd October 2017. They have great importance in terms of improving and securing substitution in medical practice. Above all, they represent a modification to take account of new scientific evidence (see Dammer et al., 2017). In December 2018, a decision by the Federal Joint Committee (Gemeinsamen Bundesausschuss, G-BA) 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 provides and other regional steering committees on the basis of the statutory 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 draft and amend federal laws (e.g. narcotics law and social welfare legislation) which also affect 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: health insurance providers for funding acute treatment (such as detoxification), pension insurance providers primarily 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 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. The BÄK is responsible for processing and updating the guidelines for substitution-based treatment in the scope of the 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)).

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

The legal basis for the treatment of people 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). Addicts 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.

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 dependence treatments. At the heart of the addiction support system are the approximately 1,540 outpatient addiction counselling and treatment centres, low-threshold facilities and specialist and outpatient facilities within institutions. Furthermore, treatment and care are provided in 360 inpatient rehabilitation facilities (incl. day care rehabilitation facilities and transition), as well as 981 sociotherapeutic facilities (for example outpatient assisted living, employment and occupational projects as well as inpatient social therapy facilities) (IFT, 2019). 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, also play a key role: they are not

only responsible for detoxification, but also for crisis intervention and treating psychiatric comorbities (Destatis, 2018).

The majority of outpatient addiction support facilities (90.3%) are funded by independent, charitable bodies, in particular the Freie Wohlfahrtspflege (Dauber et al., 2020a). In inpatient treatment, independent charitable institutions provide 53.5% of the support facilities (Dauber et al., 2020b). In addition, public and private entities are also active in outpatient (5.9% and 1.7% respectively) and inpatient (12.0% and 29.6% respectively) addiction treatment. The number of other involved entities is small. They account for 2.1% of outpatient and 4.9% of inpatient facilities (Dauber et al., 2020a & b).

The heavily differentiated and compartmentalised support system enables the provision of individual counselling and treatment. The large number of areas of responsibility and funding agencies does make cooperation between the various facilities, authorities and institutes involved in treatments more 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 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 Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, 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, 26.3% of outpatient facilities reported having written contracts with facilities or services in the area of addiction treatment, 16.7% with employment, qualification and employment promotion facilities or services. 45.2% of facilities had made other agreements with self-help associations (Braun et al., 2020a).

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 (1,540 facilities) (IFT, 2019). 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, to 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 (see section 3, New developments, Emergency addiction counselling). Generally, counselling is carried out free of charge.

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	1,540	Outpatient facilities, includes: - specialised counselling and treatment centres - low-threshold facilities - specialist outpatient facilities and outpatient facilities within institutions	No information
General primary health care (e.g. GPs)	>2,607**	Medical practice/psychotherapeutic practice (mainly outpatient substitution treatment)	>79,700**
General mental health care	No information	Socio-psychiatric services/community psychiatric services	No information
Prisons (in-reach or transferred)	No information***	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 figures 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 shown here refer exclusively to the number of substituting doctors and substitution patients on the reference date in 2019. Since medical practices are the first port of call, a significantly higher number can be assumed in both cases (BOPST, 2020).

*** Based on resolutions by the ministries of justice, the German Prison Rules of Procedure (Vollzugsgeschäftsordnung, VGO) have been changed in correctional institutions. As a result, the structure and content of the published data changed from 2019 and data on the number of correctional institutions is no longer available from that year onwards. For further information, see Schneider et al. 2020, Prison workbook.

(IFT, 2019; Bundesopiumstelle, BOPST, 2020)

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 1.4.8). 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.

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 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 (Sächsisches Staatsministerium für Soziales und Verbraucherschutz, 2018).

Generally, the outpatient counselling and treatment centres has not changed significantly in recent years. It is evident, however, that municipal financing is decreasing in some communities, while at the same time the demand profile has expanded (further information in section 3 New developments - emergency addiction counselling). Referrals from addiction counselling and treatment centres continue to make up the largest proportion of all referrals into medical rehabilitation.

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

For additional, current information on the availability and utilisation of outpatient drug treatment services, see section 1.4.4, Targeted interventions.

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

The specialist psychiatric clinics and the addiction psychiatry departments of general hospitals and university clinics play a fundamental role in addict care. Every year, they carry out over 106,000[1] addiction treatments in total which are not related to alcohol or tobacco dependence (Destatis, 2020). These include detoxification, qualified withdrawal, crisis intervention and comorbidity treatment. The costs for these treatments are generally borne by the statutory, and where applicable private, health insurance providers.

Inpatient treatment also includes inpatient rehabilitation (withdrawal). The costs of withdrawal treatment are primarily borne by the statutory pension insurance providers. With the German Flexible Pension Act (Flexirentengesetz) 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 comorbitity. The costs of these treatments are generally borne by the social welfare offices of the municipalities, on the basis of SGB XII.

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[1] This figure is calculated using the very detailed diagnosis data of hospital patients from the Federal Statistical Office (Statistisches Bundesamt [Destatis]). It includes all treatments with the primary diagnosis ICD-10-GM-2017 F11 to F16 as well as F18 and F19 (Destatis, 2020).

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

Type of facility EMCDDA term	Total number of facilities	Type of facility National definition	Number of persons treated
Hospital-based residential drug treatment	218**	Specialised psychiatric hospitals/specialist departments	106,007*
Residential drug treatment (non-hospital based)	360**	Inpatient rehabilitation facilities	30,072***
Therapeutic communities	No information	No information	No information
Prisons	No information**	Secure psychiatric units	No information
Sociotherapeutic drug treatments	981**	Sociotherapeutic facilities	No information

Source: *Destatis, 2020; **IFT, 2019; *** DRV, 2020c[1]

** Based on resolutions by the ministries of justice, the German Prison Rules of Procedure (Vollzugsgeschäftsordnung, VGO) have been changed in correctional institutions. As a result, the structure and content of the published data changed from 2019 and data on the number of correctional institutions is no longer available from that year onwards. For further information, see Schneider et al. 2020, Prison workbook.

1.2.5 Further aspects of available inpatient treatment services (T1.2.5)

Around 10% of facilities which provide inpatient withdrawal treatment, have developed concepts to also offer withdrawal options to patients in substitution treatment. The requirements for this were set out 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[3] decreased by a further 4.1% to 73,916 in 2019 (2018: 77,116) (DRV, 2020a). In addition, the rate 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

[2] The KDS was revised in 2017 and the data collection was 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.

[3] This figure represents all applications for withdrawal treatment submitted to the DRV. Consequently, the figure shown includes treatment for both legal and illegal drugs.

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, no later than seven days prior to the end of the withdrawal treatment a seamless transition into rehabilitation is requested 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. For this purpose, a list is made available to hospitals by rehabilitation agency contact partners. Rehabilitation agencies have to process decisions within five working days. In addition, patients from qualified withdrawal treatment should be prioritised when allocating places (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. However, a smaller proportion is 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.

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 3 Types of ownership structure 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)	5.9%	90.3%	1.7%	2.1%
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.

(Dauber et al., 2020a)

Table 4 Types of ownership structure in inpatient treatment in per cent (%)

	Public ownership	Charitable ownership	Private ownership	Other
Specialised psychiatric hospitals/specialist departments	29.0%*	34.0%*	37.0%*	-
Inpatient rehabilitation facilities	12.0%**	53.5%**	29.6%**	4.9%**
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)	No information	No information	No information	No information

(*Destatis. 2020[4]; **Dauber et al., 2020b)

[4] The percentage listed is referring to the general number of hospitals is Germany, not only the ones who are treating people with addiction issues. Differentiated numbers are not available. The numbers refer to the data year 2018.

1.3 Key data

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 percent (%)

	Repeat inpatient	Outpatient	Inpatient treated for the first time	Outpatient
F11 Opioids	13.7%	31.7%	9.0%	7.7%
F12 Cannabinoids	29.4%	32.3%	36.6%	64.7%
F13 Sedatives/hypnotics	2.7%	1.9%	1.5%	1.5%
F14 Cocaine	8.5%	6.8%	12.6%	6.9%
F15 Stimulants	19.8%	16.0%	23.4%	13.6%
F16 Hallucinogens	0.1%	0.07%	0.1%	0.1%
F18 Volatile substances	0.04%	0.04%	0.0%	0.03%
F19 Other psychotropic substances/multiple substance use	25.7%	11.3%	16.8%	5.4%
Total number (N)	**8,145**	**33,569**	**1,097**	**21,558**

Source: Dauber et al., 2020a & b, T2.02

Outpatient Treatment

In 2019, data from a total of 324,874 treatments (not including one-off contacts) carried out in 863 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 48.7% of all primary diagnoses in outpatient addiction care in 2019). For 2019, the DSHS contains data on the primary diagnoses from a total of 62,549 treatments that were started or completed in outpatient psychosocial addiction support counselling or treatment centres due to problems with illicit drugs (Dauber, Künzel, Schwarzkopf & Specht, 2020a).

1.3.2 Today, only 23.1% of cases 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 (45.2%) 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 64.7%. The second largest group, some way behind, is first-time clients with the primary diagnosis of stimulants (13.6%), ahead of opioid-related disorders (7.7%) (Dauber et al., 2020a). Repeat clients were also predominantly those with cannabinoid and opioid-related disorders (32.3% and 31.7% respectively) (see (T1.3.1)

Table 5).

Inpatient treatment

Table 6 Patients treated on an inpatient basis by primary diagnosis in percent (%)

ICD-10 GM	Hospital statistics*	DRV***		DSHS		
	2017	2019	2018****	2019*****		
	Total			Males	Females	Total
F11 Opioids	30.2%	95.8% (drugs) 4.2% (medicinal drugs)	15.6%	13.2%	13.6%	13.3%
F12 Cannabinoids	18.0%		34.0%	31.8%	25.8%	30.6%
F13 Sedatives/ hypnotics	9.0%		2.8%	1.5%	6.7%	2.6%
F14 Cocaine	4.4%		8.4%	10.3%	4.7%	9.2%
F15 Stimulants	10.4%		22.7%	18.7%	25.0%	19.9%*
F16 Hallucinogens	0.6%		0.1%	0.1%	0.1%	0.1%
F18 Volatile substances	0.2%		0.03%	0.0%	0.2%	0.03%
F19 Other psychotropic substances/multiple substance use	27.4%		16.4%	24.3%	23.9%	24.3%
Total number (N)	**106,007**	**10,195**	**9,398**	**7,716**	**1,921**	**9,640 ***

* Three of the persons treated indicated 'indeterminate' sex: two were treated with the primary diagnosis F15 and one with the primary diagnosis F19.

Source: ** Destatis, 2020; ***; DRV 2020c; **** Braun et al., 2019, *****Dauber et al., 2020b (T3.01)

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). Out of the total of 35,485 inpatient treatments for substance-related disorders in 142 facilities documented by the DSHS in 2019, 9,640 were related to illicit substances (including sedatives/hypnotics and volatile solvents) (Dauber et al. 2020b). 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 30.6% and the proportion of treatments on the grounds of opioids is 13.3%. In relation to all primary diagnoses recorded in the area of addiction, treatments due to cannabinoids represent, at 9.5%, the second largest diagnosis group in inpatient treatment, after treatments due to alcohol, at 65.4%. The proportion of treatments based on stimulant use (19.9% of all inpatient treatment for illicit drugs, 6.2% of all inpatient addiction treatment overall) declined for the first time in 2019 (2018: 22.7% and 7.1% respectively; Table 6) (Dauber et al., 2020b).

Table 7 Summary: all clients in treatment

	Number of clients
Total clients in treatment	According to the DSHS with primary diagnosis illicit drugs
	outpatient: 62,549
	inpatient: 9,640
Total OST clients	79,700
Total	**No information**

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

Source: Dauber et al., 2020a, b; BOPST, 2020

1.3.3 Distribution of primary drug in the total population in treatment (1.3.2)

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

Primary diagnosis	Inpatient	Outpatient
F11 Opioids	13.3%	23.1%
F12 Cannabinoids	30.6%	45.2%
F13 Sedatives/hypnotics	2.6%	1.7%
F14 Cocaine	9.2%	6.8%
F15 Stimulants	19.9%	14.5%
F16 Hallucinogens	0.1%	0.1%
F18 Volatile substances	0.03%	0.04%
F19 Other psychotropic substances/multiple substance use	24.3%	8.5%
Total number (N)	**9,640**	**62,549**

Source: Dauber et al., 2020a & b, T3.01

1.3.4 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.

1.3.5 Characteristics of clients in treatment (T1.3.4)

Outpatient Treatment

The collection of the KDS of 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 are (in descending order) F12 - Cannabinoids, F11 - Opioids and F15 - Stimulants.

The clients are predominantly male in almost all primary diagnosis groups. Only for patients treated for volatile substances are the same proportion of women and men (50% each) treated in an outpatient basis (see Dauber et al., 2020, section 3).

Table 9 Patients treated on an outpatient basis, by primary diagnosis and gender in percent (%)

Primary diagnosis	Outpatient		
	Male	Female	Undefined/unknown
F11 Opioids	22.7%	24.9%	13.2%
F12 Cannabinoids	47.0%	37.8%	61.8%
F13 Sedatives/hypnotics	1.1%	4.0%	0.0%
F14 Cocaine	7.5%	4.1%	4.4%
F15 Stimulants	12.9%	21.1%	10.3%
F16 Hallucinogens	0.1%	0.2%	0.0%
F18 Volatile substances	0.02%	0.1%	0.0%
F19 Other psychotropic substances/multiple substance use	8.7%	7.8%	10.3%
Total number (N=100%)	**49,984**	**12,497**	**68**

Source: Dauber et al., 2020a & b, T3.01

The average age for the illicit drugs diagnosis groups was 32.1; for female clients it was somewhat younger, at 31.5, than for male clients, at 32.2. Those with the primary diagnosis F13 - Sedatives/hypnotics are the oldest diagnosis group on average at 42.6 years old; F16 hallucinogens, at 25.6 years old, and Cannabinoids, at 25.2 years old, are the youngest. If one differentiates within this data by gender, male clients with the primary diagnosis F12 -

Cannabinoids (25.1 years old) are the youngest and F13 - Sedatives/hypnotics (39.2 years old) the oldest; among female clients, the youngest average age group is in the diagnosis group F16 - Hallucinogens (23.2 years old) and the highest is also F13 - Sedatives/hypnotics (46.3 years old) (see Dauber et al., 2020a, T 3.02).

Between 22.6% (F16) and 51.6% (F14) of all clients treated on an outpatient basis have a partner (see Dauber et al., 2020a, T3.04), between 16.7% (F18) and 60.6% (F13) live with their partner in one household (ibid, T3.04). On average, the women undergoing treatment have 1.52 children (men: 1.7 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; Dauber et al., 2020a, T3.04).

Between 11.3% (F15) and 44.6% (F14) of all clients treated on an outpatient basis have a migration background[5]. Within that group, a distinction is made between those who migrated themselves, those who migrated with parents and third generation migrants (Dauber et al, 2020a, T3.12). The primary diagnoses with the largest proportion of people with a migration background are F14 - Cocaine (44.6%), F11 - Opioids (37.5%), and F18 - Volatile substances (28.6%) (ibid, T3.12). Of cocaine addicts with a migration background, 28.3% are originally from Turkey. Among people with the primary diagnosis F11 Opioids, 17.7% of those with a migration background are from Russia, and 14.7% from Kazakhstan. The largest proportion of migrants with the primary diagnosis F18 Volatile substances are from Turkey, Kazakhstan and Italy (each 16.7%) (ibid, T3.13).

The proportion of clients without any started vocational training was under 20% in the majority of primary diagnoses. Three relatively higher proportions can be found for the primary diagnoses Other psychotropic substances/multiple substance use (22.6%), Cannabinoids (35.4%) and Volatile substances (50%) (Dauber et al., 2020a, T3.16).

On average, 10.2% of male and 8.7% 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 (15.6%), Other psychotropic substances/multiple substance use (14.2%) and Stimulants (12%) (Dauber et al., 2020a, T3.15).

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, whilst for Psychotropic substances/multiple substance use opioids it is even more than half. The group with the fewest unemployed people was those treated for hallucinogens (see Dauber et al, 2020a, T3.18).

[5] Knowledge as to the home countries of the clients can play a role in needs-based planning, for example in relation to language and culturally sensitive services in the area of treatment and counselling (see section 1.4.4.4, targeted interventions: migrants/refugees) or prevention (see Friedrich et al., 2020). When analysing this data, however, it should be taken into account that it is only a sample of clients who have actually entered the addiction support system. The figures must not be confused with actual demand.

Inpatient treatment

The largest proportion of people treated on in inpatient basis in the diagnosis group “illicit drugs” is, for both male and female patients, that with the primary diagnosis F11 Cannabinoids (31.8% and 25.8% respectively). The second most frequent diagnosis is, also for both genders, F15 Stimulants (18.7% and 25.0% respectively). The lowest proportion of treatments was for the diagnoses F18 Volatile substances (0.0%) and F16 Hallucinogens (0.05%). Looking at the gender distribution by diagnosis group, it is noticeable that significantly more men than women were being treated in most primary diagnosis groups. An exception is the diagnosis F13 Sedatives/hypnotics (48.0% male vs 52.0% female) (see Dauber et al., 2020b, T3.01).

The average age of persons undergoing treatment in four out of the eight primary diagnoses is between 31 and 38 years old (F11, F14, F15, F19). The oldest patients on average are those receiving treatment for the use of sedatives/hypnotics (43.8 years old), the youngest for volatile substances (24.7 years old) (see Dauber et al., 2020b, T3.02).

Excluding those treated for sedatives/hypnotics (F13), more than half of those treated for all primary diagnoses live alone see Dauber et al., 2020b, T3.04).

The majority of people treated on an inpatient basis does not have a migration background[6]. The two diagnosis groups with the highest proportion of migrants are F14 Cocaine (43.3%) and F11 Opioids (34.4%) (see Dauber et al., 2020b). The greatest proportion of migrants with a disorder due to the use of cocaine come from Turkey (37,2%). 26.8% of migrants who were treated on the basis of opioids came from Russia (Dauber et al., 2020b).

The proportion of clients without even a partial vocational training was, with the exception of the diagnosis group hallucinogens, under 20% for all of those treated. Overall, most patients have an vocational qualification. An also sizeable proportion has started higher or vocational education but not finished it (see Dauber et al., 2020b, T3.16).

15.3% of male and 18.7% 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, for all genders) hallucinogens (42.9%), stimulants (14.3%) and cocaine (12.3%) (Dauber et al., 2020b, T3.15). 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. The proportion of clients without even a partial vocational training was, with the exception of the diagnosis group hallucinogens, under 20% for all of those treated. Overall, most patients have an vocational qualification. An also sizeable proportion has started higher or vocational education but not finished it (see Dauber et al., 2020b, T3.16).

15.3% of male and 18.7% of female clients in the inpatient treatment system have left school without school-leaving qualifications. The rates are highest among those treated with the

[6] As already explained, the migration background in these calculations is summarised as the client’s own migration, that of their parents, and migration in the third generation.

primary diagnoses (in descending order, for all genders) hallucinogens (42.9%), stimulants (14.3%) and cocaine (12.3%) (Dauber et al., 2020b, T3.15).

Children, adolescents and young adults

Table 10 Distribution of primary diagnoses among children, adolescents and young adults in per cent (percentage proportion of all treatment cases by primary diagnosis)

Primary diagnosis	DSHS								
	Outpatient						Inpatient		
	-14		15-17		18-19		-14	15-17	18-19
F11 Opioids	**0.81%**	(0.03%)	**0.81%**	(0.3%)	**2.1%**	(0.7%)	-	**6.06%** (0.3%)	**3.4%** (1.0%)
F12 Cannabinoids	**83.25%**	(1.8%)	**88.09%**	(15.7%)	**81.5%**	(14.9%)	-	**83.33%** (1.9%)	**54.6%** (7.1%)
F13 Sedatives/hypnotics	**0.16%**	(0.1%)	**0.24%**	(1.1%)	**0.6%**	(3.1%)	-		**0.3%** (0.4%)
F14 Cocaine			**0.48%**	(0.6%)	**1.5%**	(1.9%)	-		**3.7%** (1.6%)
F15 Stimulants	**10.95%**	(0.7%)	**6.71%**	(3.7%)	**8.5%**	(4.9%)	-	**6.06%** (0.2%)	**16.7%** (3.3%)
F16 Hallucinogens			**0.16%**	(12.9%)	**0.2%**	(12.9%)	-		**0.5%** (22.2%)
F18 Volatile substances	**0.16%**	(4.5%)	**0.08%**	(18.2%)	**0.0%**	(4.5%)	-		
F19 Other psychotropic substances/multiple substance use	**4.67%**	(0.5%)	**3.43%**	(3.2%)	**5.6%**	(5.4%)	-	**4.55%** (0.1%)	**20.9%** (3.4%)

Source: Dauber et al., 2020a, 2020b

A not insignificant proportion of patients treated are children (under 14 years old), adolescents (15-17 years old) and young adults (18-19 years old)[7]. Due to their physical and psychological stage of 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 outpatient and inpatient treatment settings - children, adolescents and young adults are treated most frequently for cannabinoids. All other primary diagnoses are below 10% in outpatient treatment cases, in all three age groups.

The numbers in brackets in the table provide information on the proportion of those treated in the corresponding age group in all treatment cases covered according to primary diagnosis. On the basis of these figures it is clear that overall a third (32.3%) of all patients treated on an outpatient basis with the primary diagnosis F12 (Cannabinoids) are younger than 20 years old. The figure is a quarter for volatile substances (27.2%) and hallucinogens (25.8%). The substance group with the lowest proportion of outpatient treatments of children, adolescents and young adults is opioids (1.03%).

From the inpatient treatment data it can be seen that 9% of patients treated on the basis of cannabinoids are under 20 years old; for hallucinogens the figure is 22.2%. The proportion of children, adolescents and young adults treated for opioids is equally low (0.4%). Even rarer overall are only treatments on the basis of sedatives/hypnotics (see 19).

[7] The definition of children, adolescents and young adults varies depending on the study. The age groups set out here were selected on the basis of their availability in the DSHS data set.

Addiction self-help

No new information is available on this. For detailed information, see the 2019 Treatment workbook (Tönsmeise et al., 2019).

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

- Deutsche Suchthilfestatistik 2020 (Dauber et al., 2020a & b)
- DRV Statistical Report on Rehabilitation 2020
- 2017 Basic Hospital Data (Statistisches Bundesamt, 2018)
- Detailed diagnosis data on patients in hospital (Destatis, 2020)
- 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 is 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 2020 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 responsibility, in the scope of diagnosis and treatment, to talk about 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 159,800 practice-based or employed doctors (outpatient) who could be the first point

of contact for patients with addiction disorders (BÄK, 2019). 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 1.4.6 to 1.4.11.

External service for counselling/treatment in prisons

Correctional institutions (Justizvollzugsanstalten, JVA) 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, for example for referral into suitable residential and care facilities. The counsellors are not part of the staff or part of 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 provide care to chronically alcohol-dependent persons, or persons dependent on other psychotropic substances with psychiatric comorbities. 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 the SGB VI as well as, subordinately, the SGB V. The pension insurance and health insurance providers are responsible for planning and quality assurance, 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 support by way of outpatient addiction support services, which offer intensive assistance. The costs can, upon request, be assumed by the responsible social welfare providers (according to SGB XII).

Employment projects/qualification measures

Jobs and work 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 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 be performed by practice based, licensed psychological psychotherapists, according to the German Psychotherapy Act (Psychotherapeutengesetz, PsychThG). Specialist doctors for psychiatry and psychotherapy, specialist doctors for psychotherapeutic medicine and doctors with the additional designation "psychotherapy" are also qualified to carry this out. 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 (Gesundheitsberichterstattung des Bundes, 2017; DGPPN, 2019). The legal basis is SGB V. Planning occurs through the psychotherapist chambers. 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 statutory health insurance providers and the DRV have funded 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 goal of improving individual quality of life. Generally, both those directly affected (addicts in addiction self-help) and relatives take part.

1.4.3 Inpatient drug treatment services (T1.4.3)

Detoxification

Detoxification treatments takes place as a rule in specialist psychiatric departments. If such departments are not available, detoxifications 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 specialist department. The legal basis is the SGB V. The *Laender* and municipalities as well as the hospital operators are responsible for planning.

Qualified withdrawal facilities/specialist hospital departments

"Qualified withdrawal" treatment complements detoxification with motivational and psycho-social services and often prepares further rehabilitative measures. Qualified withdrawal takes place in special departments of specialist hospitals or special facilities where the psychophysical peculiarities of withdrawal from alcohol and psychotropic substances are appropriately taken into account. 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 couples 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 of the different forms of treatment is set individually. 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 geared to the individual needs of the addicted persons.

Aftercare services can be accessed, for example via the DRV's website www.nachderreha.de or directly via the providers (for example in the local Caritas locations in Germany, Diakonie Deutschland).

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 between 25 and 50 treatment places and thus number amongst the smaller rehabilitation facilities. Further

information can be found in the Selected Issue Chapter "Inpatient Treatment of Drug Addicts in Germany" of the REITOX Report 2012 (Pfeiffer-Gerschel et al., 2012).

Treatment in prisons

The secure psychiatric units 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 according to 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, such that after release no further offences would be expected. Individual and group therapy measures are used as well as psycho-pharmacological treatments, complemented by accompanying ergo and physical therapy. Further information on this subject can be found in the Prison workbook (Schneider et al., 2020).

Table 11 Availability of key interventions in inpatient 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, see Bartsch et al., 2018)

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. These are also performed in the inpatient setting. It is intended, in particular, for those patients who have a higher need for rehabilitation, such as addicts with psychiatric comorbidities. The legal basis is 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 contents and objectives of the transition treatment can be found in a publication of the German Association for Inpatient Addict Support (Bundesverband für stationäre Suchtkrankenhilfe e.V., buss, 2016).

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

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

Inpatient 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) (DHS, 2019).

1.4.4 Targeted interventions (T1.4.5)

Migrants/refugees

In recent years, great efforts have been made to create appropriate counselling and treatment services for asylum seekers, since drug use and dependence - whether it began in a foreign country or in the destination country or during the journey - represents a relevant topic for care. The consideration of language and cultural barriers, in particular, is of central importance. A 2018 research study showed that networks were set up in many cities with regard to refugees, in which addiction support also played a part (Kuhn, 2018). In order to support counselling and treatment factilities in implementing and carrying out qualified services, there are projects and planned research whose documentation and results are provided for this purpose:

The “Guidance” project[8] 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, further training courses and coaching sessions are carried out for employees in refugee support, of the youth

[8] Notdienst Berlin e.V., Guidance [online] www.guidance-berlin.de

welfare office, of youth support, of assisted living and of 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).

The joint project PREPARE [Prevention and Treatment of Substance Use Disorders in Refugees] is focussed on the prevention and treatment of addiction problems among refugees. The four subprojects are supported by, among others, the Charité – Universitätsmedizin Berlin, the University of Emden/Leer and the Centre for Interdisciplinary Addiction Research (Zentrum für interdisziplinäre Suchtforschung, ZIS) at the University of Hamburg. The aims of the joint project are, among other things:

- Information as to the prevalence of addiction problems among refugees,
- Identification of possible subgroups with special needs,
- Assessment of the needs of the support system in dealing with refugees,
- Development of a culturally adapted tool to collect data on addiction problems
- Development and evaluation of a treatment programme for refugees with psychological stress following traumatic experiences and addiction problems.

The project is being conducted in the scope of the Federal Ministry of Education and Research (Bundesministeriums für Bildung und Forschung, BMBF) funding initiative on the psychological health of refugees, and is running from 2019 to 2024 (ZIS, 2020).

The PaSuMi pilot project (Partizipation, Suchthilfe und Migration - participation, addiction support and migration), from the DAH and funded by the BMG, was run from 2017 to 2019 in eight local addiction prevention facilities in Berlin, Bielefeld, Dortmund, Hamburg and Nuremberg. The aim of the project was to adapt addiction prevention and harm reduction services to the needs and living environments of a dynamic and heterogeneous migrant population. The manual compiled from the knowledge gained is made available for download on the PaSuMi website[9] under Infos > Material (Aidshilfe, 2020).

The nationwide addiction support directory[10] of the DHS and the buss facility search database[11] offers users the option to filter counselling and treatment services and inpatient therapy services according to the desired language in which the service is provided.

Older drug addicts (40+)

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

[9] PaSuMi pilot project [online:] www.pasumi.info.

[10] Addiction support directory [online:] www.suchthilfeverzeichnis.de.

[11] buss facility directory [online:] www.therapieplaetze.de.

from the Federal Criminal Police Office (Bundeskriminalamt, BKA) also shows that the average age of drug-related deaths has increased in the past: while the average age was 26 in 1982, by 2017[12] it had reached 38.9 years old (BKA, 2018; Kraus & Seitz, 2018).

Facilities such as Condrobs[13] offer low-threshold and acceptance oriented support for older drug addicts. This includes, in addition to addiction counselling, an assisted living facility and an employment project.

Another 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 45 inpatient places in differently designed accommodation facilities. The goal 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 target group of people admitted by LÜSA 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 (LÜSA, no date).

In addition, inpatient facilities such as the salus clinic in Hürth offer special treatment programmes for older drug addicts, with its “55+ programme for experienced alcohol and drug patients” (“55+ Programm für LEBENSERFAHRENE Alkohol- und Drogenpatienten”)[14]. Further services can be identified via the DHS addiction support directory and the buss facility database, that are specifically and exclusively aimed at older people.

New psychoactive substances (NPS) and methamphetamine

After cannabis and the group of amphetamines/methamphetamines, NPS are the most frequently consumed illegal substances in Germany (Atzendorf, Rauschert, Seitz, Lochbühler & Kraus, 2019).

Recommendations for action 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, DGPPN, 2016).

For the purpose of evaluating inpatient withdrawal treatment, until March 2020 the BMG has funded the “Crystal-Project” (“Crystal-Projekt”), a comparative study in the Hochstadt District Hospital and the Mecklenburg MEDIAN Clinic[15]. Prepublished information on the study results

[12] Due to a change to the BKA database, no data is available for 2018 or 2019 in relation to the average age of drug-related deaths. Further information on the problem of drug-related deaths can be found in the 2020 Harms and Harm Reduction workbook (Neumeier et al., 2020, section 1.1).

[13] Condrobs e.V. [online:] www.condrobs.de.

[14] Flyer for the service [online:] https://www.salus-kliniken.de/fileadmin/contents/Kliniken/Huerth/Dokumente/Flyer/Sucht/Flyer_55_.pdf [accessed: 27 Aug. 2020].

[15] An extensive presentation of the studies can be found in the 2019 Treatment workbook (Tönsmeise et al., 2019).

shows, that the comparative group - which received treatment based on an adapted, psychotherapeutic and specially tailored group manual for methamphetamine users – and the control group – which received treatment as usual – archieved comparable results in all catamnestic surveys. However, the main treatment duration was shorter in the comparative group. The group manual can be assessed and downloaded on the webside of the hospital of the University Munich[16] (Hospital od the University Munich, n.d.).

Gender-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. Nevertheless, there is as yet no systematic nationwide data collection on gender specific addiction support services in Germany.

In outpatient addiction treatment there are, however, gender-specific services in many cities and metropolitan areas. For example, there are addiction support facilities aimed exclusively at women or men, for example:

- LAGAYA[17] is a psychosocial addiction counselling and addiction treatment centre for women and girls, as well as their relatives and other attachment figures in Stuttgart. As well as individual and group counselling, outreach counselling and care, online addiction counselling via email and psychosocial care, counselling and treatment of patients receiving substitution treatment are offered.
- FrauSuchtZukunft Verein zur Hilfe suchtmittelabhängiger Frauen e.V.[18] (approx. “WomanSeeksFuture association for the support of substance dependent women”) offers a variety of counselling and treatment services to women in Berlin. As well as psychosocial care, counselling and clearing, crisis interventions and outpatient addiction therapy, visits and counselling in prisons are offered to women, for example.
- Boys’ ResorT[19] is a group service of the Hannover Drug Counselling (Drogenberatung Hannover), which is aimed exclusively at male adolescents and young adults with high-risk consumption of drugs, gambling, media etc.

In addition, some gay and lesbian counselling facilities and AIDS support facilities offer addiction counselling specifically for people in the LGBTQ+ community, for example:

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[16] Group manual „Crystal-Project“ [online:] http://www.klinikum.uni-muenchen.de/Klinik-und-Poliklinik-fuer-Psychiatrie-und-Psychotherapie/download/de/forschung/Sucht/BMG-Crystal-Projekt-Manual.pdf [accessed: 19.Oct. 2020].

[17] LAGAYA, Verein zur Hilfe suchtmittelabhängiger Frauen e.V. [online] www.lagaya.de [accessed: 27 Aug. 2020].

[18] FrauSuchtZukunft Verein zur Hilfe suchtmittelabhängiger Frauen e.V [online:] https://frausuchtzukunft.de/ [accessed: 27 Aug. 2020].

[19] Drogenberatung Hannover [online:] https://step-niedersachsen.de/einrichtungen/drobs-hannover/beratung [accessed: 27 Aug. 2020].

- Schwulen Beratung Berlin (Gay Counselling Berlin)[20] offers an *open queer addiction group*, in which people can discuss the subject of substance use and dependency without prior registration. In addition, it provides information about relevant topics such as *chemsex*. a free, anonymous online guide to help affected people change their use habits can be obtained from the website.
- SHALK[21] NRW is a self-help network that has existed since 1994 for homosexual and bisexual people with an addiction disorder, that is currently established in nine cities in North Rhine-Westphalia.

There is also a counselling centre which has specific services primarily for trans, non-binary and gender diverse people and relatives, couples, families and people who are connected to the topic professionally: 4be TransSuchthilfe[22] in Hamburg offers counselling and support for addiction issues, as well as referral into further support. Clients are supported by experienced peers and psychotherapists. The counselling centre also organises, on request, group, multiplier and school events as well as further education on the topic.

Inpatient facilities and therapeutic residential communities have also developed gender-specific rehabilitation concepts. For example, the Bernhard-Salzmann Clinic in Gütersloh[23] offers a concept for the treatment of women suffering from dependence disorders. The therapeutic housing association “Die Zwiebel”[24] in Berlin or Condrobs in Munich also have specific services for women in different life situations, for example drop-in centres, addiction counselling facilities, and sociotherapeutic, clean and aftercare shared accommodation. 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 LWL Coordination Office for Drug Related Issues (Koordinierungsstelle Sucht) provides, to anyone who is interested, an extensive summary of practice relevant literature on the topic of male-specific addiction work on its website[25]. It also provides a list with male-specific addiction support services, such as the specialist clinic St. Marienstift[26] in

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20 Schwulen Beratung Berlin [online] www.schwulenberatungberlin.de/wir-helfen/wir-helfen-alkohol-drogen [accessed: 20 Jul. 2020].

21 SHALK NRW [online] www.shalk.de [accessed: 20 Jul. 2020].

22 4be TransSuchtHilfe in Hamburg [online:] https://www.therapiehilfe.de/for_be_trans_sucht_hilfe.html [accessed: 27 Aug. 2020].

23 Bernhard Salzmann Klinik. LWL–Rehabilitationszentrum Ostwestfalen. Concept for the treatment of female addicts [online]. https://www.lwl.org/527-download/BSK/Konzepte/Behandlung_abhaengiger_Frauen.pdf [accessed: 12 Aug. 2020].

24 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. 2020].

25 Can be found at [online:] https://www.maennersache-sucht.de/de/erganzendes-material/ [accessed: 27 Aug. 2020].

26 Fachklinik St. Marienstift [online:] https://www.sucht-fachkliniken.de/marienstift.html [accessed: 27 Aug. 2020].

Neuenkirchen-Vörden, which, as well as services such as individual and group therapy, psychosocial counselling and psychoeducation and occupational therapy, has a special focus on the treatment of trauma. Facilities such as the Adolf Mathes Haus[27] from the Munich Catholic Men's Welfare Association (Katholischen Männerfürsorgeverein München e.V., KMFV) offer men with addiction problems living space, daily structured programmes and support for occupational qualifications, training and finding work, as well as psychological and therapeutic services, addiction counselling and relapse prevention.

Other target group specific services, which are aimed exclusively at men or women, can also be searched for using the DHS addiction support directory and the buss facility directory[28].

Addicted pregnant women and parents

The "Dresden clinical pathway for crystal meth" is a concept developed by the TU Dresden and tested in practice, which facilitates interdisciplinary and needs-oriented care and treatment of pregnant women who use crystal meth. The goal of the evaluation of the "Dresden clinical pathway for crystal meth" (Oct. 2017 to Sep. 2020) is 1.) to deduce its effectiveness, 2.) to ascertain the extent to which the basic concept can be implemented in other regions, and 3.) to determine the requirements that apply to interdisciplinary and cross-system care. The overarching objective of the project is to develop a framework for a national expansion of the project and to explain it by means of an implementation manual (Haarig & Mathiebe, no date).

There are some inpatient services and clinics which provide special treatment services for substance-using pregnant women. The Rhein-Mosel specialist clinic Andernach[29] offers both outpatient and inpatient support: The PEPERINA project in the mother and child outpatient clinic offers support to pregnant women and mothers with small children, in the form of psychiatric diagnosis and treatment, talking therapy and social services counselling as well as support with organising help at home. Within the framework of the inpatient services, the treatment of women seeking treatment for their addictive substance use during pregnancy is a focus of the facility.

A study by the Ludwig-Maximilian University of Munich suggests that there is a lack of representative data on the subject of substance use during pregnancy in Germany but that such data is urgently needed in order to determine how high the need for treatment is and to close gaps in treatment demand (Hoch et al., 2019).

Currently, the "SHIFT+" intervention, an addiction support family training for addicted parents by the German Institute on Addiction and Prevention Research (Deutsches Institut für Sucht- und Präventionsforschung, DISuP) is being further developed and evaluated. The project

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[27] Adolf Mathes Haus [online:] https://www.kmfv.de/einrichtungen-und-dienste/einrichtungssuche/einrichtung/adolf-mathes-haus/show/index.html [accessed: 27 Aug. 2020].

[28] It should generally be noted that corresponding, gender-specific treatment or counselling methods are not necessarily used in all services exclusively aimed at men or women.

[29] Rhein-Mosel-Fachklinik Andernach [online:]https://www.landeskrankenhaus.de/rhein-mosel-fachklinik-andernach [accessed: 27 Aug. 2020].

builds on the “SHIFT”[30] programme, which was conceived and extensively evaluated in the scope of the research project “Crystal meth & family II - conception and evaluation of an intervention for methamphetamine addicted parents to promote family resilience and parental competence”, funded by the BMG. In “SHIFT”, eight 90-minute, modularised intervention units cover the promotion of positive parenting, the stabilisation of parental abstinence and the strengthening of family resilience. As SHIFT has proven to be an effective project in practice, SHIFT+ will also be expanded, in the scope of the further developed, to the remaining area of dependence on illegal substances. The addition of modules for relatives is also intended to enhance the area of family resilience. The implementation of SHIFT+ is carried out at ten practice locations nationwide in collaboration with addiction and youth support. In the ten 90-minute sessions, tried and tested addiction and behavioural therapy techniques and programmes are taught. Using a randomised research design, the intervention will be assessed for its effectiveness and acceptance. The first results are expected before the end of this year.

Minors and adolescents

There is also no systematically prepared data for addiction specific services in the healthcare of dependent children and adolescents[31]. Databases similarly list normal addiction counselling and treatment centres that also care for children and adolescents.

However, in many cities and districts there are youth and addiction-specific outpatient facilities. They are mostly utilised by young cannabis users who have come to the attention of the authorities due to the use of other psychotropic substances. Often, these facilities offer evaluated programmes positioned at the crossover between prevention and treatment, such as "Early Intervention with Drug Users Coming to the Attention of Law Enforcement for the First Time"[32] (FreD - Frühintervention bei erstauffälligem Drogenkonsum) and the programme “Realize it”[33] 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 74 records nationally for clinics and rehabilitation institutions which offer specialised treatment of children and adolescents who use illicit drugs (as of July 2020, DHS, 2020a).

Specifically in the area of children and adolescents, there are a range of internet-based programmes (see section 1.4.5), which facilitate access to information and support.

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30 Further information on the project can be found on the DISuP website at https://www.katho-nrw.de/katho-nrw/forschung-entwicklung/institute/disup/forschungsprojekte/crystal-meth-und-familie-ii/ [accessed: 17 Jun. 2020].

31 The term “children” refers to people under 14 years old, “adolescents” those between 15 and 17 years old. Definitions may differ from study to study.

32 FreD - Frühintervention bei erstauffälligem Drogenkonsum. [Online:] https://www.lwl-fred.de/de/ [accessed: 17 Jul. 2020].

33 Realize it! Counselling for drug use. [Online:] https://www.realize-it.org/ [accessed: 17 Jul. 2020].

In addition, the Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung, BMBF) funds "IMAC-Mind"[34], 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 can be 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.

People with an intellectual disability

The pilot project TANDEM - special *help for special people in the network of disabled and addiction support*[35] (TANDEM – *Besondere Hilfen für besondere Menschen im Netzwerk der Behinderten- und Suchthilfe*) of the LWL Koordinationsstelle Sucht is intended to promote the sustainable development of networking structures between addiction support and disabled support. The aim is to develop suitable addiction support services for people with an intellectual disability. The pilot project started in September 2018 and will run to the end of August 2021, with six facilities or three Tandems from disabled and addiction support taking part.

In addition, the LWL offers an online facility directory, the database of which contains addiction specific services for people with intellectual disabilities from six *Laender*[36].

Further information on the topic of people with an intellectual disability and addiction can be found in the REITOX report 2014 from the EMCDDA (Pfeiffer-Gerschel et al., 2014).

1.4.5 E-Health services for drug addicts (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 most well-known and oldest project is "drugcom.de"[37], 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.

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[34] IMAC-Mind [online] https://www.imac-mind.de/ [accessed: 17 Jul. 2020].

[35] TANDEM [online:] https://www.lwl-ks.de/de/TANDEM/ [accessed: 27 Aug. 2020].

[36] Geistige Behinderung und Sucht – Einrichtungsverzeichnis [online:] https://www.geistige-behinderung-und-sucht.de/de/gbs-verzeichnis/ [accessed: 27 Aug. 2020].

[37] Drugcom [online] www.drugcom.de [accessed: 27 Aug. 2020].

There are online counselling options via chat or email available to visitors to the website. In addition, addiction counselling facilities in the vicinity can be found.

In addition to online chat counselling, Drugcom.de has specific evaluated treatment programmes available, e.g. “Quit the shit”[38], 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”[39], 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 a chat service, a supported consumption journal, individual counselling and check ups for those affected and their relatives/friends, all as online services. All counselling services are free of charge, strictly confidential and can take place anonymously if desired.

A service specialised in methamphetamine is the "Breaking Meth"[40] 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 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 reflections on use. Due to the care provided by specialist staff, there is also the possibility of a 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*[41] (Breaking Meth, no date).

SoberGuides[42] is a digital addiction self-help project by Guttempler in Deutschland. It offers those affected and their releatives the option to make contact with specially trained, volunteer, clean addicts, so-called “sober guides”, who then accompany them intensively for up to three months. The contact is free and carried out (if requested) anonymously by telephone or email. Those affected can view the profiles of the *sober guides* on the project’s website and decide themselves which guide they want to contact, depending on the addictive substance and consultation hours given.

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

Due to the COVID-19 (corona) pandemic, online services have become much more important. Further information on this topic can therefore be found in section 3, New Developments.

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38 “Quit the Shit” [online] https://www.quit-the-shit.net/qts/ [accessed: 27 Aug. 2020].

39 Online Suchtberatung KOiNTER [online] https://kointer.de [accessed: 27 Aug. 2020].

40 Breaking Meth [online] https://breaking-meth.de [accessed: 27 Aug. 2020].

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

42 SoberGuides [online:] www.soberguides.de [accessed: 02 Sep. 2020].

1.4.6 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. 59.4%[43] (Dauber et al., 2020a, T6.04) of those treated on an outpatient basis finish the intervention as planned, compared to 67.3% (Dauber et al., 2020b, T6.04) in the inpatient area. In outpatient treatment, the highest proportions of premature dropout are found in patients with the primary diagnoses of opioids (46.8%), other psychotropic substances/multiple substance use (40.7%) and volatile substances (40.0%); in inpatient treatment it is volatile substances (66.7%), hallucinogens (42.9%) and opioids (36.4%) (Dauber et al., 2020a & b).

At the beginning of 2020, the FVS published the catamnesis data from three[44] 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 success[45] (DG-Sucht, 2001; DG-Sucht, 1985). The most recent results of the cross-facility drug catamnesis on the basis of the discharge year 2017 have seen success levels increase slightly again, year on year. The catamnestic success rate is 70.4% (DGSS1) (2016: 67.7%, 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 17.2% of patients are still successfully abstinent one year after inpatient drug rehabilitation (DGSS 4) (2016: 20.7%; 2015: 23.3%; 2014: 23.8%; 2013: 24.9%). On average, relapsing rehabilitation clients used addictive substances 15.4 weeks after their release. With the help of data from patients who suffered a relapse during the catamnesis and provided information on the relapse

[43] For this figure, the number of diagnosis groups F11-16 and F18-19 ending treatment as planned was compared to the number of all treatments from all diagnosis groups.

[44] In the evaluation of patients released in 2017, data was evaluated from only half as many institutions as in 2016. This reduced data pool is presumably accounted for by the conversion phase to the new German Core Data Set, KDS 3.0, which was used for the first time in the year of release, 2017. Due to this conversion, data is only comparable to a limited extent with the years prior to the switch.

[45] The most favourable method of calculation, DGSS1, includes all catamnesis respondents who were discharged as planned. Under the KDS, a patient is classified as abstinent after a relapse, if they have been abstinent in the last 30 days of the survey period. The strictest method of calculation, DGSS4, includes all 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.

period, it could be determined that the probability of relapse is highest in the first three months after the end of treatment (61.9%) (Kemmann et al., 2020).

The addiction self-help and abstinence associations also collect data with regard 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, according to their own account (Naundorff et al., 2018).

1.4.7 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 "Recommendations 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 for focus on employment in medical rehabilitation - BORA" (Gemeinsamen Arbeitsgruppe Berufliche Orientierung in der medizinischen Rehabilitation, BORA) (2014). These recommendations 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 is gradually coming 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 in an institution-

centred manner (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 funding 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).

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.

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

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

- Medical, pharmaceutical or care staff in an inpatient medical rehabilitation facility, a public health authority, a nursing home/care home or a hospice[46],
- Medical or care staff, who work for an outpatient care service or a specialised outpatient palliative care facility[47],
- Pharmacists or non-dispensing pharmaceutical staff in a pharmacy[48],
- Medical or specialist care staff in a hospital[49] and
- Staff employed in state-approved addiction support facilities who have been trained accordingly[50].

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

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

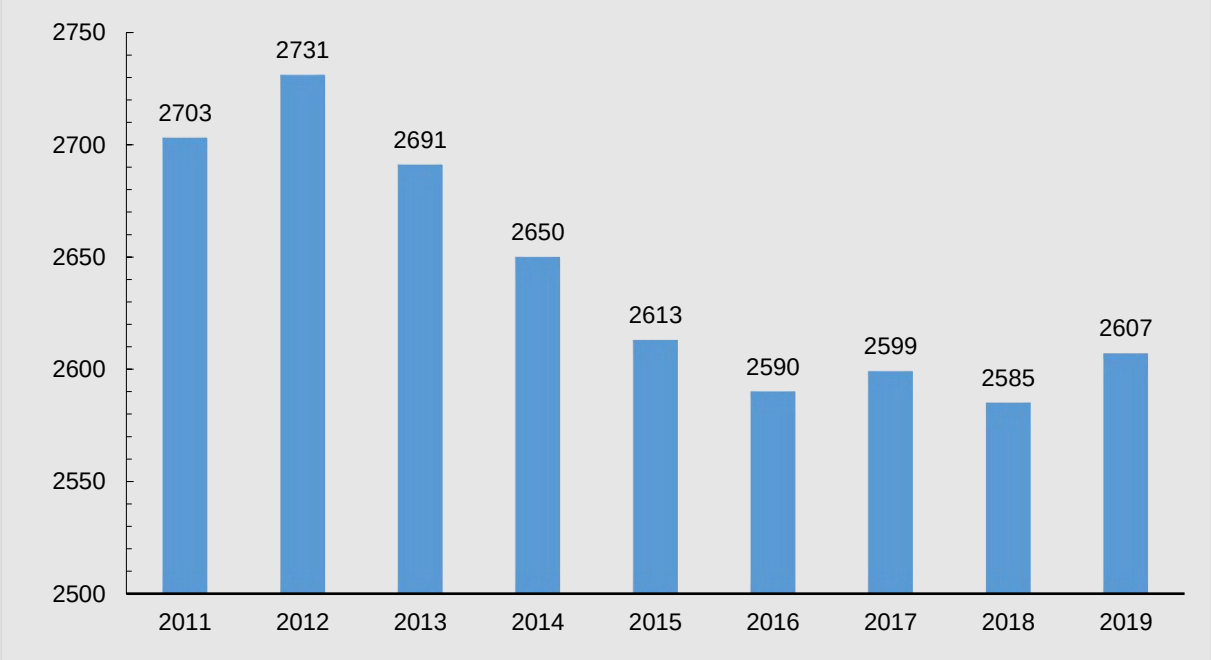
[47] To the extent the substituting doctor does not work for that care service or facility themselves and has made an agreement with the respective care service or facility.

[48] To the extent the substituting doctor has made an agreement with the respective pharmacist.

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

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

practices specialising in substitution treatment work in close cooperation with psychosocial care (PSC) facilities, which are mostly funded by charitable organisations. A total of 2,607 doctors providing substitution treatment reported opioid addicts requiring treatment to the substitution register in 2019. The number of doctors providing substitution treatment has slightly risen from the previous year (see Figure 1). In 2018, 568 doctors - i.e. around 22% - used the colleague consultation rule: according to that rule, doctors without a qualification to medically treat addiction can treat up to ten substitution patients simultaneously (since 2 October 2017, previously it was up to three patients) if they involve a suitably qualified doctor as a consultant in the treatment. The doctors who availed themselves of the colleague consultation rule treated around 1% of all substitution patients (BOPST, 2020).



Source: BOPST (2020)

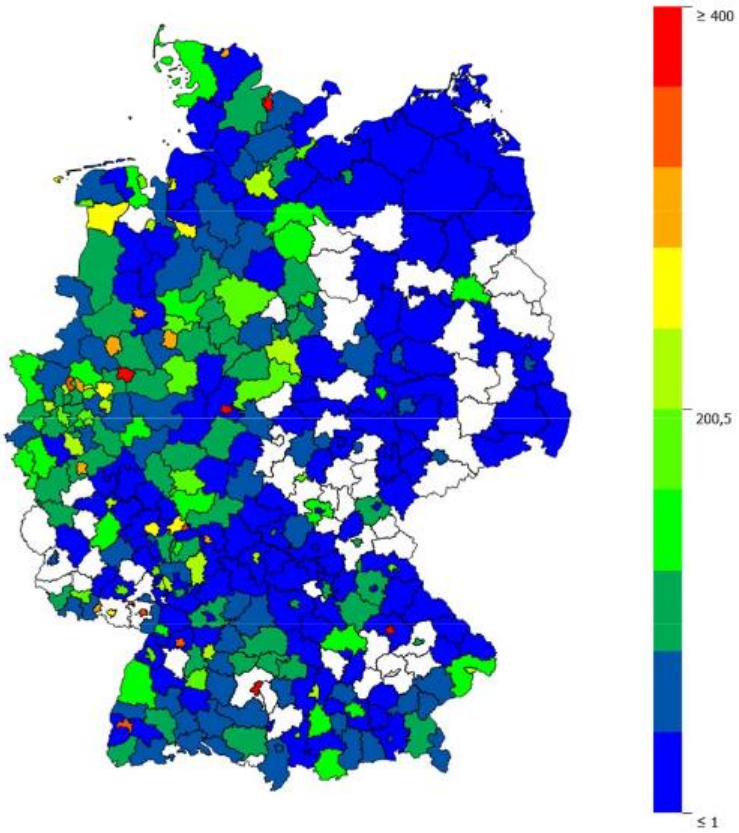
Figure 1 Number of substituting doctors 2011-2019

The nationwide average number of reported substitution patients per substitution doctor is 31, however there are huge variations between the individual *Laender* (Hamburg: 43; Brandenburg: 6.2). Around 14% of substitution doctors had 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 (27%) that only treat up to three substitution patients (BOPST, 2020).

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 2).

1.4.9 Number of substituting clients (T1.4.10)

On the reference date, 1 July 2019, the number of substitution patients was 79,700. This represented the highest figure for 10 years (see Figure 3). In 2019, around 91,700 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, 2020).



Presentation: Bundesopiumstelle (BOPST) (2020), Report on the Substitution Register, p. 9.

Source: Bundesinstitut für Arzneimittel und Medizinprodukte/BOPST (2020).

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

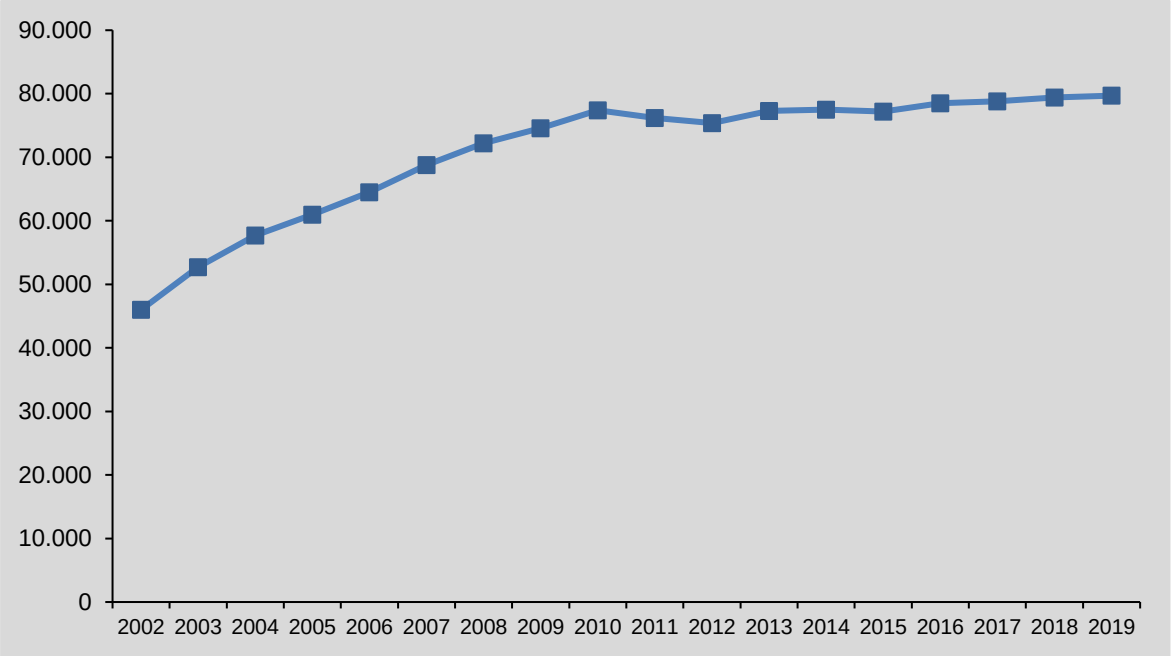
Figure 2 Number of substitution patients reported per 100,000 population for each district or independent city on the reference date 1 January 2019

The majority of patients receiving substitution treatment are treated on an outpatient basis by practice-based doctors or in specialised outpatient clinics.

The proportions of substances used in substitution treatment have shifted in the past few years away from methadone (38.1%) and towards levomethadone (35.9%). The proportion accounted for by buprenorphine (23.2%) has remained broadly constant over the last five years (see BOPST, 2020).

1.4.10 Characteristics of clients in OST (T1.4.11)

No new information is currently available on this.



Source: BOPST (2020)

Figure 3 Number of reported substitution patients in Germany, 2002-2019 (reference date 1 July)

1.4.11 Further aspects on organisation, access and availability of OST (T1.4.12)

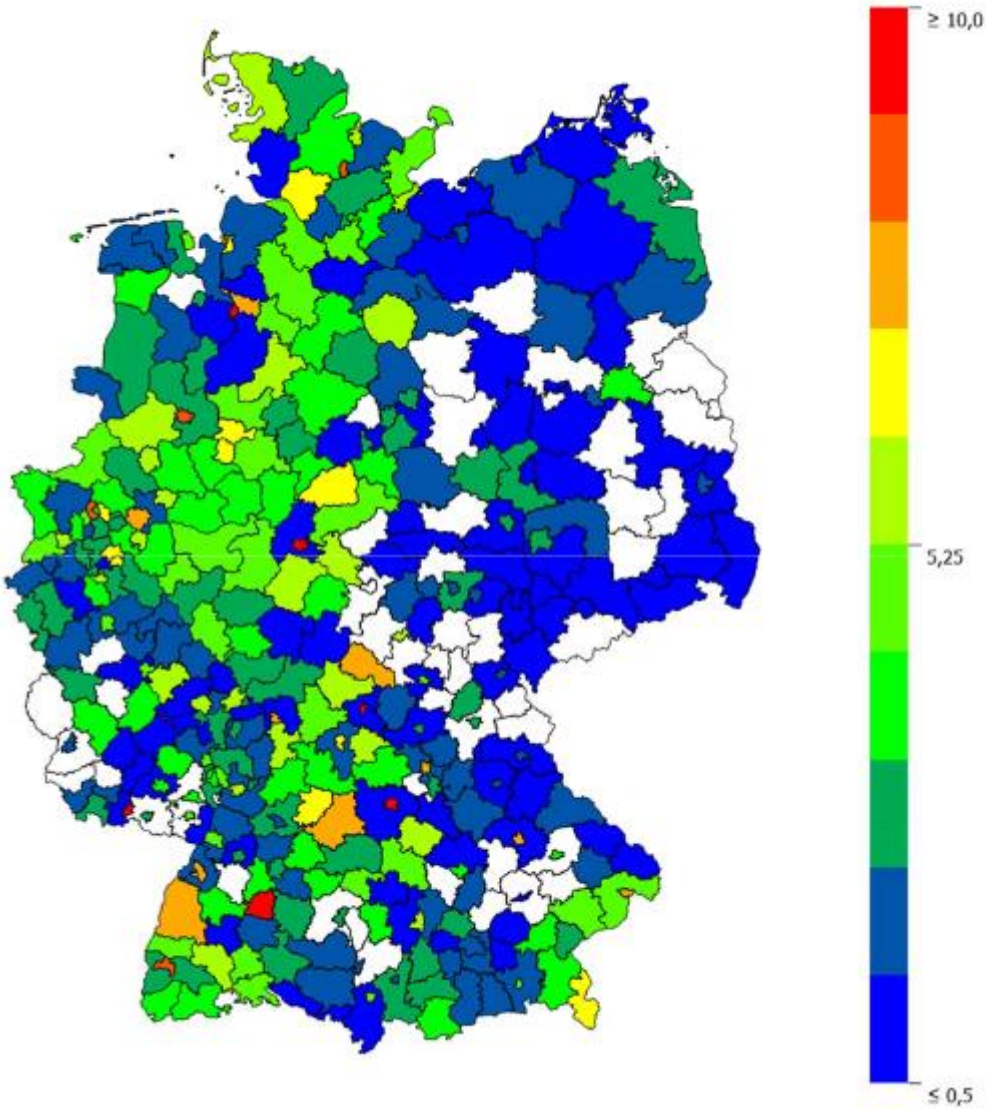
The provision of substitution treatment has been a cause for concern for some years, in particular in rural regions (see Pfeiffer-Gerschel et al., 2014). In such regions, only a few doctors are responsible for large districts and they are sometimes difficult for patients to reach (see Presentation: Bundesopiumstelle (BOPST) (2020), Report on the Substitution Register, p. 8.

Source: Bundesinstitut für Arzneimittel und Medizinprodukte/BOPST (2020).

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

Figure 4). In addition, ever increasing numbers of older doctors are retiring with hardly any younger doctors, willing to work in the field of substitution treatment, 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 towns or rural areas only being reached to a limited extent. In order, among other things, to address this problem, improve the legal 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 1.4.8). See also section 3.1 of the REITOX Report 2017, Legal Framework (Dammer et al., 2017).

Furthermore, the support system is facing the challenge of providing care for long-term substitution patients or aging drug addicts with accompanying health limitations up to and including nursing care (see section 1.4.4).



Presentation: Bundesopiumstelle (BOPST) (2020), Report on the Substitution Register, p. 8.

Source: Bundesinstitut für Arzneimittel und Medizinprodukte/BOPST (2020).

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

Figure 4 Number of substituting doctors per 100,000 population for each district or independent city reporting figures in the first six months of 2019

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 result of the study is a series of 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 (T1.5.1)

As a result of various professional societies and experts working together, guidelines and recommendations for action for the treatment of drug dependence are constantly being developed. The overview is presented in reverse chronological order:

- The German SARS-CoV-2 Medicinal Product Supply Ordinance (SARS-CoV-2-Arzneimittelversorgungsverordnung) came into force at the end of April, defining possible exceptions to the German Regulation on the Prescription of Narcotic Drugs (Betäubungsmittel-Verschreibungsverordnung, BtMVV) during the corona pandemic. During the period of validity, substituting doctors are permitted, for example, to treat more patients than previously, and to prescribe (take home) medicinal drugs for a period of seven days or, in individual cases, up to 30 days. In addition, the regulations concerning the group of people handing over the substitution drugs for immediate use have been relaxed, and the legal possibility has been created to hand over the substitution drug prescription to the patient even without a personal consultation (Bundesanzeiger, 2020) (further information can be found in section 2 Trends).
- By way of an order of 6 September 2018, the G-BA revised the regulations under which opioid addicts are able to receive substitution supported therapy paid for by the statutory health insurance. The previously predominant abstinence-oriented treatment approach has been replaced with a therapeutic approach with more broadly defined objectives, which, for example, enshrines, as treatment goals, ensuring survival and abstinence from unlawfully purchased and acquired opioids. The order came into force on 7 December (G-BA, 2018).
- At the end of 2017, a work aid was 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 also updated in line with the state of knowledge in medical science (BÄK, 2017b).

Further guidelines and recommendations for action from previous years can be found in the 2019 Treatment workbook (Tönsmeise et al., 2019).

In addition to the treatment guidelines, the funding agencies also have other quality assurance instruments. The German Pension Fund (Deutsche Rentenversicherung Bund, DRV) carries out annual evaluations of medical rehabilitation of persons with dependence disorders: to this end, the facilities supported by the DRV are assessed 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, selected at random, are reviewed 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 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).

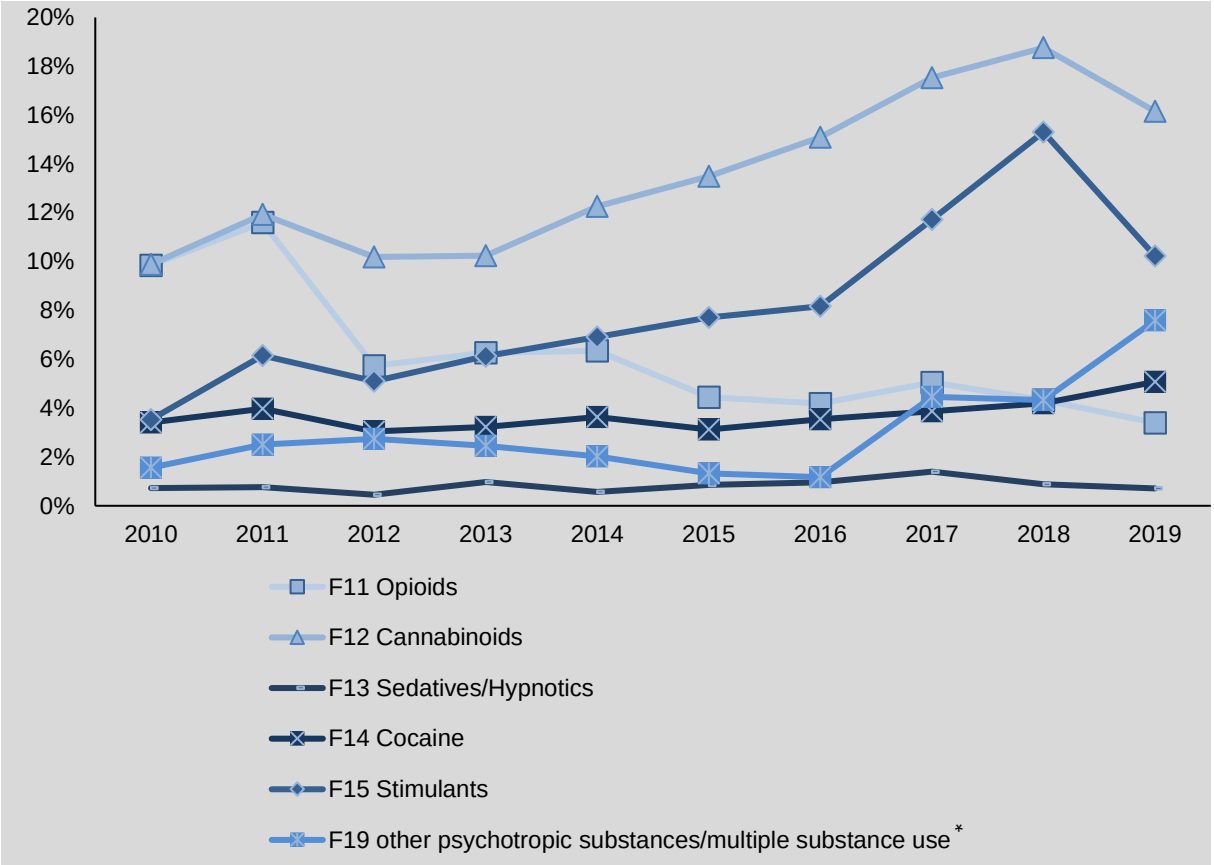
It remains the case that the medical rehabilitation of people with dependence disorders may only be provided by specialist staff with the relevant further training. In this context, the DRV has produced guidelines for the further training of specialist staff working in individual and group therapy within 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 primary responsibility in relation to 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

2.1 Long-term trends in numbers of clients entering treatment and in OST (T2.1)

Clients treated for the first time

As can be seen from Figure 5, the proportion of patients treated for the first time on the basis of cannabinoids has continuously increased in recent years (2013: 10%, 2018: 19%), however it declined for the first time in 2019 (-3%). A similar, but not quite so prevalent trend could be seen for the primary diagnosis F15 Stimulants. The proportion of patients treated for the first time on the basis of other psychotropic substanes or multiple substance use (F19) increased by 3% in the previous year. The proportions of patients treated for the first time with primary diagnoses F11 Opioids and F13 Sedatives/hypnotics are small, at 3% and 1% respectively. The primary diagnoses F16 Hallucinogens and F18 Volatile substances have remained under 1% over the entire observation period.



The primary diagnoses F16 Hallucinogens and F18 Volatile substances have remained under 1% over the entire observation period. They were therefore excluded from the illustration as it is hard to represent them graphically.

* Multiple substance use included only from DSHS 2017 onwards

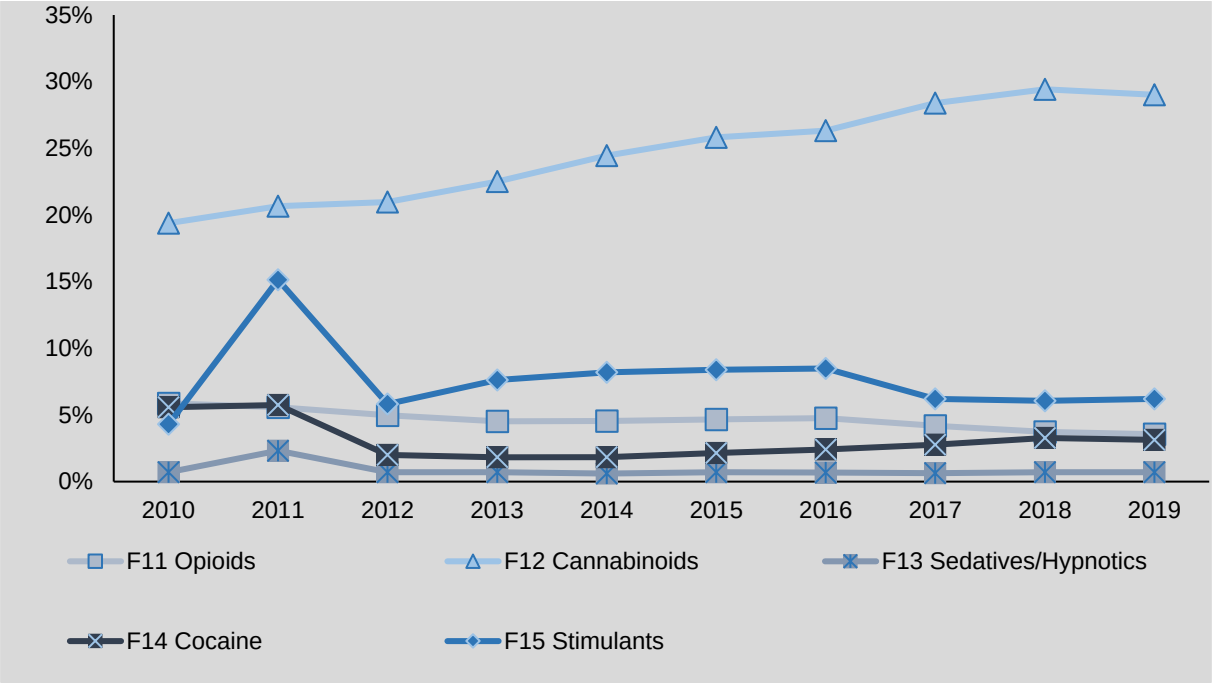
The percentage numbers shown relate to the proportion the respective primary diagnoses account for among all treatment cases recorded in the DSHS (F10-F19, F50, F63).

Due to the change in the KDS, from 2017, data is only comparable to a limited extent with the years prior to the change.

Source: Deutsche Suchthilfestatistik, available at: https://suchthilfestatistik-datendownload.de/Daten/download.html

Figure 5 Patients treated for the first time on an inpatient basis, by primary diagnosis and year (2010-2019) in per cent (%).

The clients treated the most frequently for the first time in an inpatient setting presented, by some margin, due to the primary diagnosis of cannabinoids. As shown in Figure 6, an upward trend can be seen since 2010, which stagnated for the first time in 2019. The percentage proportion of clients treated for the first time for other primary diagnoses has remained broadly constant for the last three years.



The primary diagnoses F16 Hallucinogens, F18 Volatile substances and F19 Other psychotropic substances/multiple substance use have been below 2.5% for the entire observation period. They were therefore excluded from the diagram for reasons of poor graphic representation.

The percentage numbers shown relate to the proportion the respective primary diagnoses account for among all treatment cases recorded in the DSHS (F10-F19, F50, F63).

Due to the change in the KDS, from 2017, data is only comparable to a limited extent with the years prior to the change.

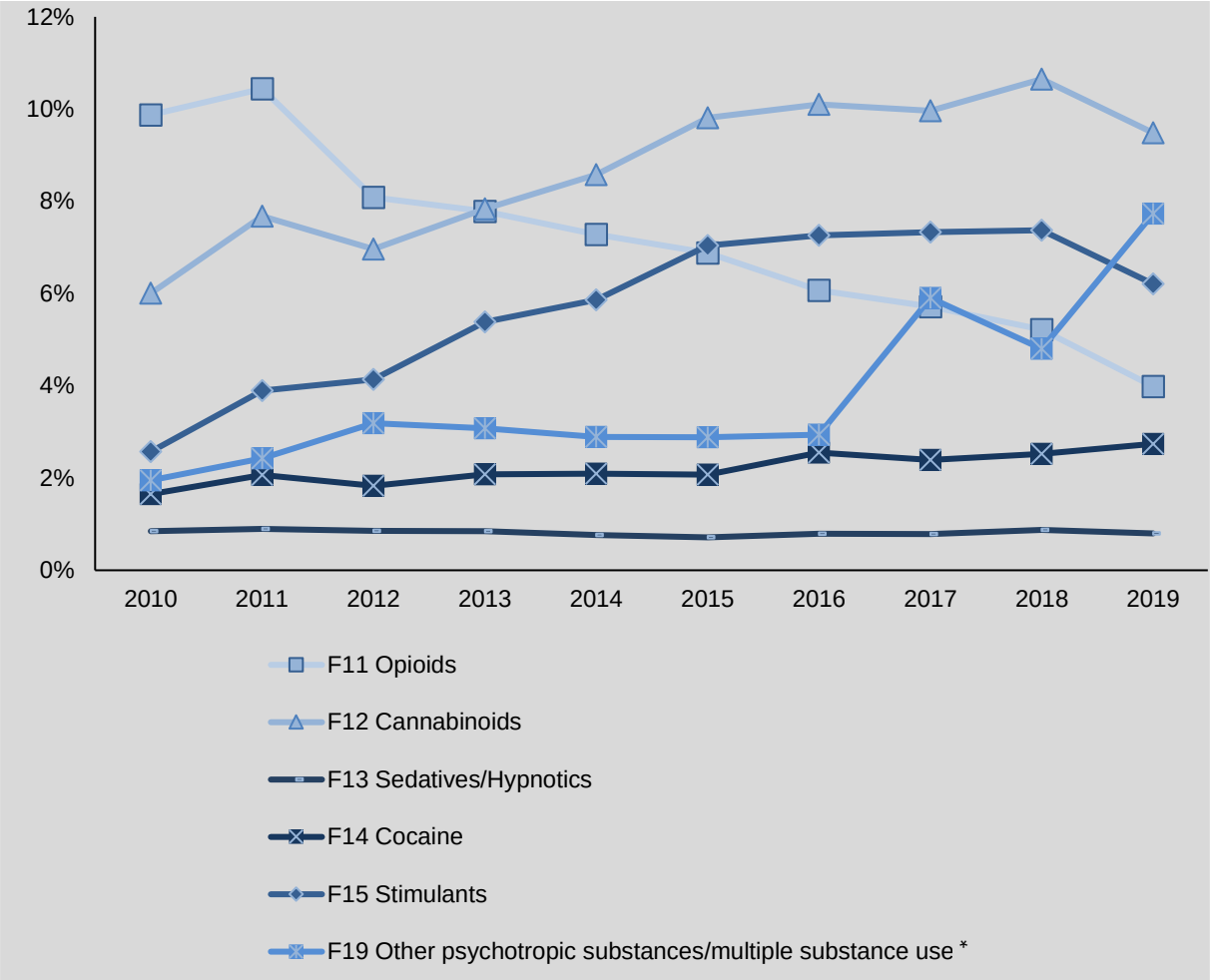
Source: Deutsche Suchthilfestatistik, available at: https://suchthilfestatistik-datendownload.de/Daten/download.html

Figure 6 Patients treated for the first time on an outpatient basis by primary diagnosis and year (2010-2019) in per cent (%).

Number of clients treated overall

Taking into account the treatment data from the previous ten years, it is striking that there have been quite some changes, particularly in the primary diagnoses in the inpatient setting. While in 2010 10% of all treatment cases were on the basis of opioids, in 2019 it was only 4%. In contrast, the respective proportion of treatment cases on the basis of cannabinoids, stimulants and other psychotropic substances/multiple substance use has significantly increased (see Figure 7).

In the inpatient setting, it can also be observed that the proportion of treatment cases on the basis of opioids has declined (16% of all inpatient addiction treatments in 2010, 9% in 2019), while increasing numbers of clients are being treated on the basis of the primary diagnosis cannabinoids (12% in 2010, 19% in 2019). In addition, an increase in clients with the primary diagnosis other psychotropic substances/multiple substance use has been observed since 2017 (0% in 2016, 4% in 2019).



The primary diagnoses F16 Hallucinogens and F18 Volatile substances have remained under 1% over the entire observation period. They were therefore excluded from the diagram for reasons of poor graphic representation.

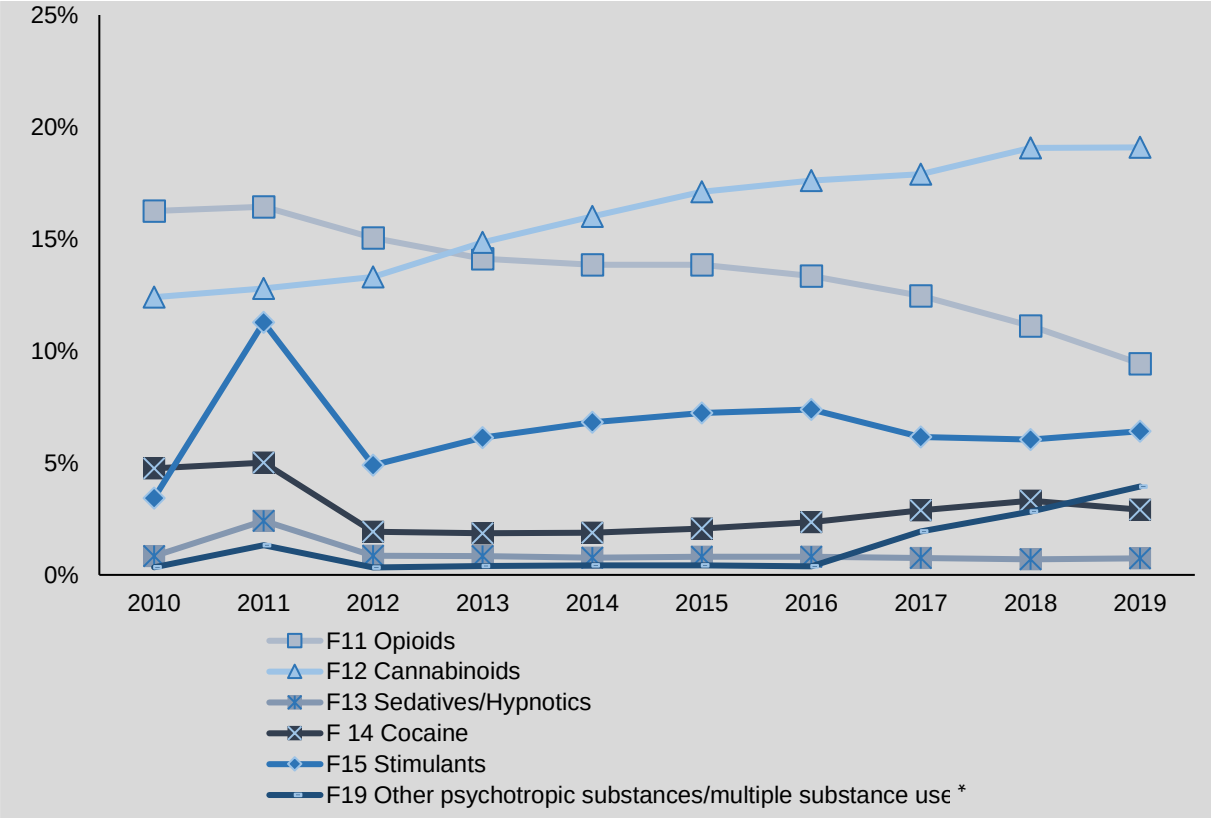
* Multiple substance use included only from DSHS 2017 onwards

The percentage numbers shown relate to the proportion the respective primary diagnoses account for among all treatment cases recorded in the DSHS (F10-F19, F50, F63).

Due to the change in the KDS, from 2017, data is only comparable to a limited extent with the years prior to the change.

Source: Deutsche Suchthilfestatistik, available at: https://suchthilfestatistik-datendownload.de/Daten/download.html

Figure 7 Patients treated on an inpatient basis, by primary diagnosis and year (2010-2019) in per cent (%).



The primary diagnoses F16 Hallucinogens and F18 Volatile solvents have remained under 1% over the entire observation period. They were therefore excluded from the diagram for reasons of poor graphic representation.

* Multiple substance use included only from DSHS 2017 onwards

The percentage numbers shown relate to the proportion the respective primary diagnoses account for among all treatment cases recorded in the DSHS (F10-F19, F50, F63).

Due to the change in the KDS, from 2017, data is only comparable to a limited extent with the years prior to the change.

Source: Deutsche Suchthilfestatistik, available at: https://suchthilfestatistik-datendownload.de/Daten/download.html

Figure 8 Patients treated on an outpatient basis, by primary diagnosis and year (2010-2019) in per cent

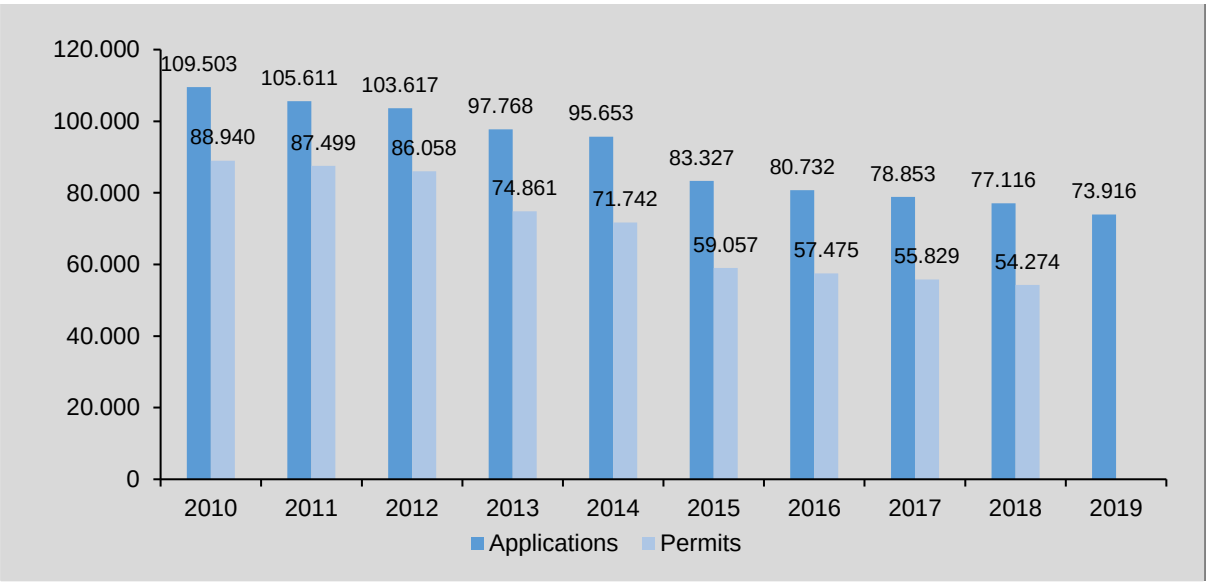
Substitution treatment

Information on trends in substitution treatment can be found in sections 1.4.8 and 1.4.9.

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 (73,916 in 2019) (DRV, 2020a). Part of this decrease is due to a change in the method of data collection since the 2015 reporting year (Ostholt-Corsten & Kley, 2019) (see Figure 9).

Despite the comprehensive collective analyses by the German pension insurance and addiction associations, no clear causes have been able to be identified to date. However, as a majority of rehabilitating patients are referred via addiction counselling facilities, a connection could potentially exist between the declining rehabilitation services and the precarious financial situation of counselling centres, which often results in fewer resources (Koch, 2020).



Source: Ostholt-Corsten & Kley, 2019, DRV (2020b)

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).

Figure 9 Addiction rehabilitation – applications and approvals (DRV) by year (2010-2019)

3 NEW DEVELOPMENTS

3.1 New developments

Depot injection for substitution therapy

Since April 2019, the active substance buprenorphine has been available in substitution therapy as a depot injection under the name “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, in particular, be a good alternative for people in rural areas who live a long way from their doctors’ practice but also for cases 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).

Zis is currently conducting (12/2019-03/2023) the study “Addiction rehabilitation of opioid addicts in treatment with injectable, subcutaneous depot buprenorphine (ARIDE)” (Suchtrehabilitation von Opioidabhängigen in Behandlung mit injizierbarem, subkutanem Depot-Buprenorphin (ARIDE)), which is intended to provide a scientifically sound assessment of possible advantages of the use of Buvidal© in addiction rehabilitation (ZIS, no date).

Addiction treatment during the COVID-19 (coronavirus SARS-CoV-2) pandemic

The corona pandemic reached Germany in 2020 where, according to the RKI, to date 228,621 people have fallen ill and 9,253 have died (status: 20 August 2020; RKI, 2020). The addiction support system has also been affected by the pandemic and is facing huge challenges.

Contact restrictions, legal frameworks (such as official occupancy stops and ordinances to free up capacity in rehabilitiation facilities to relieve acute hospitals), hygiene measures, and distancing regulations have led to counselling and treatment services only being possible on a reduced and/or limited basis and some facilities have had to pause their services temporarily. There is no representative data on the actual situation at the addiction support facilities. However, some surveys have been carried out (Raiser et al., 2020). It is important to keep in mind that those can only be seen as snapshots and need to be analysed with reservations.

In an ad hoc survey by the DHS and its member associations between 14 and 24 April 2020, 33% of facilities interviewed reported that the hospitals and clinics with which they cooperate were offering withdrawal treatments during the corona crisis to the same extent as they were before. 24% reported that the service was significantly (more than 60%) reduced, 19% reported that only emergency cases were being admitted and 12% reported that withdrawal treatments were no longer being offered at all (DHS, 2020b; Raiser et al, 2020)[51].

In addition, the Professional Association on Drugs and Addiction (Fachverband Drogen und Sucht e.V., fdr+) conducted a member survey between 10 and 17 June 2020. The evaluations show restrictions in the structure of services during the pandemic. Moreover, 90% of respondents reported an increased workload, which can be attributed to the change in making contact with clients, additional workload due to protection measures, inner-psychological stress due to the effects of the pandemic, such as anxiety or stress due to a different or particularly hard hit clientele (fdr+, 2020a, b).

The fact that not only disinfection materials and protective masks but also childcare and corona tests were temporarily unavailable or difficult to obtain, presented many addiction support agencies, for a time, with situations in which protecting the health of employees, and also clients and patients, and maintaining counselling/treatment services were not compatible, or only to a limited extent (Raiser et al., 2020).

The practice of dispensing substitution drugs was, in particular, considerably complicated and restricted by the effects of the corona pandemic, as it requires regular, often even daily, contact with the dispensing location and the specialist staff there. This is further complicated by the fact that substitution patients are a vulnerable group during the pandemic due to their often weakened immune system. Even at the beginning of the pandemic, various parties in addiction support called for support measures for substitution practice and an adjustment of the dispensing guidelines in the current circumstances.

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[51] For the interpretation of this data it is neccesary to keep in mind that it was collected at a time when clinical capacities had to be kept free for potentially incoming corona patients. It is also important to note, that clinics and hospitals themselves were not inclueded in the survey. Therefore the perceived capacities can differ from the actual capacities. According to field experts, the treatment suppy has rapidly improved since.

The SARS-CoV-2-Arzneimittelversorgungsverordnung came into force at the end of April, defining possible exceptions to the BtMVV. During the period of validity, substituting doctors are permitted, for example, to treat more patients than previously, and to prescribe (take home) medicinal drugs for a period of seven days or, in individual cases, up to 30 days. In addition, the regulations concerning the group of people handing over the substitution drugs for immediate use have been relaxed, and the legal possibility has been created to hand over the substitution drug prescription to the patient even without a personal consultation (Bundesanzeiger, 2020). “With this ordinance, we are securing substitution therapy for addicts, even during the corona pandemic. It was very important for me that we achieve this, as almost 80,000 people in Germany are dependent on the daily administration of substitution medication. Any interruption can have life-threatening consequences […]” explained the Federal Government Commissioner on Narcotic Drugs, Daniela Ludwig, in a press release when the new legal ordinance came into effect (Drogenbeauftragte, 2020).

In addition to the Arzneimittelversorgungsverordnung, a range of handouts are available, intended to help substitution treatment providers and substituting people in practice. For example, SANOFI (2020a, b) published hygiene tips for substitution practice as well as a flyer with safety information for substituting patients; the Conference of the Chairmen of Quality Assurance Commissions of the Associations of Statutory Health Insurance Physicians in Germany (Konferenz der Vorsitzenden von Qualitätssicherungskommissionen der Kassenärztlichen Vereinigungen) provides advice for substituting doctors (Jeschke & Meyer-Thompson, 2020). An additional example is that of a temporary, low-threshold substitution outpatient clinic set up at the Drob Inn in the Counselling and Healthcare Centre St. Georg in Hamburg, in order to expand the local services for the target group (Drogenkurier, 2020).

Moreover, the German Bundestag passed the Krankenhausentlastungsgesetz. The act provides for compensation payments of 60% for losses in the GKV sector (i.e. rehabilitation patients in the SGB V sector), compared to the average occupancy level of the GKV share in 2019 (BMG, 2020). Various efforts have also been made in the areas of addiction treatment and counselling, in order to adapt or supplement services in spite of the pandemic, in order that they can be continued or resumed. Video and teleconferences, as well as restructuring of the range of services with regard to times and capacity utilisation could often be set up at short notice. Many of those involved also found other individual and creative solutions to enable them to continue their work. For example, the LWL Koordinationsstelle Sucht organised online seminars, in which participants met, for example, on pre-arranged “blind dates”, to go for a walk in pairs to exchange views on selected issues (LWL-Koordinationsstelle Sucht, 2020).

Emergency addiction counselling

Addiction counselling facilities have, through their work, a kind of bridging function to the healthcare system. Irrespective of this, their work is indispensable and often life-saving for the clients affected and their relatives, as well as for specialist staff who come into contact with addiction problems etc.

However, in recent years, experts have observed with increasing concern that municipal financing, which accounts for the majority of all financing for addiction counselling facilities, has stagnated. Back in April 2019, addiction support and welfare organisations published a call for stable financing for addiction counselling facilities (DHS, 2020c).

This situation has now become even more acute as a result of the coronavirus pandemic. According to an fdr+ member survey on the corona pandemic, 70% of the facilities and organisations surveyed reported that their liquidity would decrease in the medium to long term. Reasons given for this were:

- Threats to the implementation of services, for example due to contact restrictions and loss of revenue,
- significant loss of revenue and
- necessary additional investments, for example due to construction measures, the creation of additional space, (technical) equipment, protective equipment and staff (fdr+, 2020b).

In order to draw further attention to the counselling centres' precarious situation, for the first time on 4 November, the *Aktionstag Suchtberatung: Kommunal wertvoll!* will take place under the auspices of the Federal Government Commissioner on Narcotic Drugs, Daniela Ludwig. The aim is to initiate dialogue between addiction counselling facilities and policymakers in the municipalities. In this way, local attention can be drawn to the urgency of (continued) financing and securing the future of addiction counselling facilities. In connection with the Action Day, the DHS published an idea pool on its website, with action formats and information intended to support potential participants in preparing their activities (DHS, 2020d).

RUMA digital – contactless recording of adherence in addiction therapy

Telemedical applications becoming increasingly importance for addiction treatment, although not yet to the same extent as for other areas of the healthcare system. The 'RUMA digital' application by RUMA GmbH had already been developed prior to the corona pandemic but the relevance the possibilities it provides have become more important under the influence of the pandemic. Urine marker technology allows patients to provide urine samples without therapist contact. When using the application in addiction treatment, the technology is used in conjunction with an app, for example to allow contactless submission of urine-samples for therapy adherence control in opioid substitution treatment. During direct contact between the doctor's practice and the patient, the app is downloaded onto the patient's smartphone and its operation and system processes are explained. The patient's face is photographed for later comparison during the video recording of the marker intake. Then, the urine markers to be used initially are given to the patient, which are labelled with an external and internal barcode. Directly before taking the marker, the barcodes allow for manipulation security within the video recording. The patient has a time window of 120 seconds to take the marker: it is swallowed and a sour candy which is supplied is then chewed to stimulate the flow of saliva. Afterwards the patient films their open mouth and tongue via the smartphone app. Possible attempts to hide the capsule somewhere in the mouth would result in the release of a colourant in the

rapidly dissolving capsule shell, staining the entire oral cavity blue. The urine-sample can personally or via courier service be taken to the practice and assigned with the barcode. RUMA digital has to date been tested in two German centres: the Ludwigsmühle Specialist Clinic and the Practice for Psychiatry and Psychotherapy in Landau (Ärzteblatt, 2020).

4 ADDITIONAL INFORMATION

No new information is available on this.

5 SOURCES AND METHODOLOGY (T5)

5.1 Sources (T5.1)

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5.2 Methodology (T5.2)

The methodology of previous years has been maintained (see Tönsmeise et al., 2019; Bartsch et al., 2018).

In general, the methodology of the respective cited study applies. Where the approach differs, this is noted at the appropriate place in the text.

6 TABLES

7 FIGURES