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Treatment

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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 as well as 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 a structure of complex collaborations. 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.

44.4% of outpatient clients who visit a treatment facility due to a problem with illegal drugs are cannabis users (56.5% of those treated for cannabis were first time clients). 21.4% of outpatients are treated for harmful opioid use. 15.5% 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 (29.2%). Other frequent diagnoses are ICD-10 F19 - Other psychotropic substances/multiple substance use (27.9%) and F15 - Stimulants (18.5%).

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 2020), the figure was 81,300. A total of 2,545 doctors providing substitution treatment reported opioid addicts to the substitution register in 2020.

Long term trends in outpatient and inpatient addiction treatment show that in 2020 the proportion of people treated for the first time due to Other psychotropic substances/multiple substance use increased further. The proportion of those treated for the first time due to cannabinoids also increased once more in 2020.

The coronavirus 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, amongst other things, restrictions on contacts and distancing rules 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 passing of German SARS-CoV-2 Medicinal Product Supply Ordinance (SARS-CoV-2-Arzneimittelversorgungs-verordnung) meant that a law came into force which defined possible exceptions to the German Ordinance on the Prescription of Narcotic Drugs (Betäubungsmittel-Verschreibungs-verordnung, BtMVV). It allowed substituting doctors, for example, to treat more patients than previously, and also to prescribe medicinal drugs to patients, who usually only receive substitution treatment under (visual) supervision for a period of seven days (take home). Furthermore, the German Hospital Relief Act (Krankenhausentlastungsgesetz) and the German Act on the Deployment of Social Service Providers (Sozialdienstleister Einsatzgesetz, SodEG) are intended to cover gaps in the area of statutory health insurance (gesetzliche

Krankenversicherung, GKV) and use compensation payments to lend support to addiction rehabilitation facilities.

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

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 (Die Drogenbeauftragte der Bundesregierung, 2012; 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 for treatment, i.a. through funding projects and awarding research contracts, as it continued to do in 2020 (see sections 1.4.4 and 1.4.5).

The Third Amending Ordinance of the German Ordinance on the Prescription of Narcotic Drugs (Dritte Verordnung zur Änderung der Betäubungsmittelverschreibungsverordnung, 3.BtMVVÄndV) (BMG, 2017), passed by the German Federal Government in 2017, revised the statutory requirements for implementing substitution treatment for opioid addicts. Medical-therapeutic matters were transferred to the guideline competence of the German Medical Association (Bundesärztekammer, BÄK). The changes have applied since 2 October 2017. They have great importance in terms of improving and safeguarding substitution in medical practice. Above all, they represent a modification to take account of new scientific evidence (Dammer et al., 2017). In December 2018, a decision by the German Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA) came into force, through which the previously predominant abstinence-based 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).

Further information on the national drug strategy can be found in the Drug Policy workbook (Neumeier et al., 2021).

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 *Land*, regional or municipal level. This is jointly agreed upon by the funding agencies, the service providers

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 therapy standards. In this respect, they consult, in regular meetings and working groups, with the associations of addiction professionals. The coordination body, i.e. the umbrella organisation, 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 German Association of Addiction Professionals (Fachverband Sucht e.V., FVS). There are also cooperations 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 in relation to 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. It is responsible for developing 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 agreed between the responsible service providers in the *Laender*, in consultation with the municipalities or the *Laender*. The individual *Länder* deal with the funding for PSC in varying ways, 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 (Sozialgesetzbuch, 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 treatment of depedency. At the heart of the addiction support system are the approximately 1,400 outpatient addiction counselling and treatment centres, low-threshold facilities and specialist and outpatient facilities within institutions. Furthermore, treatment and care are provided in 340 inpatient rehabilitation facilities (incl. day care rehabilitation facilities and transition), as well as in around 890 sociotherapy facilities (for example outpatient assisted living, employment and occupational projects and inpatient social therapy facilities) (IFT, 2020). The 394 specialist psychiatric departments (92[1] of which are exclusively for the treatment of addiction disorders) with a total of 4,348[1] 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; Destatis, 2021a).

The vast majority of outpatient addiction support facilities (90.9%) are funded by independent, charitable bodies, in particular the Freie Wohlfahrtspflege (Künzel, Murawski, Schwarzkopf & Specht, 2021a). In inpatient treatment, independent charitable institutions provide 60.7% of the support facilities (Künzel, Murawski, Schwarzkopf & Specht, 2021b). In addition, public and private funding entities are also involved in outpatient addiction treatment (6.2% and 0.9% respectively) and inpatient addiction treatment (9.3% and 24.4% respectively). The number of other entities involved is small. They account for 2.0% of outpatient and 5.2% of inpatient facilities (Künzel et al., 2020a & b) (see Table 3 & Table 4).

The very diverse and well-differentiated 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 institutions involved in treatments more difficult, however.

Many addiction support providers, especially in the larger cities, offer a variety of services for drug dependent people: 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 provider network). In this context, a differentiation is made between written contracts, common concepts and other agreements. For example, 26.8% of outpatient facilities reported having written contracts with facilities or services in the area of addiction treatment,

[1] This figure was not specifically looked at separately in the latest publication by Destatis (2021a). Therefore, while the number of specialist psychiatric departments refers to the data year 2019 (Destatis, 2021a), the number of departments exclusively for the treatment of addiction disorders is the number from the data year 2018. The true number is likely to have fallen. In order to present an approximate picture, however, it was decided that the number would not be removed.

16.6% with employment, qualification and employment promotion facilities or services. 47.0% of facilities had made other agreements with self-help associations (Künzel et al., 2021a).

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 strengthening and outpatient treatment (1,399 facilities) (IFT, 2020). They are the first port of call for clients with addiction problems, if 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 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 EMCDDA term	Total number of facilities	Type of facility National definition	Number of persons treated
Specialised drug treatment centres	1,399*	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)	>2,545**	Medical practice/psychotherapeutic practice (mainly outpatient substitution treatment)	>81,300**
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

(*IFT, 2020; **Bundesopiumstelle [BOPST], 2021)

* 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 on specialised treatment centres, low-threshold facilities, outpatient facilities within institutions and whole-day outpatient sociotherapy facilities, outpatient assisted living and occupational projects are not yet 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 2020. Since medical practices are one of the first ports of call, a significantly higher number can be assumed in both cases (BOPST, 2021).

*** 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, hence data on the number of correctional institutions is no longer available from that year onwards. For further information, see Schneider et al. 2021, Prison workbook.

Outpatient substitution treatment is, as a rule, carried out in doctors' practices. Such practices are an important factor in the treatment of opioid addicts. Doctors perform the medical treatment, including prescribing substitution 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.

The socio-psychiatric services and community psychiatric centres are, among many other things, responsible for addicts. 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)

As far as the availability and provision of individual treatment and support services are converned, there are differences between the *Laender*. In rural regions especially, there are difficulties in ensuring region-wide care to patients (e.g. those who wish to receive substitution treatment) (see section 1.4.10). 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.

Generally, outpatient counselling and treatment centres have not changed significantly in recent years. It is evident, however, that municipal financing is decreasing in some places, 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 (Künzel et al., 2021b).

1.2.3 Further aspects on the availability of outpatient treatment provision and utilisation (T1.2.3)

For additional, up-to-date 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

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, in total, over 106,400[2] addiction treatments which are not related to alcohol or tobacco dependence (Destatis, 2021b). These include detoxification, qualified withdrawal, crisis intervention and comorbidity treatment. The costs of such treatment 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 multiple chronic issues, frequently those with psychiatric comorbidity. The costs of these treatments are generally borne by the social welfare authorities of the municipalities, on the basis of SGB XII.

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[2] 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, 2021). The number refers to the data year 2019.

Table 2 Network of inpatient addiction support (number of facilities and people treated) [3]

Type of facility EMCDDA term	Total number of facilities	Type of facility National definition	Number of persons treated
Hospital-based residential drug treatment	219**	Specialised psychiatric hospitals/specialist departments	106,426*
Residential drug treatment (non-hospital based)	340**	Inpatient rehabilitation facilities	13,061***
Therapeutic communities	No information	No information	No information
Prisons	No information****	Secure psychiatric units	No information
Sociotherapeutic drug treatments	981**	Sociotherapeutic facilities	No information

(*Destatis, 2021b; **IFT, 2020; *** DRV, 2021a)

*** This relates to the number of withdrawal treatments recorded at the DRV as being due to a depence on illicit drugs.

**** 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, hence data on the number of correctional institutions is no longer available from that year onwards. For further information, see Schneider et al. 2021, Prison workbook.

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

Due to the coronavirus pandemic, inpatient treatment for addicts has been limited. However, the Federal Government Commissioner on Narcotic Drugs successfully committed to reopen inpatient drug treatment facilities as quick as possible. In addition, it cannot be ruled out that it has also had an influence on patients' willingness to use services. Figures for the data year 2020 cant therefore only be compared to those from previous years to a limited extent (see section 3.1).

1.2.6 Further aspects of inpatient drug treatment provision and utilisation

Although demand for inpatient treatment remains high, the number of applications for rehabilitation treatments[4] decreased by a further 4.0% to 70,976 in 2020 (c.f. 2019: 73,916; 2018: 77,116) (DRV, 2021b). 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

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

[4] This figure represents *all* applications for withdrawal treatment received by the DRV due to a dependence disorder (e.g. including alcohol).

Entzug/Suchtrehabilitation"), which took effect 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, a request for seamless transition into rehabilitation is made by the hospital and the attending doctor, with the consent of the patient, no later than seven days before the end of the withdrawal treatment. This can be an inpatient or an all-day outpatient rehabilitation, or a combination treatment. A list of contact persons at the rehabilitation providers is made available to hospitals for this purpose. Rehabilitation providers 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 provided by charities in Germany. A smaller proportion is, however, in public ownership, mostly municipal facilities. Outpatient substitution treatment is generally carried out by doctors' practices, which are privately operated. The public health service is involved in the care of addicts through socio-psychiatric services and community psychiatric centres. They often care for patients with a psychiatric disorder as well as an addiction disorder. Data is not collected nationally, but only at *Land* level, and sometimes even only at municipality level. Therefore, it is not possible to make detailed statements on the number of services or 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)	6.2%	90.9%	0.9%	2.0%
Low-threshold facilities	No information	No information	No information	No information
Medical practice/psychotherapeutic practice (mainly outpatient substitution treatment*)	Minority	-	Majority	-
Socio-psychiatric services/Community psychiatric services*	No information	No information	No information	No information
Facilities in prisons	No information	No information	No information	No information

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

(Künzel et al., 2021a)

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

	Public ownership	Charitable ownership	Private ownership	Other
Specialised psychiatric hospitals/specialist departments[5]	28.5%*	33.7%*.	37.8%*	-
Inpatient rehabilitation facilities	9.6%**	60.7%**	24.4%**	5.2%**
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, 2021a[5]; **Künzel et al., 2021b)

[5] The percentage figures shown relate to all hospitals in Germany and not only those that are active in the area of addiction treatment. Differentiated data is not available. The data relates to the data year 2018.

1.3 Key data (T1.3)

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

Table 5 Proportion of people treated for the first time and repeat patients by primary diagnosis in per cent (%)

ICD-10-GM	Repeat inpatient	Outpatient	Inpatient treated for the first time	Outpatient
F11 Opioids	92.1%	85.5%	7.9%	14.5%
F12 Cannabinoids	83.6%	43.5%	16.4%	56.5%
F13 Sedatives/hypnotics	89.9%	62.1%	10.1%	37.9%
F14 Cocaine	88.7%	59.4%	11.3%	40.6%
F15 Stimulants	91.0%	64.6%	9.0%	35.4%
F16 Hallucinogens	100%	40.5%		59.5%
F18 Volatile substances	100%	27.3%		72.7%
F19 Other psychotropic substances/multiple substance use	91.8%	74.8%	8.2%	25.2%
Total number (N)	**6,971**	**33,490**	**862**	**22,204**

(Künzel et al., 2021a & b, T2.02)

Outpatient Treatment

In 2020, data from a total of 315,586 treatments (not including one-off contacts), carried out in 854 outpatient facilities, was collected within the DSHS. However, these figures also include treatments for tobacco and alcohol. For the following remarks, only those clients who were primarily treated for an illicit substance (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 48.0% of all primary diagnoses in outpatient addiction care in 2020). For 2020, the DSHS contains data on the primary diagnoses from a total of 61,662 treatments that were started or completed in outpatient psychosocial addiction support counselling or treatment centres due to problems with illicit drugs (Künzel et al., 2021a).

Today, only 21.4% of cases with a primary diagnosis related to illicit drugs concern clients who have primarily entered counselling or treatment due to a dependence on or harmful use of opioids. Almost half of all cases (44.4%) concern clients with a mental or behavioural disorder due to cannabinoids (see Table 8) (Künzel et al., 2021a). Cannabinoids were also the most common factor (62.7%) among persons who were in addiction-specific treatment due to illicit substances for the first time. The second largest group, some way behind, is first-time clients with the primary diagnosis of stimulants (14.0%), ahead of opioid-related disorders (7.5%) (Künzel, Murawski, Schwarzkopf & Specht, 2021c). Repeat clients were also predominantly

those with cannabinoid and opioid-related disorders (32.1% and 29.3% respectively) (see (T1.3.1)

Table 5) (Künzel et al., 2021a).

Inpatient treatment

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

ICD-10 GM	Hospital statistics**	DRV***	DSHS			
	2019	2020	2019****	2020*****		
	Total			Males	Females	Total
F11 Opioids	29.2%	Medicines / illicit drugs of which 81.3% men & 18.7% women	13.3%	12.2%	11.7%	12.1%
F12 Cannabinoids	18.6%		30.6%	29.8%	26.8%	29,2%
F13 Sedatives/ hypnotics	9.2%		2.6%	1.3%	5.9%	2.2%
F14 Cocaine	4.6%		9.2%	11.1%	5.2%	10.0%
F15 Stimulants	11.2%		19.9%	17.3%	23.4%	18.5%*
F16 Hallucinogens	0.5%		0.1%	0.1%	0.0%	0.1%
F18 Volatile substances	0.2%		0.03%	0.04%	0.0%	0.03%
F19 Other psychotropic substances/multiple substance use	26.4%		24.3%	28.2%	27.0%	27.9%
Total number (N)	**106,426**	**8,539**	**9,640**	**7,675**	**1,877**	**9,553***

(**Destatis, 2021b; ***DRV 2021c; ****Dauber et al., 2020 (T3.01); *****Künzel et al., 2021b (T3.01))

*One of the persons treated indicated 'indeterminate' sex.

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 treatment in hospital (Statistical Report on Hospital Diagnoses, Krankenhausdiagnosestatistik), and rehabilitation treatment (Statistical Report of the German Statutory Pension Insurance Scheme, Statistik der Deutschen Rentenversicherung). Out of the total of 33,880 inpatient treatments for substance-related disorders, in 135 facilities, documented in the DSHS in 2020, 9,553 were related to illicit substances (including sedatives/hypnotics and volatile solvents) (Künzel et al., 2021b). Of the treatments with primary drug problems recorded in the DSHS, the proportion of those with a primary diagnosis based on dependence on or harmful use of cannabinoids was 29.2% and the proportion of treatments on the grounds of opioids was

12.1%. Regarding all primary diagnoses recorded in the area of addiction, treatments due to cannabinoids represent, at 9.7%, the second largest diagnosis group in inpatient treatment, after treatments due to alcohol, at 63.9%. The proportion of treatments due to stimulant use (18.5% of all inpatient treatments for illicit drugs, 6.1% of all inpatient addiction treatments overall) fell once more in 2020 (c.f. 2018: 22.7% and 7.1% respectively; 2019: 19.9% and 6.2% respectively; Table 6) (Braun et al., 2019; Dauber et al., 2020; Kunzel et al., 2021b).

Table 7 Summary: all clients in treatment

	Number of clients
Total clients in treatment	According to the DSHS with primary diagnosis illicit drugs
	outpatient: 61,662
	inpatient: 9,553
Total OST clients	81,300
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.

(Künzel et al., 2021a, b; BOPST, 2021)

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

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

Primary diagnosis	Inpatient	Outpatient
F11 Opioids	12.1%	21.4%
F12 Cannabinoids	29.2%	44.4%
F13 Sedatives/hypnotics	2.2%	1.7%
F14 Cocaine	10.0%	7.3%
F15 Stimulants	18.5%	15.5%
F16 Hallucinogens	0.1%	0.1%
F18 Volatile substances	0.03%	0.02%
F19 Other psychotropic substances/multiple substance use	27.9%	9.6%
Total number (N)	**9,553**	**61,662**

(Künzel et al., 2021a & b, T3.01)

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

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

here. To this end, for example, the percentage share of the individual primary diagnoses (illegal drugs) was recalculated, for example, using the sum of the absolute number of treatment cases due to illicit drugs.

1.3.4 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.

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

Primary diagnosis	Outpatient		
	Male	Female	Indeterminate/unknown
F11 Opioids	21.0%	23.0%	19.0%
F12 Cannabinoids	46.1%	37.5%	52.4%
F13 Sedatives/hypnotics	1.1%	3.9%	0.0%
F14 Cocaine	8.0%	4.6%	11.1%
F15 Stimulants	13.7%	22.3%	11.1%
F16 Hallucinogens	0.1%	0.2%	0.0%
F18 Volatile substances	0.01%	0.04%	0.0%
F19 Other psychotropic substances/multiple substance use	9.8%	8.5%	6.3%
Total number (N=100%)	**48,990**	**12,609**	**63**

(Künzel et al., 2021a & b, T3.01)

The average age at the start of care for the illicit drugs diagnosis groups was 32.5; for male clients it was somewhat younger, at 31.6, than for female clients, at 32.2. People with the primary diagnosis F13 – Sedatives/hypnotics represent the oldest diagnosis group on average, at 41.8 years old; F12 – Cannabinoids, at 25.5 years old, are the youngest. If one divides the data by gender, male clients with the primary diagnosis F18 – Volatile substances (23.9 years old) are the youngest and F11 – Opioids (40.2 years old) the oldest; among female clients, the lowest average age group is in the diagnosis group F16 – Hallucinogens (25.3 years old) and the highest is F13 – Sedatives/hypnotics (46.6 years old) (Künzel et al., 2021a, T3.02).

Between 33.3% (F18) and 54.1% (F14) of all clients treated on an outpatient basis have a partner (Künzel et al., 2021a, T3.03), between 23.2% (F12) and 56.0% (F13) live with their

partner in the same household (ibid, T3.04). On average, the women undergoing treatment have 0.7 children (men: 0.5 children) (Künzel et al., 2021a, T3.06).

Between 11.6% (F15) and 39.7% (F14) of all clients treated on an outpatient basis have a migration background[6]. This report takes into account data from people who have migrated themselves, as well as from those who were born as children of migrants (Künzel et al, 2021a, T3.12). The primary diagnoses with the largest proportion of people with a migration background are F14 – Cocaine (39.7%) and F11 – Opioids (37.1%) (ibid, T3.12). 29.8% of cocaine addicts with a migration background are originally from Turkey. Among people with the primary diagnosis F11 - Opioids, 16.8% of those with a migration background are from Russia, and 13.8% from Kazakhstan (ibid, T3.13).

The proportion of clients who had never started any vocational training was under 25% in the majority of primary diagnoses. Three relatively high proportions can be found for the primary diagnoses of Other psychotropic substances/multiple substance use (22.4%), Hallucinogens (31.3%) and Cannabinoids (33.3%) (Künzel et al., 2021a, T3.16). However, these three diagnosis groups are, at the same time, also the three diagnosis groups (illicit drugs) with the youngest clientele (Künzel et al., 2021a, T3.02).

On average, 10.2% of male and 8.8% 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 (13.6%), Other psychotropic substances/multiple substance use (13.3%) and Stimulants (11.8%) (Künzel et al., 2021a, T3.15).

Inpatient treatment

The largest proportion of people treated on in inpatient basis in the diagnosis group “illicit drugs” is, for male patients, that with the primary diagnosis F12 - Cannabinoids (29.8%) and for female patients F19 - Other psychotropic substances/multiple substance use (27.0%). The situation is then reversed for the second largest diagnosis group: Among men, it is F19 - Other psychotropic substances/multiple substance use (28.2%) and for women F12 - Cannabinoids (26.8%). The fewest treatments among male patients are for F18 - Volatile substances (0.04%) and F16 - Hallucinogens (0.1%). For women, it was F14 - Cocaine (5.2%) and F13 - Sedatives/hypnotics (5.9%). 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. The diagnosis groups Hallucinogens and Volatile substances/multiple

[6] The figures stated are the total number of clients per diagnosis group who themselves migrated, or who were born as children of migrants.

Information on clients’ home countries can be a factor 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, targeted interventions: migrants/refugees) or prevention (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.

substance use even had 100% men. An exception is the diagnosis F13 - Sedatives/hypnotics (47.4% male vs 52.6% female) (Künzel et al., 2021b, T3.01).

The average age of patients treated on an inpatient basis with the primary diagnoses F11-F16, F18 and F19 was 34.7 years old when care began. The oldest patients on average were those receiving treatment for the use of sedatives/hypnotics (42.8 years old), the youngest for cannabinoids (29.6 years old) (Künzel et al., 2021b, T3.02).

Excluding those treated for hallucinogens (F16), more than half of those treated for all primary diagnoses live alone (Künzel et al., 2021b, T3.04).

Between 78.4% (F14 - Cocaine) and 100% (F16 - Hallucinogens) of patients treated on an inpatient basis due to illicit drugs are German nationals (Künzel et al., 2021b, T3.11). The two diagnosis groups with the highest proportion of migrants[7] are F11 - Opioids (39.1%) and F14 - Cocaine (37.2%) (see ibid, T3.12). The greatest proportion of migrants with a disorder due to the use of cocaine and treated on an inpatient basis come from Turkey (31.6%). 21.4% of migrants who were treated due to opioids came from Russia (see ibid, T3.13). The proportion of those treated with no migration background was significantly over 50% in all diagnosis groups. For the diagnosis groups F16 - Hallucinogens and F18 - Volatile substances it was even 100% (see ibid, T3.12).

The proportion of clients who had not even started vocational training, with the exception of those with the diagnosis of F16 - Hallucinogens (25.0%) and F18 - Volatile substances (33.3%) was under 25%. Overall, most patients have a vocational qualification. Another large proportion has started higher or vocational education but not finished it (Künzel et al., 2021b, T3.16).

On average[8], 11.3% of male and 8.4% of female clients in the inpatient treatment system have left school without any school-leaving qualifications. The rates are highest among those treated with the primary diagnoses (in descending order, for all genders) F19 - Other psychotropic substances/multiple substance use (12.5%), F12 - Cannabinoids (12.4%) and Cocaine (12.2%) (Künzel et al., 2021b, T3.15). All diagnosis groups have a large proportion of unemployed clients. With the exception of the diagnosis F18 - Volatile substances and F13 - Sedatives/hypnotics, they make up significantly more than half in all diagnosis groups (Künzel et al., 2021b, T3.18).

[7] As already explained, the migration background in these calculations combines people who themselves are migrants as well as people who were born to parents who had migrated to Germany.

[8] That is the average value from the primary diagnosis groups F11-F16, F18 and F19.

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						Statistical Report on Hospital Diagnoses (Krankenhausdiagnose-statistik) (Destatis)			
	Outpatient			Inpatient						
	-14		15-17		-14	15-17		-14		15-17	
F11 Opioids	**0.6**	(0.005)	**0.9**	(0.1)	**0**	**3.1**	(0.1)	**2.0**	(0.1)	**2.3**	(0.3)
F12 Cannabinoids	**82.1**	(0.7)	**85.3**	(6.5)	**0**	**70.8**	(1.7)	**43.1**	(2.0)	**48.7**	(10.4)
F13 Sedatives/ hypnotics	**0.4**	(0.003)	**0.7**	(0.1)	**0**	**0**	(0)	**3.7**	(0.4)	**2.9**	(1.2)
F14 Cocaine	**0.6**	(0.005)	**0.7**	(0.1)	**0**	**0**	(0)	**1.0**	(0.2)	**1.4**	(1.2)
F15 Stimulants	**11.2**	(0.1)	**7.9**	(0.6)	**0**	**13.8**	(0.3)	**21.3**	(1.7)	**15.7**	(5.6)
F16 Hallucinogens	**0.2**	(0.002)	**0.3**	(0.02)	**0**	**0**	(0)	**2.1**	(3.5)	**2.0**	(14.7)
F18 Volatile substances	**0.4**	(0.003)	**0.02**	(0.002)	**0**	**0**	(0)	**0.9**	(4.7)	**0.3**	(6.4)
F19 Other psychotropic sustances/ multiple substance use	**4.5**	(0.04)	**4.3**	(0.3)	**0**	**12.3**	(0.3)	**25.9**	(0.9)	**26.8**	(4.0)

(Künzel et al., 2021a, 2021b; Destatis, 2021b)

A not insignificant proportion of patients treated are children (under 14 years old) and adolescents (15-17 years old)[9]. Due to their stage in their physical and psychological development, they are, in light of the health impacts of drug use, a particularly vulnerable group. Treatment data from the DSHS shows that - both in outpatient and inpatient treatment settings - children and adolescents are treated most frequently for cannabinoids. According to the DSHS data, more than two thirds are in the respective age group; according to Destatis, it is just under half of all treatment cases in the corresponding age group. In the inpatient treatment setting, no treatment cases for children under the age of 14 were recorded in the DSHS.

The numbers in brackets in the table provide information on the proportion of all recorded treatment cases accounted for by the respective age group. From these figures, it is clear that a not insignificant 7.2% of all patients treated on an outpatient basis with the primary diagnosis F12 (Cannabinoids) were not yet adults. According to the Statistical Report on Hospital Diagnoses, this figure was even as high as 12.4%. For the primary diagnosis Hallucinogens, the proportion of children and adolescents was 18.2%. As is clear from the other data, the proportion of children and adolescents treated is, however, mostly low (see Table 10).

[9] 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).

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

- Deutsche Suchthilfestatistik 2021 (Künzel et al., 2021a & b)
- Statistical Report by the German Statutory Pension Insurance Scheme, Rehabilitation (DRV, 2021c)
- 2019 Basic Hospital Data (Destatis, 2021a)
- Detailed diagnosis data on patients in hospital (Destatis, 2021b)
- Regional monitoring systems, such as
    - BADO in Hamburg (Lahusen, Martens & Neumann-Runde, 2020)
    - COMBASS in Hessen (Neumann-Runde, Kalke & Werse, 2020)

Information on prevalence of use can be found in the Drugs workbook (Neumeier et al., 2021).

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 trained staff working there 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 sometimes also by the *Laender*. Further information can be found in the 2020 Harms and Harm Reduction workbook (Neumeier et al., 2021).

Practice-based doctors

Practice-based doctors are frequently the first port of call for people with an addiction problem. It is their responsibility, as part of the diagnosis and treatment, to talk about any 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 161,400 practice-based or employed doctors (outpatient) who could be the first point of contact for patients with addiction disorders (BÄK, 2021). 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 (Justizvollzugsanstalt, 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 1.2.1).

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 provide community psychiatric centres or socio-psychiatric services, which are also responsible for persons suffering from dependence, on the basis of the German Public Health Service Act (Gesetz über den öffentlichen Gesundheitsdienst, ÖGDG). They frequently care for addicts with psychiatric comorbidities. They counsel patients and refer them to suitable treatment or long-term care, such as specific residential accommodation.

Outpatient medical rehabilitation

Services in a variety of facilities are available to provide withdrawal treatment in an outpatient rehabilitative setting: counselling and treatment facilities, specialist walk-in clinics, whole-day outpatient facilities or day clinics. The legal basis is primarily 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 difficulties in coping with everyday life to remain in their own home or shared accommodation. They receive help in the form of outpatient addiction support services, which offer intensive assistance and care. 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 “job centres”, the German Pension Fund (Deutsche Rentenversicherung, DRV), the social welfare providers and the service providers are responsible for the planning.

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

Outpatient psychotherapeutic treatment

Psychotherapy can be performed by practice-based, licensed psychological psychotherapists, according to the German Psychotherapists 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. The legal basis is SGB V. Planning occurs through the chambers of psychotherapists. It is not known what percentage of psychotherapists 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 service is based on voluntary cooperation. A characteristic element of the self-help principle is the regular and voluntary exchange of thoughts and experiences among participants with the goal of improving individual quality of life. Generally, both those directly affected and relatives take part. 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.

1.4.3 Inpatient drug treatment services (T1.4.3)

Detoxification

Detoxification treatments take 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 lays the groundwork for further rehabilitative measures. Qualified withdrawal takes place in special departments of specialist hospitals or special facilities where the psychophysical peculiarities of withdrawal from the respective 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 couple and family sessions or seminars as well as non-verbal forms of therapy (design and music therapy). This is complemented by work and occupational therapy, sports and exercise therapy and other indicated treatment services. Social counselling and preparation for the subsequent support services (e.g. "after-care") always form a part of withdrawal treatment. The spectrum of medical rehabilitation also includes social advice, social law advice and career guidance. Medical rehabilitation has a time limit. The treatment time for the different forms of treatment is set individually. The legal bases are 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 very 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 are among the smaller rehabilitation facilities.

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 criminals' offence or of treating 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 exercise therapy. Further information on this subject can be found in the Prison workbook (Schneider et al., 2021).

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, 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. This is 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 the content and objectives of the transition treatment can be found in a publication by 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 refers to 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, as drug use and drug dependence - whether it began in a foreign country, 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 had been built 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 facilities in implementing and carrying out qualified services, there are projects and planned research whose documentation and results are provided for this purpose:

The “LOGIN” project (living situation of adult refugees in Germany), conducted by the Centre for Interdisciplinary Addiction Research at the University of Hamburg and funded by the BMG, has the objective of determining the prevalence of substance use among refugees as well as the utilisation of addiction support services by substance-using refugees. In order to ensure a representative sample, more than 1,600 refugees in four *Laender* (North Rhine-Westphalia, Bavaria, Saxony, Lower Saxony) will be surveyed in the scope of the project, via tablet in their native language and with interpreters. The project has been extended to the end of 2021 due to the coronavirus pandemic. The intention is for recommendations to be made using the results of the study, to facilitate refugees’ access to outpatient addiction support.

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:

- learning about the prevalence of addiction problems among refugees,
- identification of possible subgroups with special needs,
- collecting data on 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 a funding initiative of the Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung, BMBF) on the psychological health of refugees, and is running from 2019 to 2024 (ZIS, 2020).

The DHS nationwide addiction support directory[10] and the buss facility search database[11] offers users the ability to filter counselling and treatment services and inpatient treatment services by 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. 48.7% of the 31,118 opioid addicts treated in hospitals were over 40 years of age. In this context, the largest group of opioid addicts is the 40 to 44-year-olds, at 18.2%. This is followed by the age groups above in turn (5-year groupings) at 12.3%, 8.8% and 4.8% respectively. At 4.7%, the over 60s group represents a not insignificant proportion (Destatis, 2021b). Data from the Federal Criminal Police Office (Bundeskriminalamt, BKA) (2018) 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).

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

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[10] Addiction support directory [online] www.suchthilfeverzeichnis.de [accessed: 15 Aug. 2021].

[11] buss facility directory [online] www.therapieplaetze.de [accessed: 15 Aug. 2021].

[12] Reliable figures on cases of narcotics seizures, total seizure quantities of individual types of drugs and cannabis plantations seized cannot be presented. In addition, in relation to drug-related deaths, no information is possible beyond the number of deaths and the causes of death, such as age ranges and gender. 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 .[accessed: 15 Aug. 2021].

In addition, inpatient facilities, such as the salus clinic in Hürth, offer special treatment programmes for older drug addicts. In the case of the salus clinic, this is its “55+ programme for alcohol and drug patients WITH LIFE EXPERIENCE” (“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.

Cocaine users

Adult cocaine use has increased in recent years (Seitz, Böttcher, Atzendorf, Rauschert, & Kraus, 2019). In order to better reach cocaine users with addiction support and prevention services, target group-specific knowledge on the motives for use and risk constellations is needed. KOKOS (consumption habits, social backgrounds and support needs of adults with high-risk or dependent cocaine use), a ZIS Hamburg project funded by the BMG and the Federal Government Commissioner on Narcotic Drugs, seeks to learn about the profiles and support needs of cocaine users. The aim of the project is to find out which people are particularly at risk of developing high risk and dependent use. Using the results, recommendations will be made for prevention and counselling measures.

Gender-specific services

The significance of the subject of "gender in addiction support" has been generally known in Germany for many years and has been covered in numerous publications, initially more towards female-specific, later also male i.e. 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 special counselling services in addiction support facilities which are aimed exclusively at women or men, for example:

- LAGAYA[15] 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 for patients receiving substitution treatment are offered.
- FrauSuchtZukunft Verein zur Hilfe suchtmittelabhängiger Frauen e.V.[16] (approx. “WomanSeeksFuture/WomanAddictionFuture association for the support of substance

[14] Flyer for the service [online] https://www.salus-kliniken.de/fileadmin/contents/Kliniken/Huerth/Dokumente/Flyer/Sucht/Flyer_55_.pdf [accessed: 15 Aug. 2021].

[15] LAGAYA, Verein zur Hilfe suchtmittelabhängiger Frauen e.V. [online] www.lagaya.de [accessed: 29 Jul. 2021].

[16] FrauSuchtZukunft Verein zur Hilfe suchtmittelabhängiger Frauen e.V [Online] www.frausuchtzukunft.de [accessed: 29 Jul. 2021].

dependent women", where "Sucht" is a play on words meaning both "seeks" and "addiction") 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, for example, are also offered to women in prisons.

- Boys' ResorT[17] is a group service run by Hannover Drug Counselling (Drogenberatung Hannover), which is aimed exclusively at male adolescents and young adults with high-risk use of drugs, gambling, media or similar.

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

- Schwulen Beratung Berlin (Gay Counselling Berlin)[18] offers an *open queer addiction group*, which people can attend without prior registration and discuss the subject of substance use and dependency. 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[19] 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.
- "quapsss" (developing quality in self-help for MSM (men who have sex with men) who use psychoactive substances in a sexual setting) is a service offered by the German Aids Service Organisation (Deutsche Aidshilfe, DAH) in cooperation with local organisations and therapeutic professionals, aimed at men who practice chemsex. The intention is for self-help groups in different cities to be initiated, with different conceptual and theoretical references, to address, through counselling and therapy, the physical and psychological problems arising from the use of psychotropic substances in a sexual context.

In addition, the counselling centre 4be TransSuchthilfe[20] in Hamburg offers counselling and support for addiction issues, as well as referral to further support, aimed primarily at trans, non-binary and gender-diverse people. Clients are supported by experienced peers and psychotherapists. The counselling centre also organises, where needed, group, multiplier and school events as well as further education on the topic.

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17 Drogenberatung Hannover [online] www.step-niedersachsen.de/einrichtungen/drobs-hannover/beratung [accessed: 29 Jul. 2021].

18 Schwulen Beratung Berlin [online] www.schwulenberatungberlin.de/wir-helfen/wir-helfen-alkohol-drogen [accessed: 29 Jul. 2021].

19 SHALK NRW [online] www.shalk.de [accessed: 29 Jul. 2021].

20 4be TransSuchtHilfe in Hamburg [online] https://www.therapiehilfe.de/standorte/4be-transsuchthilfe/ [accessed: 29 Jul. 2021].

Some inpatient facilities and therapeutic residential communities have also developed gender-specific rehabilitation concepts. For example, the Bernhard-Salzmann Clinic in Gütersloh[21] offers a concept for the treatment of women suffering from dependence disorders. The therapeutic housing association “Die Zwiebel”[22] 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 or 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.

Moreover, 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[23]. In addition, it offers a list of male-specific addiction support services.

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[24].

Pregnant women and parents with a drug dependency

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 large the need for treatment is and to close gaps in treatment demand (Hoch et al., 2019). There are, however, some inpatient services and clinics which provide special treatment services for substance-using pregnant women. The Lindenhof rehabilitation clinic (Rehaklinik Lindenhof)[25] in Schallstadt-Wolfenweiler, for example, offers mother-child addiction therapy, which allows up women being treated to be accompanied by two children between the ages of zero and primary school age. In addition, pregnant women are also admitted, especially those undergoing substitution.

Currently, the “SHIFT+” intervention, an addiction support family training for drug-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

[21] 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: 29 Jul. 2021].

[22] Die Zwiebel, therapeutic residential community for women. [Online] https://www.prowoberlin.de/Angebot3/die-zwiebel-therapeutischer-wohnverbund-fuer-abh%C3%A4ngigkeitserkrankte-frauen.html [accessed: 29 Jul. 2021].

[23] Can be found at [online] https://www.lwl-ks.de/de/publikationen/p-mann-und-sucht/ [accessed: 29 Jul. 2021].

[24] 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.

[25] Rehaklinik Lindenhof [online] www.rehaklinik-lindenhof.de [accessed: 29 Jul. 2021]

project builds on the “SHIFT”[26] 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 development, to cover 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. The intervention will be assessed, using a randomised research design, for its effectiveness and acceptance. Due to coronavirus-related delays, the project period has been extended.

The “STAERKE” project (Suchttherapeutisches Akutprogramm für Eltern zur ressourcenorientierten Kompetenzstärkung in der Erziehung, Acute addiction therapy programme for parents to strengthen resource-oriented competence in parenting) is a project funded by the BMG and carried out at the Central Institute of Mental Health in Mannheim (Zentralinstitut für Seelische Gesundheit, ZI Mannheim). The aim is to develop a therapy which simultaneously treats addiction disorders and strengthens parenting skills[27].

Minors and adolescents

There is also no systematically prepared data for addiction-specific services in the healthcare of children and adolescents with dependence disorders[28]. Likewise, databases 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"[29] (FreD - Frühintervention bei erstauffälligem Drogenkonsum) and the programme

[26] 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: 5 Aug. 2021]

[27] Project STAERKE. [Online] https://www.bmfsfj.de/resource/blob/95354/076596362455af26733a2bedf0a32d6e/staerkung-familialer-beziehungs-und-erziehungskompetenzen-data.pdf [accessed: 8 Sep. 2021].

[28] 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.

[29] FreD - Frühintervention bei erstauffälligem Drogenkonsum. [Online:] https://www.lwl-fred.de/de/ [accessed: 5 Aug. 2021]

"Realize it"[30] 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 18 records nationally for clinics and rehabilitation institutions which offer specialised treatment of children and adolescents who use illicit drugs (as of July 2021, DHS, 2021).

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

The Drug Affinity Study from the German Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA) shows that the cannabis use of children, adolescents and young adults has increased over the last few years (BZgA, 2020). The BMG therefore funds the project "FriDA" (Early Intervention for Drug Abuse in Adolescence, Frühintervention bei Drogenmissbrauch in der Adoleszenz), which aims to improve access to cannabis-using minors in outpatient addiction support. The FriDA counselling concept is intended to be implemented and evaluated in twelve institutions up until March 2023.

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.

In particular, the rights of children of addicted parents have been strengthened with the coming into force of the Act to Strengthen Children and Youth (Kinder- und Jugendstärkungsgesetz, KJSG). From now on, they have the option, even without their parents' or youth welfare office's consent, to contact a suitable counselling facility directly. Closer cooperation between doctors and youth welfare offices has also been facilitated by the Act (Drogenbeauftragte der Bundesregierung, 2021a).

People with an intellectual disability

The pilot project TANDEM - *special help for special people in the network of disabled and addiction support* (TANDEM – *Besondere Hilfen für besondere Menschen im Netzwerk der Behinderten- und Suchthilfe*[31]) from 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 ran from September 2018 to the end of August 2021, with six facilities or three Tandems from disabled and addiction support taking part.

„Aktion:beratung"[32] (mental disability and problem substance use) is a BMG-funded project implemented as a cooperation between EVIM - Gemeinnützige Behindertenhilfe GmbH,

[30] Realize it! Counselling for drug use. [Online:] https://www.realize-it.org/ [accessed: 5 Aug. 2021].

[31] TANDEM [online] https://www.lwl-ks.de/de/projekte/tandem/ [accessed: 2 Aug. 2021].

[32] aktion:beratung [online] www.aktionberatung.de [accessed: 6 Aug. 2021].

Jugendberatung und Jugendhilfe e. V., the Institute for Social Work and Social Pedagogy (Institut für Sozialarbeit und Sozialpädagogik) and the Department of Social Work at Fulda University. In the pilot location in Wiesbaden, different aims are pursued within the project: Based on models for counselling people who use addictive substances, a counselling concept for people with intellectual disabilities is to be developed. The knowledge, media, methods and information material generated will also be made available in a database. The project relies on the consistent participation of people with intellectual disabilities in the implementation of the project.

In addition, the LWL offers an online directory of facilities, the database for which contains addiction specific services from six *Laender* for people with intellectual disabilities[33].

1.4.5 E-Health services for drug addicts (T1.4.6)

The probably most well-known and oldest project is "drugcom.de"[34], a project run by the 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 avail themselves of professional counselling. The goal of the service is to encourage communication about drugs and addiction and encourage a self-critical examination by addicts of their own use behaviour. There are online counselling options via chat or email available to visitors to the website. In addition, people can find addiction counselling facilities in their area.

In addition to online chat counselling, drugcom.de also has specific, evaluated treatment programmes available, e.g. “Quit the shit”[35], the core element of which is an online diary of use and which is supplemented by anonymous online counselling services. The online addiction counselling project “KOiNTER”[36], 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 added. KOiNTER currently offers a chat service, a supported use diary, 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.

One service specialised in methamphetamine is the "Breaking Meth"[37] web portal. It is operated by the Drug Scouts project in Leipzig and the 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 presence of specialist staff, there is also the possibility of especially low-

[33] Geistige Behinderung und Sucht – Einrichtungsverzeichnis [online] https://www.lwl-ks.de/de/schwerpunkte/GeiBuS/gbs-verzeichnis/ [accessed: 2 Aug. 2021].

[34] Drugcom [online] www.drugcom.de [accessed: 25 Aug. 2021].

[35] “Quit the Shit” [online] https://www.quit-the-shit.net/qts/ [accessed: 27 Aug. 2021].

[36] Online Suchtberatung KOiNTER [online] https://kointer.de [accessed: 27 Aug. 2021].

[37] Breaking Meth [online] https://breaking-meth.de [accessed: 27 Aug. 2021].

threshold contact with the support system. In addition, abstinent users who possibly cannot or do not wish to take the option of a self-help group are offered a possibility to communicate via “be clean” (“clean sein”) and “stay clean” (“clean bleiben”).

“SoberGuides”[38] is a digital addiction self-help project by Guttempler in Deutschland. It offers those affected and their relatives 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 of charge and carried out anonymously, if requested, 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.

The national pilot project “Digital lodesmen” (“Digitale Lotsen”[39]) addresses addiction support professionals within nationwide education courses. The plan is for these people to be given the ability to develop a scientifically-based attitude to the topic of digitisation in the field of addiction support, to derive, as “digital lodesmen” (ship’s pilots), approaches to action in practice. The project is currently being tested in three locations; once the project is concluded it is hoped that it can be rolled-out Germany-wide.

In the project “Digi-Sucht”[40] (“Digi-Addiction”) (digital addiction counselling), a concept is being developed for the implementation of a nationwide, inter-agency, digital counselling platform for municipal addiction support. The project is being run by the Berlin-based delphi Gesellschaft für Forschung, Beratung und Projektentwicklung mbH (delphi society for research, counselling and project development), in collaboration with the relevant *Land* bodies and funded by the BMG (Tossmann & Leuschner, 2021).

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

Due to the COVID-19 pandemic, online services have become much more important. Further information on this topic can therefore be found in section 3, New Developments. To date, however, there is still no systematic overview in Germany of e-health or online services for the counselling and treatment of drug addicts.

1.4.6 Treatment outcomes and recovery (T1.4.7)

A treatment being "finished as planned" is a tangible criterion for assessing success. A differentiation is made between release on

- regular or
- therapeutic grounds

[38] SoberGuides [online:] www.soberguides.de [accessed: 8 Aug. 2021].

[39] Digitale Lotsen [online] https://www.hls-online.org/arbeitsbereiche/suchthilfe/themenfelder/digitale-lotsen/ [accessed: 8 Aug. 2021].

[40] DigiSucht [online] https://delphi.de/entwickeln/konzeption-digitale-suchtberatung/ [accessed: 8 Aug. 2021].

- premature end with therapist consent or
- a planned switch to a different facility.

With respect to the aspect of "finished as planned" as a success indicator, there are differences between the substance classes as well as between outpatient and inpatient care. 61.7%[41] (Künzel et al., 2021a, T6.04) of those treated on an outpatient basis finish the intervention as planned, compared to 69.7% (Künzel et al., 2021b, T6.04) for the inpatient setting. In outpatient treatment, the highest rate of ending treatment as planned is among patients with the primary diagnosis hallucinogens (71.9%) and sedatives/hypnotics (69.8%), in Inpatient treatment it is hallucinogens (8.0%) and stimulants (70.9%). The highest frequency of unplanned[42] ending of treatment in outpatient care is in the diagnosis group volatile substances (56.3%) and in inpatient care the primary diagnosis opioids (37.1%) (Künzel et al., 2021a & b).

At the beginning of 2021, the FVS published the catamnesis data from five of its member clinics that meet the standards of the German Society for Addiction Research and Addiction Treatment (Deutsche Gesellschaft für Suchtforschung und Suchttherapie, DG-Sucht) and take into account the various types of calculation method regarding treatment success (DGSS 1-4[43]) (DG-Sucht, 2001; DG-Sucht, 1985). The most recent results of the cross-facility drug catamnesis on the basis of the discharge year 2018 have seen success levels increase again, year on year.

The catamnestic success rate is 79.9% (DGSS 1) (2017: 70.4%, 2016: 67.7%; 2015: 75.4%; 2014: 74.4%) for consistently abstinent patients and for abstinent patients following a relapse over 30 days prior to the survey. The most conservative estimate is that 20.1% of patients are still successfully abstinent one year after inpatient drug rehabilitation (DGSS 4) (2017: 17.2%; 2016: 20.7%; 2015: 23.3%; 2014: 23.8%). On average, relapsing rehabilitation clients used addictive substances 13.6 weeks after their release. With the help of data from patients who stated that they suffered a relapse during the catamnesis and provided information on the relapse period, it could be determined that the probability of relapse is highest in the first three months after the end of treatment (68.1%) (Kemmann et al., 2021).

1.4.7 Integration and participation (T1.4.8)

The central concerns of additional counselling and treatment in Germany are social, societal and occupational integration and participation and these are anchored in the goals of addiction

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41 For this figure, the number of treatments ended as planned in the diagnosis groups F11-16 and F18-19 was compared to the number of all treatments from those diagnosis groups.

42 The ending of treatment is described as unplanned if the treatment is terminated early either at the request of the client or for disciplinary reasons, or if an unplanned switch to another facility took place, or if the patient died.

43 The most convenient method of calculation, DGSS 1, 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, DGSS 4, includes all those treated and assesses non-responses and incomplete catamnesis responses by definition as relapses (DG-Sucht, 2001; DG-Sucht, 1985). DGSS 1 tends rather to produce an overestimate of rehabilitation success, DGSS 4 tends to produce an underestimate.

support. Parties such as the pension insurance providers 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 (Neumeier et al., 2021 - Drug policy workbook).

Of particular note are, for example, the "Proposals for enhancing the employment related aspects of medical rehabilitation of persons with dependency disorders of 14 November 2014" (“Empfehlungen zur Stärkung des Erwerbsbezugs in der medizinischen Rehabilitation Abhängigkeitskranker vom 14. November 2014”) drawn up by the "Joint working group on the focus on employment in medical rehabilitation - BORA" (Gemeinsame Arbeitsgruppe Berufliche Orientierung in der medizinischen Rehabilitation, BORA) (2014). These recommendations are intended to encourage the approach of people being supported 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 as well as other contributing institutions are involved at an early stage. 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 addicts seeking work. The aim of this is to optimise administrative processes before, during and after the medical rehabilitation of addicts (DRV, 2018).

Another relevant point is that 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 people suffering from dependency), 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, 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”[44]) in May 2018. 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).

[44] reha-pro [online] www.modellvorhaben-rehapro.de [accessed: 15 Aug. 2021].

In addition to the state services, there are numerous projects and facilities run by welfare organisations as well as other charitable facilities, mostly run 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 are allowed to prescribe opioid-based treatment (substitution). Since the Third Amending Ordinance of the German Ordinance on the Prescription of Narcotic Drugs (Dammer et al., 2017, section 3.1), the group of people authorised to dispense substitution drugs has been expanded (BMG, 2017). In addition to substituting doctors and their specialist staff, authorisation is now also available to, for example

- Medical, pharmaceutical or care staff in an inpatient medical rehabilitation facility, a public health authority, a nursing home/care home or a hospice[45],
- Medical or care staff, who work for an outpatient care service or a specialised outpatient palliative care facility[46],
- Pharmacists or non-dispensing pharmaceutical staff in a pharmacy[47],
- Medical or specialist care staff in a hospital[48] and
- Staff employed in state-approved addiction support facilities who have been trained accordingly[49].

Nevertheless, only doctors offer the treatment form, even if sometimes not in their own practices but in facilities provided by the public health service. Above all, large practices specialising in substitution treatment work in close cooperation with psychosocial care (PSC) facilities, which are mostly funded by charitable organisations. A total of 2,545 doctors providing substitution treatment reported opioid addicts requiring treatment to the substitution register in 2020. The number of doctors providing substitution treatment has thus slightly fallen from the previous year (see Figure 1). Therefore, the Federal Government Commissioner on Narcotic Drugs and BÄK launched the initiative “Substitution treatment - routes back into life” (Substitutionstherapie - Wege zurück ins Leben). The initiative aims to strengthen the medical

[45] Where the substituting doctor does not work in the respective facility themselves and has made an agreement with that facility.

[46] Where 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.

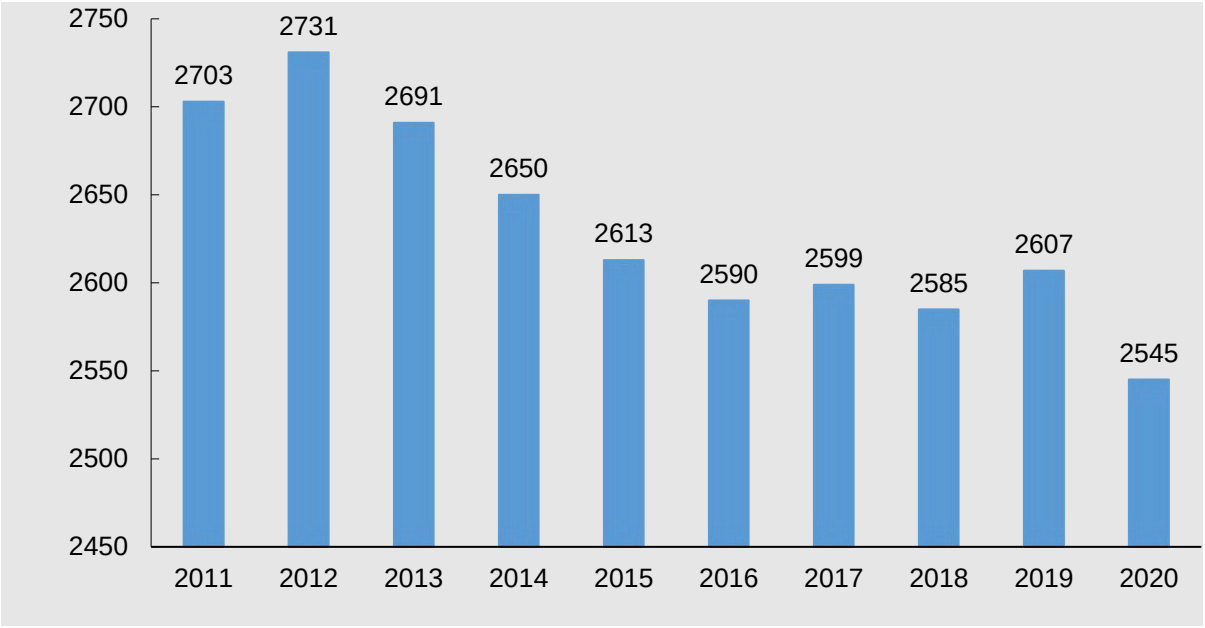
[47] Provided the substituting doctor has made an agreement with the respective pharmacist.

[48] Where the substituting doctor does not work for the hospital themselves and has made an agreement with the hospital.

[49] Where the substituting doctor does not work in the respective facility themselves and has made an agreement with the facility.

care of opioid addicts and in particular attract younger and future generations of doctors into the field of addiction medicine.

In 2020, 563 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 1.5% of all substitution patients (BOPST, 2021).



(BOPST, 2021)

Figure 1 Number of reporting substituting doctors 2011-2020.

The nationwide average number of reported substitution patients per substitution doctor is 32, however there are huge variations between the individual *Laender* (Hamburg: 47.4; Brandenburg: 5.2). 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 (25%) that only treat up to three substitution patients (BOPST, 2021).

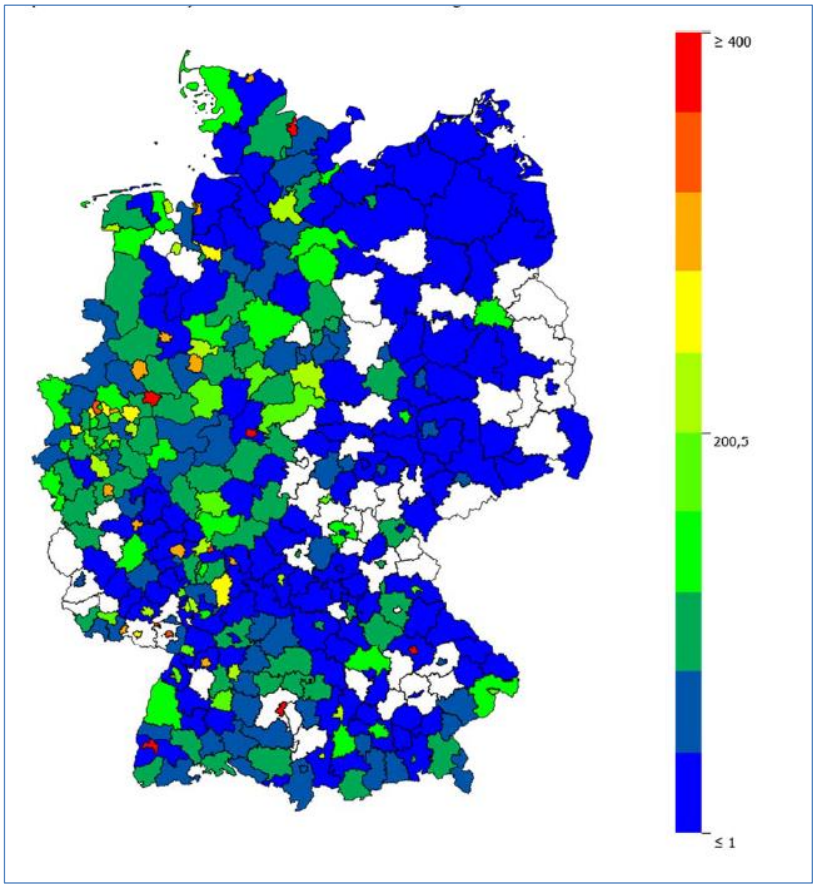
Access to substitution treatment is subject to strong regional differences. Firstly, the proportion of substitution patients in the total population is much higher in the city states (especially Bremen, Hamburg and Berlin), possibly because of the surrounding urban hinterland effect, than in the large-area 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 2020, the number of substitution patients was 81,300, representing a new peak (see Figure 3). This could be due, among other things, to the

coronavirus pandemic and an easing in the treatment of opioid addicts with substitution drugs in the scope of the SARS-CoV-2-Ordinance on the Supply of Medicinal Products (SARS-CoV-2-Arzneimitelverordnung) (see section 1.4.11). During the lockdowns in March/April 2020 and November/December 2020, an increase in substitution patients was observed: Following the lockdown, an increase was recorded from 80,350 (reference date of 1 March 2020) to 81,250 (reference date of 1 May 2020). This represents a 2% year-on-year increase, whereas this figure was under 1% in each of the years between 2016 and 2019.

In 2020, around 85,700 registrations, de-registrations or changed registrations of patient codes were recorded in the substitution register. This high number is, for example, due to the fact that the same people were registered and deregistered several times (BOPST, 2020).



Presentation: Bundesopiumstelle (BOPST) (2021), Report on the Substitution Register, p. 10.

Source: Bundesinstitut für Arzneimittel und Medizinprodukte/BOPST (2021).

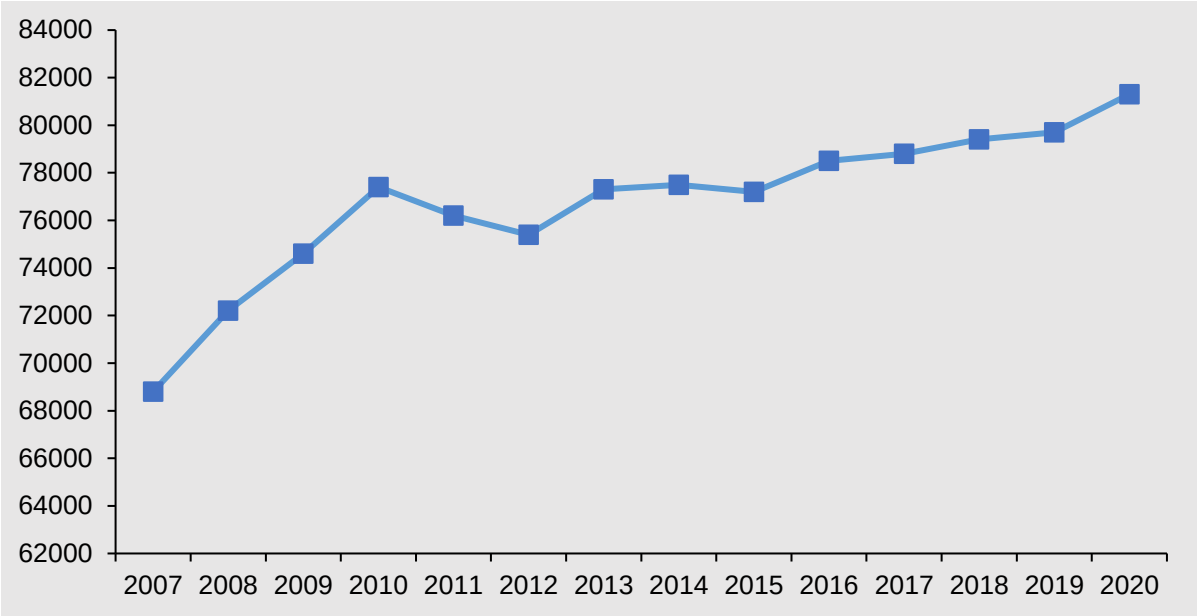
Note: No substitution patients are registered in the districts and cities coloured white on the map.

Figure 2 Number of substitution patients reported per 100,000 population for each district or city on the reference date of 1 January 2020

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 (36.6%) and towards levomethadone (36.8%). The proportion

accounted for by buprenorphine (23.4%) has remained broadly constant for many years (see BOPST, 2021).



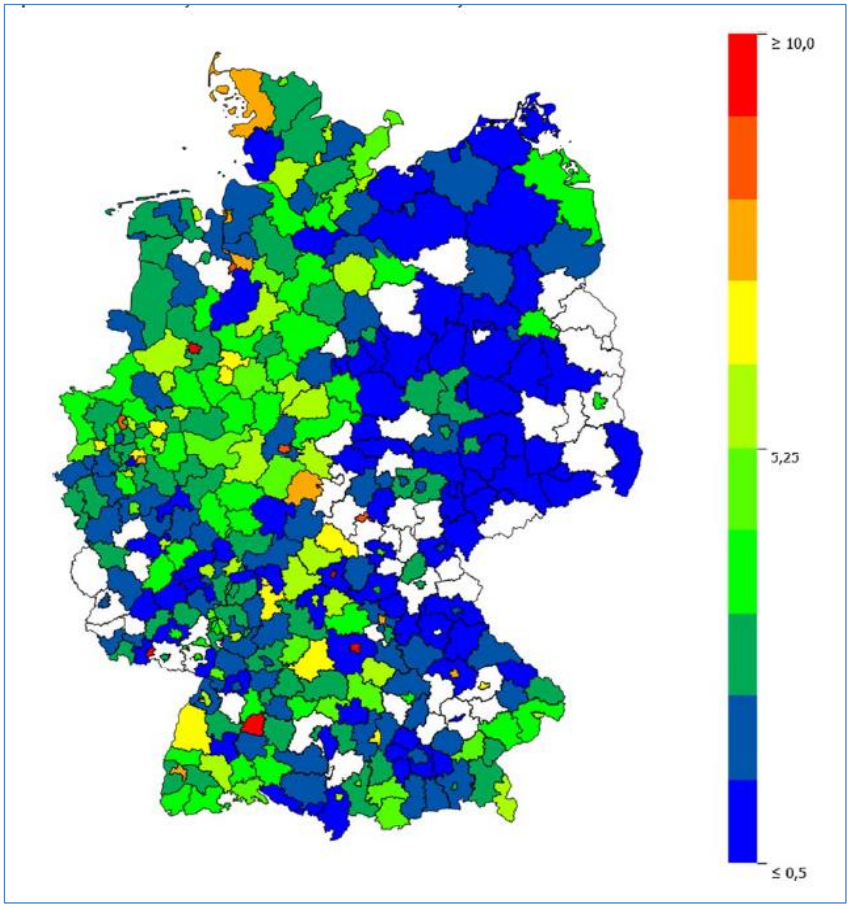
(BOPST, 2021)

Figure 3 Number of reported substitution patients in Germany, 2007-2020 (reference date 1 July)

1.4.10 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 rural districts and they are sometimes difficult for patients to reach (see Figure 4). Compounding the problem, ever increasing numbers of older doctors are retiring with hardly any younger doctors who are prepared to carry out substitution treatment coming through. 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).

When the SARS-CoV-2-Arzneimittelverordnung came into force on 21 April 2020 with the measures for easing substitution treatment, the use of substitution treatment has been made much lower-threshold. This benefits also people in rural areas, for example. The provisions apply up to 31 May 2022 (Werse & Klaus, 2020). Further information can be found in section 3.1 “Initiatives for strengthening substitution treatment”.



Presentation: Bundesopiumstelle (BOPST) (2021), Report on the Substitution Register, p. 9.

Source: Bundesinstitut für Arzneimittel und Medizinprodukte/BOPST (2021).

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

Figure 4 Number of substituting doctors per 100,000 population for each district or independent city reporting data in the first six months of 2020

1.4.11 Quality assurance in drug treatment (T1.5)

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:

- In March 2021, the Bavarian Academy for Addiction and Health Issues (Bayerische Akademie für Sucht- und Gesundheitsfragen, BAS) published recommendations on substitution treatment for minors. The available studies on this topic have to date been rather limited, however it is undisputed that substitution treatment can also be helpful for minors in certain circumstances. The BAS' recommendations are intended to place helpful information into the hands of medical professionals and addiction and youth support workers.
- The SARS-CoV-2-Arzneimittelversorgungsverordnung came into force at the end of April 2020, defining possible exceptions to the BtMVV during the coronavirus pandemic. During the period it is in effect, substituting doctors are permitted, for example, to treat more

patients than before, 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 that can hand out substitution drugs for immediate use have been relaxed, and the legal possibility has been created to hand over the prescription for the substitution drug 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 predominantly 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).

Further guidelines and recommendations for action from previous years can be found in the 2019 and 2020 Treatment workbooks (Tönsmeise et al., 2019 & 2020).

In addition to the treatment guidelines, the funding agencies also have other quality assurance instruments.

Inpatient rehabilitation facilities are generally obliged to have introduced a recognised rehabilitation-specific quality management (QM) system so that they can be provided with patients by the statutory rehabilitation agencies (German Statutory Pension Insurance Scheme, health insurance funds, accident insurance funds, employers' liability insurance associations). This is also required by the legislature, e.g. in the scope of Sec. 137d SGB V or Sec. 20 SGB IX (old version) or Sec. 38 SGB IX (from 13 December 2016). The facilities can choose from more than thirty QM procedures that are recognised by the German Federal Association for Rehabilitation (Bundesarbeitsgemeinschaft für Rehabilitation e.V., BAR). The German Accreditation Body (DAkkS) monitors the certification bodies as far as accreditation is concerned. Inpatient rehabilitation facilities entering the market must provide the required certification within half a year of starting to operate. If deficiencies are found at the first certification stage, the inpatient rehabilitation facility is granted a time limit of up to nine months to make the necessary improvements. If the deficiencies are not remedied in time, the facility does not receive certification.

Outpatient facilities are not obliged to have a quality management system. They do, however, have the option of gaining quality assurance certification. Some service providers - for example some charities - have developed their own audits with quality assurance requirements, which their members must satisfy. Coordination and certification is carried out by independent providers.

In addition, the German Pension Fund (Deutsche Rentenversicherung Bund, DRV) carries out annual evaluations of medical rehabilitation facilities treating persons with dependence disorders: Within this evaluation, the facilities to which the DRV sends patients are assessed in a peer-review process and the quality of the rehabilitation process is measured. 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 evaluated according to the same criteria. In addition, the persons undergoing rehabilitation treatment are surveyed on 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. Addiction counsellors and therapists firstly require relevant basic training in the area of social work, social pedagogy, medicine, psychology or nursing etc. In addition, they must be able to show that they have completed certified additional training in addiction counselling/addiction therapy, recognised by the DRV, before they can charge for their services. Addiction professionals require additional training in “addiction medicine basic care”. Today, there are also specific courses of study, which are usually completed alongside their work or as a dual course, for example study courses such as social work or psychology with an addiction-specific focus, or such as Master of Science in addiction therapy, which includes certification as an addiction therapist.

Cooperation between different professional groups from social work, psychology, psychiatry and other medical fields forms an essential part of the treatment standards for drug dependence. As for outpatient services (in particular counselling centres), quality assurance and professional supervision are mainly in the hands of the organisations that fund these facilities, or the *Laender* and municipalities. The primary responsibility in relation to detoxification and withdrawal, in contrast, lies first and foremost with the respective funding agency (statutory health insurance providers (Gesetzliche Krankenversicherung, GKV) and pension insurance providers (Rentenversicherung, RV)) (Pfeiffer-Gerschel et al., 2012).

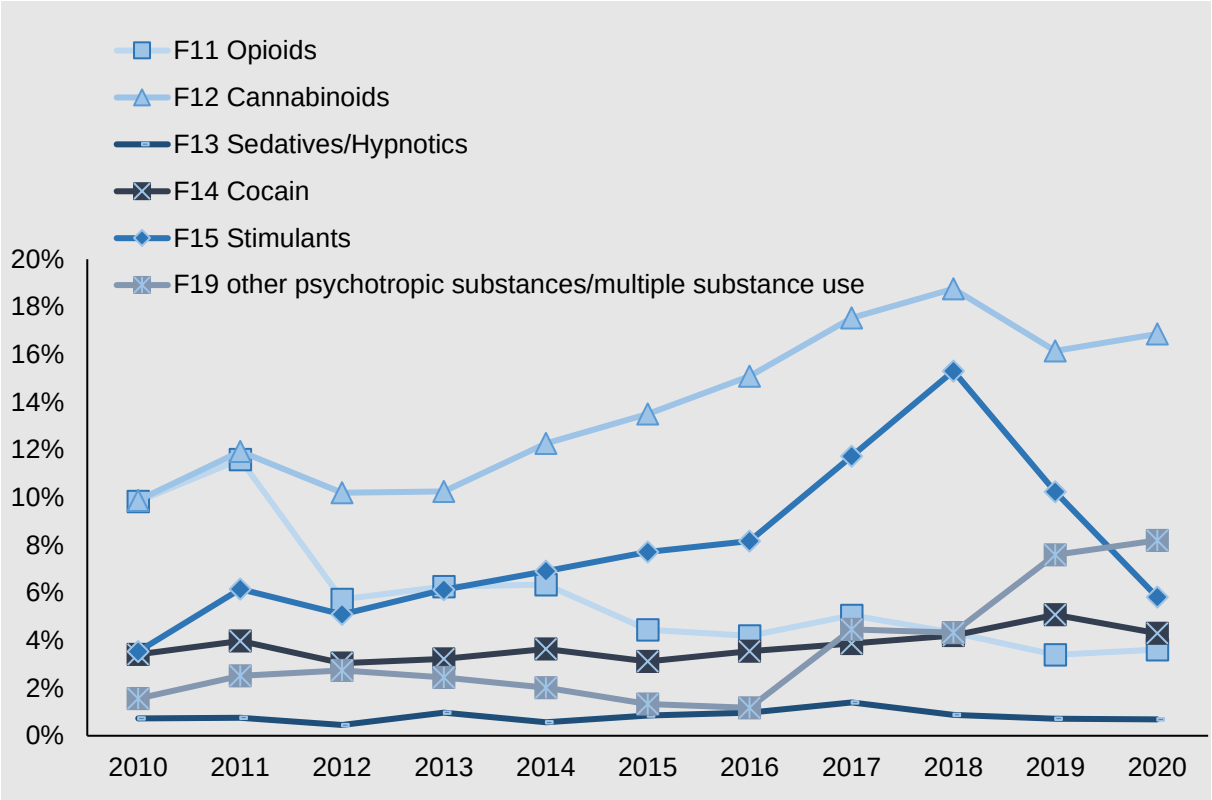
2 TRENDS (T2)

2.1 Long-term trends in the number of people 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 on an inpatient basis for the first time due to cannabinoids has continuously increased in past years (2013: 10%, 2018: 19%), before declining for the first time in 2019 (-3%). Since then it has increased once more, however (+8% to 16.9%). A similar, but not quite so prevalent trend could be seen for the primary diagnosis F15 stimulants. For this group, however, the proportion of patients treated on an inpatient basis for the first time has almost halved in the last year (2019: 10.2%; 2020: 5.8%). The proportion of patients treated for the first time due to other psychotropic substances

or multiple substance use (F19) increased again and now stands at 8.2%. The proportions of patients treated on an inpatient basis for the first time with primary diagnoses F11 - Opioids and F13 - Sedatives/hypnotics are small, at 3.6% and 0.7% respectively. No inpatient treatments were recorded by the DSHS for 2020 for the primary diagnoses F16 - Hallucinogens and F18 - Volatile substances. Over the last ten years, the percentage share of patients treated on an inpatient basis for these primary diagnoses has remained constant at less than 1%.



The primary diagnoses of 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

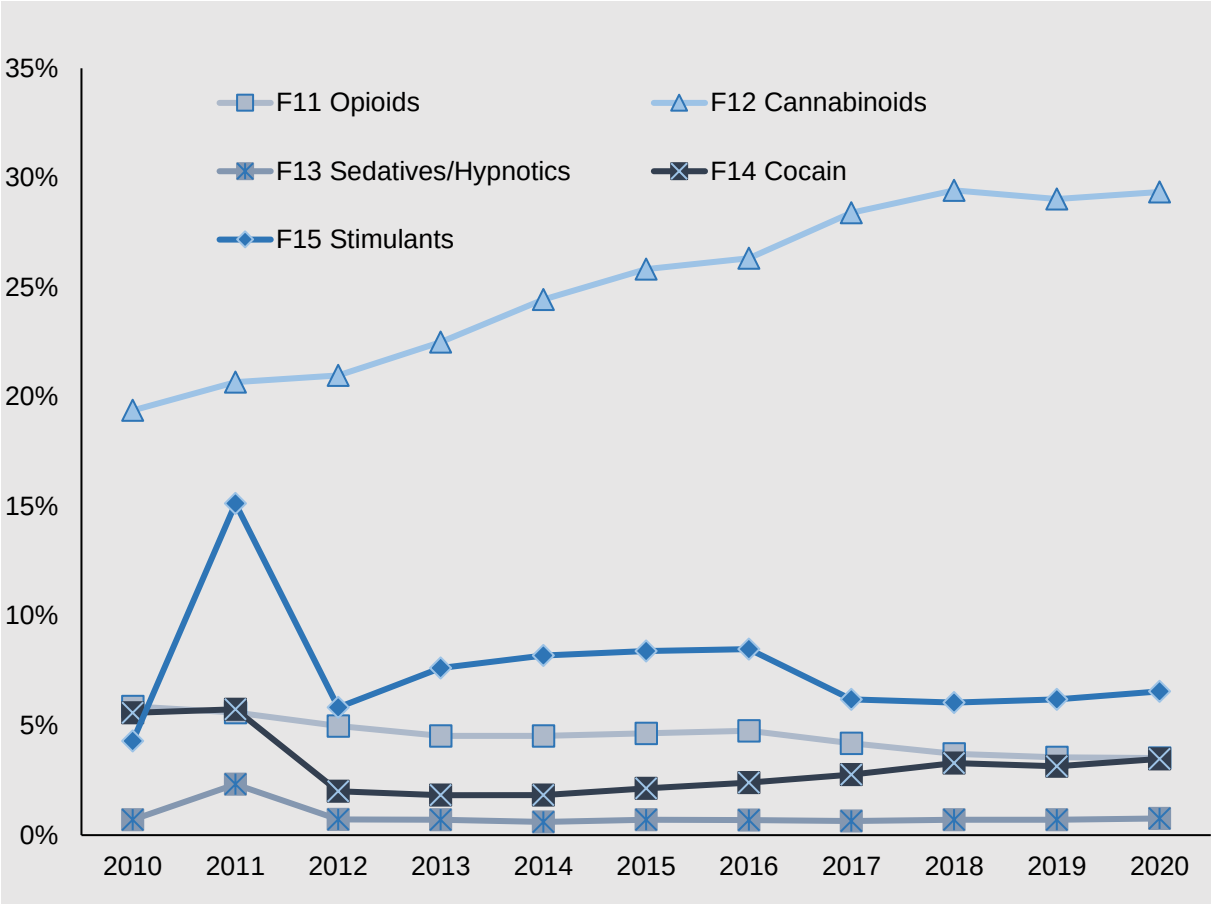
The percentage figures shown relate to the proportion the respective primary diagnosis accounts for among all treatment cases recorded in the DSHS (F10-F19, F50, F63).

Due to the change in the KDS, data from 2017 onwards can only be compared with the data from the years prior to the change to a limited extent.

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 (2010-2020) in per cent (%).

The group of clients treated the most frequently for the first time in an inpatient setting presented, by some margin, due to the primary diagnosis of cannabinoids (29.3%). As can be seen from Figure 6, there has been an upward trend since 2010, which stagnated for the first time in 2019, but which has more recently increased once more (+3%). The percentage 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 we4re therefore excluded from the diagram for reasons of poor graphic representation.

The percentage figures given relate to the proportion the respective primary diagnosis accounts for among all treatment cases recorded in the DSHS (F10-F19, F50, F63).

Due to the change in the KDS, data from 2017 onwards can only be compared with the data from the years prior to the change to a limited extent.

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

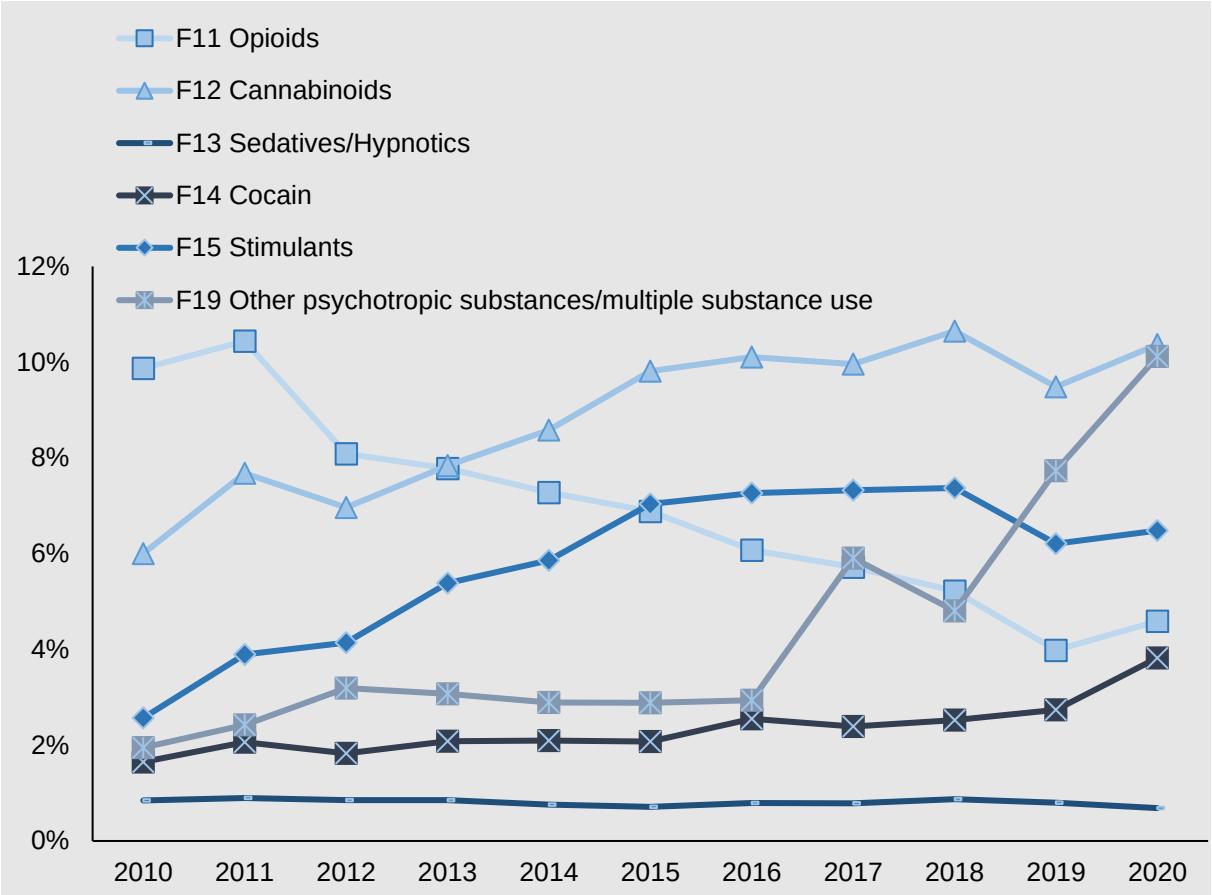
Figure 6 Patients treated for the first time on an outpatient basis by primary diagnosis and year (2010-2020) in per cent (%).

Number of clients treated overall

Looking at the treatment data from the previous ten years, it is striking that there have been quite some changes, particularly in the proportions of primary diagnoses in the inpatient setting. While in 2010, 10% of all treatment cases were still due to opioids, in 2020 it was only 4.6%. In contrast, the respective proportion of treatment cases due to cannabinoids, stimulants and other psychotropic substances/multiple substance use has significantly increased (see Figure 7).

It can also be observed in the outpatient setting that the proportion of treatment cases due to opioids has declined (16% of all inpatient addiction treatments in 2010, 9% in 2020), while increasing numbers of clients are being treated due to the primary diagnosis of Cannabinoids (12% in 2010, 19.5% in 2020). In addition, an increase in clients with the primary diagnosis

Other psychotropic substances/multiple substance use has been observed since 2017 (0% in 2016, 4.4% in 2020).



The primary diagnoses of 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.

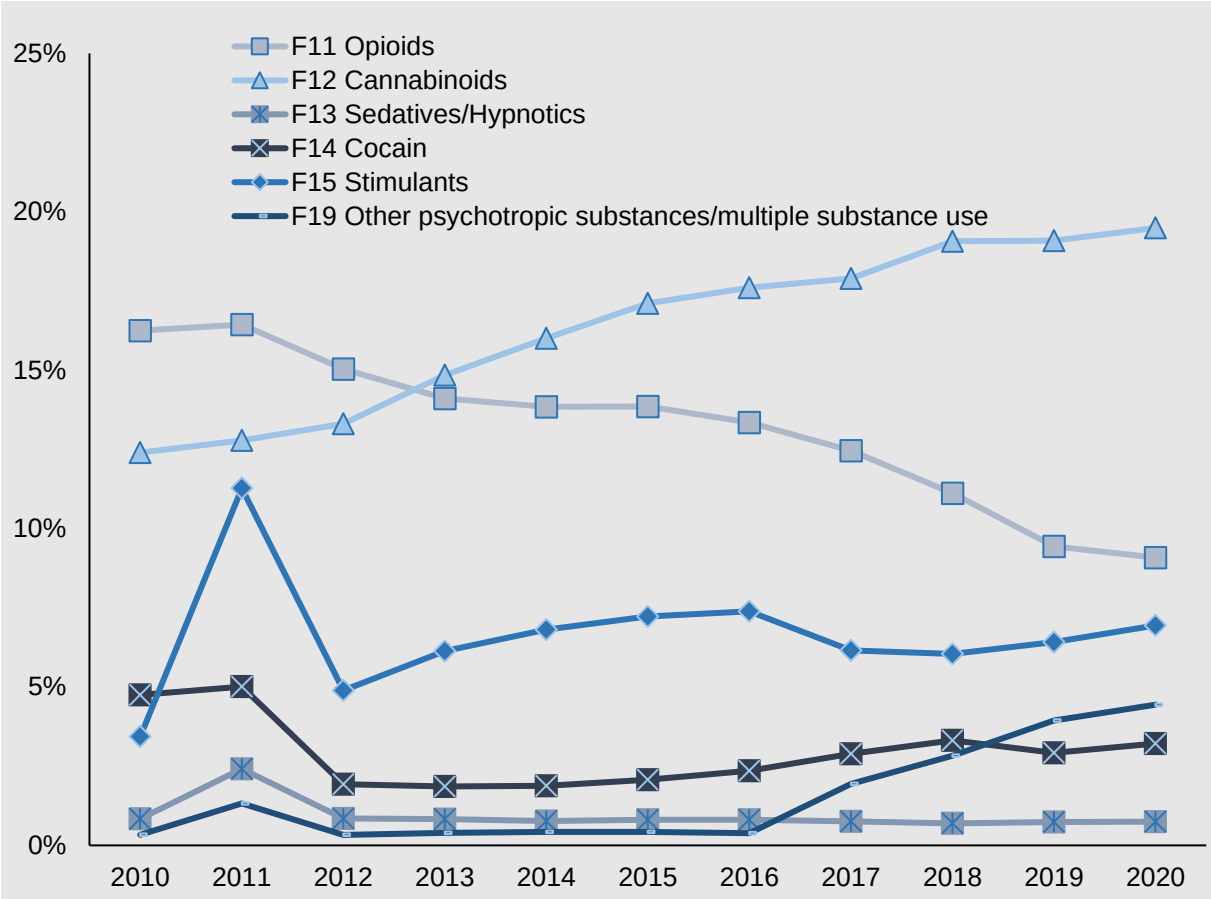
* Multiple substance use included only from DSHS 2017 onwards

The percentage figures given relate to the proportion the respective primary diagnosis accounts for among all treatment cases recorded in the DSHS (F10-F19, F50, F63).

Due to the change in the KDS, data from 2017 onwards can only be compared with the data from the years prior to the change to a limited extent.

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 (2010-2020) in per cent (%).



The primary diagnoses of 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 figures given relate to the proportion the respective primary diagnosis accounts for among all treatment cases recorded in the DSHS (F10-F19, F50, F63).

Due to the change in the KDS, data from 2017 onwards can only be compared with the data from the years prior to the change to a limited extent.

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 (2010-2020) in per cent

Substitution treatment

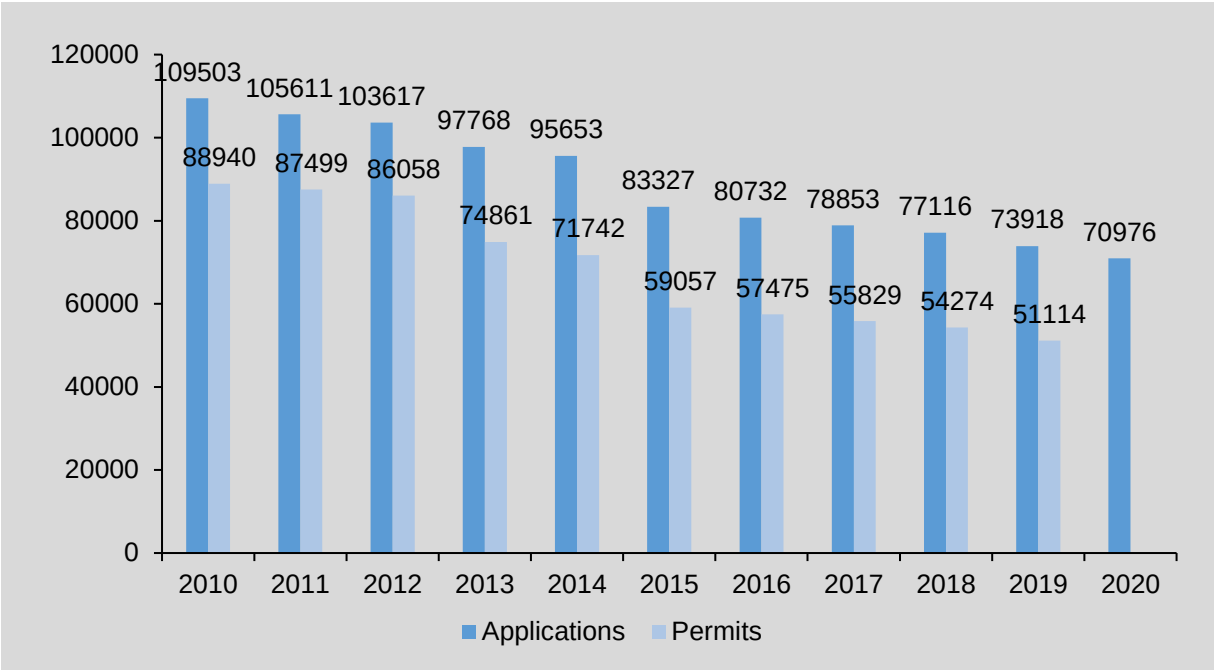
Information on trends in substitution treatment can be found in sections 1.4.8 and 1.4.9.

Rehabilitation

The total number of rehabilitation services financed by the DRV in the area of addiction has continuously fallen in recent years (see Figure 9) (DRV, 2021a). Part of this decrease is due to a change in the method of data collection since the 2015 reporting year (Ostholt-Corsten & Kley, 2019).

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 rehabilitation patients are referred via addiction counselling facilities, a connection

could potentially exist between the fall in rehabilitation services and the precarious financial situation of counselling centres, which often results in fewer resources (Koch, 2020).



Source: Simon, Märtin & Falk (2021), DRV (2021a,b)

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 (2010-2020).

3 NEW DEVELOPMENTS (T3)

3.1 New developments (T3.1)

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

The coronavirus pandemic reached Germany in 2020 as a result of which, according to the RKI, to date 3,784,433 people have fallen ill and 91,754 have died (status: 6 August 2021; RKI, 2021). The addiction support system has also been affected by the pandemic and is facing huge challenges.

Contact restrictions, legal frameworks (such as official bodies issuing stops on admissions and ordinances to free up capacity in rehabilitation facilities to relieve acute hospitals), hygiene measures, and distancing regulations, led, especially in 2020, to counselling and treatment services only being possible on a reduced and/or limited basis. Some facilities have had to pause their services temporarily (Adorjan et al., 2021; Vogelsang, 2020; Werse & Klaus, 2020; DHS, 2020a). According to studies, these effects were or are strongly felt by both staff and especially clients (Werse & Kamphausen, 2021). Addicts are considered a marginalised and heavily stigmatised group who are often believed to have a high need for care as far as their treatment/counselling is concerned. Through pandemic-related restrictions in care and

psychosocial stresses caused by the pandemic, for example the ongoing limits on contact between people, there is an increased risk of use and relapse. In this context, another particular problem is that those affected usually have poor access to the health system due to their stigmatisation whilst being considered, due to their use and often associated comorbidities, an especially vulnerable group with regard to COVID-19 (Adorjan, Haussmann, Rauen & Pogarell, 2021). Comprehensive, representative data on the situation regarding the addiction support system and addicts does not yet exist. Further information on the topic of consumption can be found in the Drugs workbook (Neumeier et al, 2021).

Through the German Social Service Providers Deployment Act (Sozialdienstleister Einsatzgesetz, SodEG) and the German Covid-19 Hospital Relief Act (Covid-19-Krankenhausentlastungsgesetz), the legislature has created possibilities for giving social service providers short-term liquidity to cushion the financial consequences of crises (BMAS, 2021; Vogelsang, 2020; BMG, 2020; Sucht Aktuell, 2020).

The SARS-CoV-2-Arzneimittelversorgungsverordnung came into force at the end of April 2020, defining possible exceptions to the BtMVV. During the period it is in effect, substituting doctors are permitted, for example, to treat more patients than before, and to prescribe (take home) medicinal drugs for patients who would usually only receive substitution treatment under (visual) supervision for a period of seven days (take home). In addition, the regulations concerning the group of people that can hand out substitution drugs for immediate use have been relaxed, and the legal possibility has been created to hand over the prescription for the substitution drug to the patient even without a personal consultation (Bundesanzeiger, 2020). The ordinance is still valid until the end of May 2022 (Drogenbeauftragte der Bundesregierung, 2021b).

In addition to the Arzneimittelversorgungsverordnung, a range of handouts are available, intended for example to help substitution treatment providers and substituting people in practice. 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, for example, advice for substituting doctors (Jeschke & Meyer-Thompson, 2020).

Various efforts have also been made in other areas of addiction treatment and counselling, in order to adapt or supplement services in spite of the pandemic, in order that they can continue to be provided or resumed. Restructuring of the range of services with regard to times and capacity utilisation was achieved. Many of those involved also found other individual and creative solutions to enable them to continue their work. Online seminars, counselling walks, counselling on park benches and telephone and video counselling are now part of the normal day-to-day activities of many addiction support facilities (Heitmann, 2021; HLS, 2021; LWL-Koordinationsstelle Sucht, 2020). While it was observed that younger people affected benefited in particular from these low-threshold online services, experts assume that many older people, especially those who are not tech-savvy, have lost contact with the addiction support system during this period (HLS, 2021; Werse & Kamphausen, 2021; Heitmann, 2020).

Initiatives to strengthen substitution treatment

Daniela Ludwig, the Federal Government Commissioner on Narcotic Drugs, has put the topic of substitution treatment high on the political agenda for the 19th legislative period by making it one of her main focusses. In this context, two very topical initiatives should be highlighted in particular:

“Substitution treatment - routes back into life” (Substitutionstherapie - Wege zurück ins Leben) is an initiative by the Commissioner and the BÄK. The initiative aims to strengthen the medical care of opioid addicts and in particular attract younger and future generations of doctors into the field of addiction medicine. The hope is that this can help close the gaps in substitution care in the long run (see section 1.4.10, Figure 4) (Ärzteblatt, 2021; Kunstmann, Bohr, Scherbaum & Wodarz, 2021). This initiative was also presented at the “Round table on substitution care” which took place in June 2021. It was the third meeting, the focus was mainly on education and further education. Doctors’ Association representatives, the German Association for Psychiatry, Psychotherapy and Psychosomatics (Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde, DGPPN) and the German Medical Students’ Association discussed those topics (Drogenbeauftragte der Bundesregierung, 2021c).

The Federal Government Commissioner on Narcotic Drugs, Daniela Ludwig, also supported the initiative “100,000 substitution patients by 2022” from the JES Bundesverband, akzept e.V. and the DAH (Drogenbeauftragte der Bundesregierung, 2021b). Currently around 50% of the 165,000 opioid addicts are in substitution treatment (see section 2.1, Substitution treatment; Drugs workbook: Karachaliou et al., 2021). According to the title of the initiative, the goal is for at least 60% of opioid addicts to be undergoing treatment by 2020 - at least 100,000 substitution patients. The campaign is directed at different target groups and actors: the aim is for people that use opioids to be made aware of substitution treatment via target group-specific media (videos and print media). A further intention is that the topic be addressed more often during counselling. Not least, this initiative also addresses policymakers, calling for services to be strengthened and expanded. The campaign started on International Drug Overdose Awareness Day, 31 August 2020. The objective of expanding substitution treatment is intended to prevent many avoidable deaths over the long-term (DAH, 2020; Drogenbeauftragte der Bundesregierung, 2020).

Depot injection for substitution treatment

The active ingredient buprenorphine has been available as a depot injection in substitution treatment since April 2019, under the name “Buvidal®”. Depending on dosage, it can be injected once a week or once a month. Previously, patients without a take-home prescription had to collect their substitution drug from their doctor or pharmacy on a daily basis and take it on-site. Buvidal® is supposed to help enable those affected to have a more self-determined life and to improve reintegration into society.

Buvidal® can be a good alternative, in particular for people in rural areas who live a long way from their doctor’s practice but also for cases of travel and longer periods of absence. The

same applies in relation to prison (Schneider et al., 2019) (European Medicines Agency [EMA], 2018; DAH, 2019; Deutsche Apotheker-Zeitung [DAZ.online], 2019).

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

Emergency addiction counselling

Addiction counselling facilities have, through their work, a kind of bridging function to the healthcare system. Independent of that, 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. In recent years, however, experts have observed with increasing concern that municipal funding, which accounts for the majority of the total funding 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, 2020b).

This situation has now become even more acute as a result of the coronavirus pandemic. According to a survey of fdr+ members on the pandemic, 70% of the facilities and organisations questioned 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+, 2020).

In order to draw attention to the counselling centres’ precarious situation, the *Aktionstag Suchtberatung: Kommunal wertvoll!* (approx.: Action day on addiction counselling: local, valuable!) took place for the first time on 4 November 2020, under the auspices of the Federal Government Commissioner on Narcotic Drugs, Daniela Ludwig. The aim was to initiate a 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 (DHS, 2020b). The Aktionstag Suchtberatung is scheduled to take place for the second time on 10 November 2021 under the leadership of the DHS and its member associations.

4 ADDITIONAL INFORMATION (T4)

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 (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