PART B: SELECTED ISSUES

11. In-patient treatment of drug addicts in Germany

11.1 History and general conditions

11.1.1 Overview

Inpatient treatment is a key element of treatment and rehabilitation forms for drug addicts. In Germany there are approximately 320 facilities with over 13,200 beds offering inpatient rehabilitation services for people with substance-related disorders. Of these, 4,000 beds are for drug addicts. The aim of rehabilitation is to achieve and maintain abstinence, remove or offset physical and mental disorders and maintain or achieve sustained reintegration into work, profession and society.

This focus chapter is based on the specifications of the EMCDDA, which has encouraged the description of inpatient care at a country level to allow an EU-wide comparison. The historical developmental trends and the current role and developments in the primary addiction support system as well as the availability and features of inpatient treatment programmes are presented accordingly. A description of quality assurance systems and a forecast of future developments complete the chapter.

Following the provisions of the EMCDDA, “in-patient treatment” is defined as a bandwidth of in-patient treatment models and programmes, therapeutic or other offers for drug users who go through medical and psycho-social interventions in the context of in-patient placement. A decisive criterion of such programmes is that they correspond to different treatment needs and consider drug use, health and quality of life as well as professional and social participation. The focus section explicitly does not deal with

- inpatient detoxification,
- programmes that are solely dedicated to the provision of social support for drug addict (e. g. emergency shelters, residential homes) and
- programmes for drug users in prisons or for drug-addicted prisoners in forensic psychiatric hospitals according to § 61 StGB.

These areas, primarily inpatient detoxification, are of course significant components of inpatient care. In order to ensure the comparability of inpatient care on an EU level, the focus is placed first and foremost on medical rehabilitation, which is closely linked to social rehabilitation measures. Abstinence obtained through detoxification should be stabilised here and dependency should be stopped on a long-term basis.

Different sources are used in order to allow an image of inpatient treatment that is as comprehensive as possible. However, they can only be compared with each other conditionally due to their selectivity. In addition to the German figures for rehabilitation treatment, basic data for addiction psychiatry, diagnostic statistics of the Statistisches

Bundesamt (Federal Statistics Office), the statistics of the Deutsche Rentenversicherung-Bund (German Pension Fund), the basic and catamnesis data of the Bundesverband für stationäre Suchtkrankenhilfe (Federal Association for Inpatient Addiction Care), basic documentation of the Fachverband Sucht (Addiction Association) as well as regional monitoring systems provide key data for inpatient treatment.

11.1.2 History of inpatient treatment

In the post-war period, addiction-care services in Germany were poorly organised and worked primarily with volunteers. In 1962, the number of inpatient facilities for alcoholics throughout Germany stood at 18 and in 1968 the number was 26. In total there were between 1,000 and 2,000 beds available. There were no specific facilities for people addicted to illegal drugs (Vogt & Scheerer 1989). In light of the rise in the number of adolescent drug users at the end of the 1960s/start of the 1970s as well as the setting of a new direction by transforming the Federal Law on Opium into the Narcotics Act (1981), the expansion of inpatient drug dependence treatment began. An important milestone was the recognition of addiction as a disease in 1968 (Federal Social Court decision of 18 June 1968) through which the costs of addiction treatment and rehabilitation had to be taken over by public insurance funds (Schmid & Vogt 1998). As a result, both demand for treatment centres for alcoholics and the need for suitable treatment programmes for drug addicts rose. Professional and systematically supported programmes developed from so-called "Release Groups" which previously served as shelters for adolescents dependent on opiates.

The necessity for differentiated programmes for alcoholics or drug addicts was confirmed in respect of inpatient treatment, in particular through the “Aktionsprogramm zur Bekämpfung des Drogen- und Rauschmittelmissbrauchs (Action Programme for Combating Drug Abuse)” from 1970:

“The lumping together of drug addicts with alcoholics or the mentally ill in psychiatric clinics should be rejected from a therapeutic point of view. The lack of individual facilities and specific departments in clinics for these groups is alarming” (BMJFG 1972).

A comprehensive support programme of the Federal Government was initiated which became known as the “Großmodell zur Beratung und Behandlung drogen- und alkoholgefährdeter und -abhängiger junger Menschen (Large-scale model on counselling and treating young people abusing drugs and alcohol)” (Schmid 2003). As part of this, rehabilitation clinics and Therapeutic (shared-living) Communities (therapeutische (Wohn-) Gemeinschaften (TG)) were promoted in addition to drug help centres. “Minimum criteria” were developed for inpatient drug treatment as part of scientific support. In particular, the employment of skilled psycho-social personnel led to increasing professionalisation of treatment facilities.

Being accepted into a Therapeutic Community (TC) was subject to significant bureaucratic hurdles, not least because of the programme’s still-limited capacity (Bühringer 1996). Inpatient and outpatient drug treatment was formed from the paradigm of abstinence as well as from a rigid therapy concept of “post-maturation” and “resocialisation”. However, these

therapeutic approaches based on confrontation and repression led to high dropout rates and subsequently low rates of success (Schmid & Vogt 1998).

On 20 November 1978, the “Empfehlungsvereinbarung Sucht” (recommendation agreement on addiction) was adopted between health insurance funds and pension insurance institutions (Association of German Pension Schemes 1978 (Verband deutscher Rentenversicherungsträger 1978). This established a maximum size of 30 beds for drug treatment centres. The reasons at the time are still applicable today: this moderate size provides drug addicts with better orientation and contributes to their comprehensive and individual support (DHS 2008). This additionally established that health insurance funds are the primary cost carriers for detoxification treatment and pension insurance funds are responsible for inpatient withdrawal treatment. This should be allowed if long-term reintegration into working life and society seem possible. Furthermore, withdrawal treatment was able to be administered only at facilities and financed by pension schemes if they were recognised by them (Verband Deutscher Rentenversicherungsträger (Association of German Pension Schemes) 1978 (Verband deutscher Rentenversicherungsträger 1978). Therapeutic Communities especially had problems meeting the requirements for financing through pension schemes since neither diagnoses were given nor treatment plans or physicians were available. In order to be recognised by pension schemes based on their quality standards, treatment facilities professionalised their concepts, strengthened their co-operation with the medical sector and focused more strongly on additional treatment qualifications (Schmid 2003).

In the 1980s, Therapeutic Communities lost their monopoly position of treating drug addicts (Schmid & Vogt 1998) (see chapter 2.2.1). Inpatient halfway homes and so-called “compact treatments” were expanded (see chapter 2.2.4) and long-term treatments were shortened as part of the Therapeutic Communities The approach to dealing with relapses changed to the extent that they were increasingly understood as a part of the therapeutic process and no longer led to direct dismissal. Different forms of medically assisted withdrawal treatment programmes were established in addition to “cold” withdrawal treatment (Schmid & Vogt 1998).

Starting in 1980, for-profit organisations supplemented the previously exclusive sponsorship of addiction services through the association of voluntary social welfare work (Täschner et al. 2010).

A significant milestone was the Betäubungsmittelgesetz (BtMG) (Law on Narcotics) that came into effect on 1 August 1981, which targeted co-operation between judicial policy, addiction support and cost centres in order to be able to combat drug addiction and associated criminality (Kraatz-Maček 2011; Künzel et al. 2012). It was now possible to allow drug addicts subjected to punishment to be treated for their dependencies outside of the penal system. Corresponding to § 35 BtMG (Law on Narcotics), the execution of penalties in particular cases can be deferred in favour of therapeutic care, counted as part of the sentence or the remaining part of the sentence can be suspended. Until 1992, this rule applied only to treatment at inpatient facilities. Since then it has been possible to allow those

convicted to comply with court-ordered conditions as part of an outpatient treatment (Schmid & Vogt 1998).

Furthermore, the renouncing of relatively uniformly-targeted, therapeutic concepts in favour of the development of addiction support programmes specific to target groups can be seen in the past two decades in the German addiction support system. A significant milestone in 2001 was the replacement of recommendation agreements from 1978 with the “Agreement on co-operation between health insurers and pension schemes for acute treatment (detoxification) and medical rehabilitation (withdrawal treatment) of dependence sufferers” (dependence illnesses agreement). This is where the form and content of treatment are presented, the specialist staff selected, the organisational structure of rehabilitation determined and the length of treatment recommended, all in a decisive manner (DRV et al. 2001c).

11.1.3 Strategies and basic framework conditions of inpatient care

According to the landmark decision of the Office of Social Affairs, Family, Health and Consumer Protection (Behörde für Soziales, Familie, Gesundheit und Verbraucherschutz, BSG) of 18 June 1968, this involves an illness requiring treatment in the case of alcohol or drug dependency (buss 2012). Under the consideration of other conditions, (see chapter 11.2.1) people with a substance-related disorder are entitled to have their costs for required acute medical (withdrawal or detoxification) and weaning-oriented treatment (medical rehabilitation) covered.

Inpatient withdrawal treatment is primarily one of the services of medical rehabilitation in Germany according to §§ 9 and 15 SGB VI. 85% of the measures for medical rehabilitation in the indication area of dependencies are funded by the German Retirement Insurance-Federation (DRV) as a pension insurer (Koch 2011). The basis for this is the “dependence illnesses agreement” from 2001. If there are no claims with respect to the statutory pension insurance (Rentenversicherung - RV) according to SGB VI, a check is performed to determine whether a claim towards cost absorption exists in the case of statutory health insurance (gesetzliche Krankenversicherung - GKV). If there are no claims with respect to RV or GKV, the competent welfare agency intervenes to finance inpatient addiction treatment in accordance with SGB XII as part of the subsidiary principle (subordinate competence) (Jungblut 2004). Unemployed and elderly citizens also have an enforceable claim to withdrawal treatment or the financing of it. In the case of officials, the respectively applicable civil servant pension arrangements are to be taken into account. Most private health insurance companies have excluded addiction treatment from their benefits on a contractual basis. Either cost transfer can be obtained on a goodwill basis or the patients must pay for treatment themselves (buss 2012). In cases involving a lack of financing for treatment, patients can resort to programmes free of charge, such as self-help.

The aim of rehabilitation is to achieve and maintain abstinence, remove or offset physical and mental disorders and maintain or achieve sustained reintegration into work, profession and society (DRV et al. 2001c).

The costs for drug rehabilitation in 2010 amounted to 17% (500 million Euros out of 3.011 billion Euros without transitional allowance) of the total cost of medical services of the DRV (German Public Pension Insurer) (Beckmann & Naumann 2012). The total expenses of the RV (Public Pension Scheme) in connection with illegal drugs in the form of medical rehabilitation, services for participating in work life and pensions as a result of reduced earning allowance amounted to approx. 171.7 million Euros in 2006. Furthermore, drug addicts receive acute medical treatment in psychiatric addiction centres of psychiatric specialist clinics and psychiatric wards of general hospitals and university clinics, for example through emergency care, crisis intervention or qualified withdrawal treatment. The expenditure of statutory health insurance companies for medication, hospitalisation, rehabilitation, etc., in connection with illegal drugs is estimated at 1.4 billion Euros (Mostardt et al. 2010).

11.2 Availability and characteristics

11.2.1 Nation-wide availability and access

Access

Medical rehabilitation is only taken into account for dependency sufferers if a need and readiness exist for rehabilitation as well as a positive rehabilitation prognosis. The approval for rehabilitation therapy requires a notification procedure in which formal and content-related criteria for approval must be met (buss 2012). The application procedure includes a medical opinion in which the necessity for withdrawal treatment is confirmed, and as a rule, a social report that is prepared by an information centre or a social service. In addition, the minimum insurance periods / payments of contributions that are individually provided depending on the insurer are required. All insurers require a minimum insight into the disorder by the affected parties and motivation for treatment and aftercare. Voluntary action is a compulsory condition for approving treatment[131]. Additionally it is expected that performance in working life can be re-established following withdrawal treatment (DRV et al. 2001c). In order to begin withdrawal treatment as early as possible, the DRV for Central Germany for example has been gradually simplifying access paths since October 2003 and eliminated the obligatory preparation of the social report in November 2011 (DRV 2012 quoted by the Federal Government Commissioner on Narcotic Drugs 2012 (Die Drogenbeauftragte der Bundesregierung 2012a). Since general practitioners are the first point of contact in 80% of cases of addiction, the decision to undergo rehabilitation can be made based on the physician's findings alone (ibid.)

The selection of the form of service is directed at the commonly established criteria of pension insurance and insurance companies (DRV et al. 2001a).

[131] "Performance and utilisation of addiction care are based on the principle of voluntary action with the exception of Section § 35 BtMG "Treatment instead of penalisation". According to § 63 and § 64 of the Strafgesetzbuch (StGB) (Penal Code), psychiatric treatment under a hospital order (Maßregelvollzug - MRV) can be mandated in special forensic psychiatric hospitals under particular circumstances for offenders with mental illnesses or addictions.

Criteria for approving inpatient rehabilitation (Dependence illness agreement, appendix 3)

- There exist severe disorders in a mental, physical or social area that bring successful completion of out-patient rehabilitation into question.
- Removal from a pathological social environment (e. g. in the case of massive family conflicts or destructive relationships with partners) is required to guarantee successful rehabilitation.
- The social environment of the dependency sufferer has no supporting function. (Note: the place of treatment alone cannot take over the function of an intact social environment.)
- The dependency sufferer is not integrated professionally and as a result requires specific services to prepare for professional reintegration, which cannot be provided on an out-patient basis.
- Lack of a stable living situation.
- It is evident that the ability to actively co-operate, regularly participate in or maintain the treatment plan in relation to the requirements of outpatient withdrawal treatment is insufficient.
- The dependency sufferer is not ready or not in the position to lead an abstinent life during outpatient withdrawal treatment and to participate in an outpatient treatment program drug-free in particular.
- A long or intensive history of addiction can be an indication of inpatient withdrawal treatment in particular against the background of the aforementioned criteria.

Fundamentally, a decision must be made on the application within six weeks (approval procedure); an “accelerated procedure” is possible in special cases. If all requirements are met, the funding agency must approve the measure. If there is no positive prognosis concerning reintroduction to occupational activity, insurance companies or welfare agencies must fund treatment according to the Federal Association for Inpatient Addiction Care (buss 2012). A negative decision must be justified, against which an objection (free of charge) can be filed.

Once approved, the rehabilitation facility invites the affected person on a short-term basis. Patients’ entitlement to express their wishes and make their choices in accordance with § 9 SGB IX must be taken into account here so as not to endanger the treatment’s chances of success before it even starts. Their wishes are to be taken into account when making decisions – generally concerning the type, scope and location of the services rendered – as well as during their execution – type, scope, intensity and quality of the withdrawal method. This could be understood to mean for example a treatment location nearby or the desire to receive outpatient withdrawal treatment. The suggestions are maintained in coordination with the affected person in the social report or in the medical opinion. If the wishes of the beneficiary are not in conflict with the duties of the rehabilitation service providers and the

principals of sound financial management are maintained, they are complied with (DRV et al. 2001c).[132] Adaptation treatment for supporting reintegration can be included if necessary.

Facility types

Through their service guarantee, rehabilitation service providers are (§ 19 Paragraph 1 SGB IX) are responsible for there being a sufficient amount of rehabilitation facilities[133] available, which meet the corresponding quality requirements. Depending on the diagnosis and indication, medical rehabilitation can start either:

- in a recognised psychosocial information centre (outpatient rehabilitation) or
- in an outpatient clinic (all-day outpatient or semi-inpatient rehabilitation) or
- in a specialised clinic or weaning ward of a psychiatric hospital (inpatient rehabilitation (buss 2012)

All facilities have to meet minimum requirements with respect to structure and quality (see Chapter 3). In addition, the configuration contains some flexibility so that there are major differences with reference to length of treatment, treatment models, treatment methods and not least the qualifications of the treatment personnel between facilities (Klosterhuis et al. 2011).

Duration

Long-term treatment in the scope of illegal drug addicts can generally last up to 26 weeks, short-term treatment 12 to 16 weeks, repeat treatments 16 weeks and interceptive treatment (relapse management and renewal following previous withdrawal treatment) 10 weeks. In addition, adaptation treatment from eleven to twelve weeks is possible. Furthermore, treatment combined with all-day outpatient and/or outpatient rehabilitation while working (with varying lengths of the inpatient module) is possible. Extending or shortening the duration of inpatient rehabilitation can be applied in case of existing medical necessity and/or negative prognosis within the framework of the reference values provided to the facilities (time budget) (DRV 2010a).

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[132] In the case of immediate treatment, such as the "Therapie sofort (Immediate Treatment)" programme of the emergency drug services in Berlin, the offering cannot always comply with the patients' entitlement to express their wishes and make choices, due to direct transition to a treatment facility. As a result of immediate appointment, selection of a facility is determined by available bed capacity (Notdienst für Suchtmittelgefährdete und -abhängige Berlin e.V. 2012).

[133] "The service guarantee regulates first and foremost the target to be reached: functionally and regionally required rehabilitation services and facilities must be available in sufficient number and quality. Which rehabilitation services and facilities are required at all, how their number and quality are to be measured and how the professionalism and regional presence are to be arranged is not defined. However, this can be specifically deduced from the requirements resulting from the type, scope, quality and other requirements of services for participation" (Welti et al. 2007).

Number of facilities and beds

In Germany there are approx. 320 facilities with over 13,200 beds offering full inpatient rehabilitation services for people with substance-related disorders (Table 11.1) (Pfeiffer-Gerschel et al. 2011). In addition, there are at least 7,500 beds available in about 300 specialised hospital wards. There are also about 300 inpatient psychiatric facilities dealing with addiction in which about 220,000 patients suffering from dependency are treated throughout the course of a year (Pfeiffer-Gerschel et al. 2011).

Table 11.1 Overview of inpatient addiction services offers

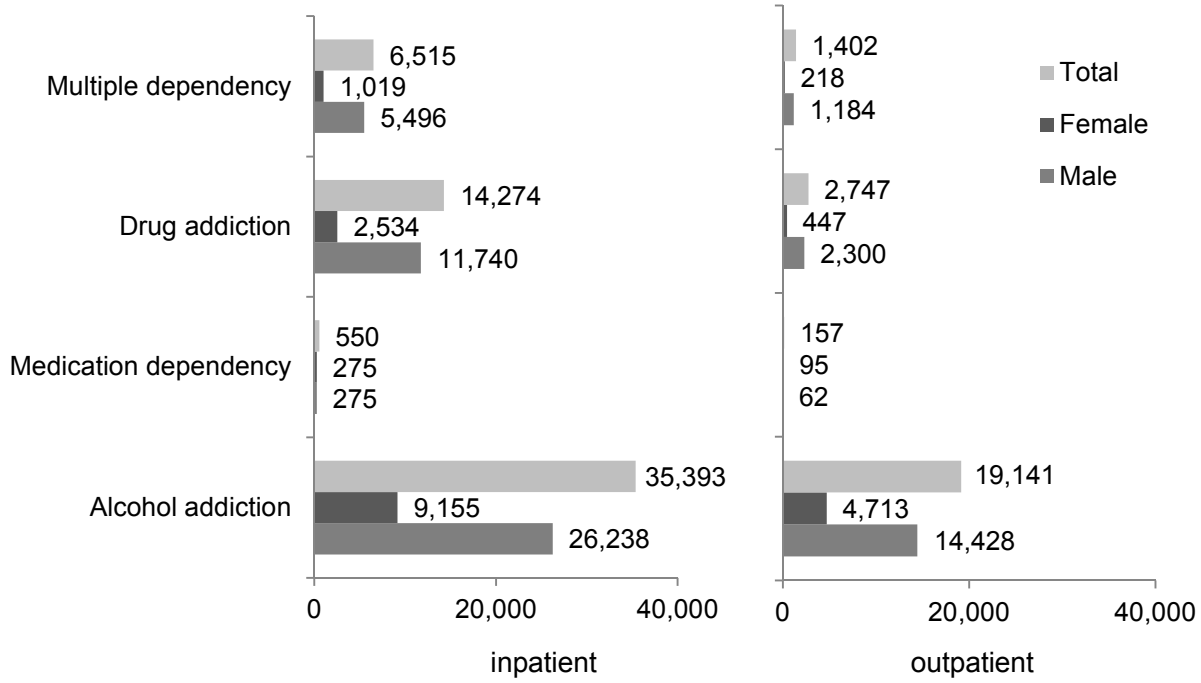
Type of facility	Number	Beds
Full inpatient withdrawal treatment facilities	>320	>13,200
→ including for drug users*		4,000*
Semi-inpatient withdrawal treatment facilities	>100	>1,000
Adaptation facilities	>115	>1,200
Social therapy facilities		
→inpatient	268	>10,700
→semi-inpatient	112	>1,200
Assisted living*	275*	7,500*
→including for drug users*	80*	2,750*
Inpatient psychiatric facilities for addictions	approx. 300	n/a

*Information pursuant to country summaries on the situation in the field of drug abuse 1998 to 2004 and forward projections by J. Leune quoted in Fachverband Sucht e.V. 2011.

Pfeiffer-Gerschel et al. 2011.

Based on the data of the Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS), Hildebrand and colleagues (2009) reported estimates for response ratios of outpatient and inpatient addiction treatment facilities. Between 45% and 60% of the estimated people who harmfully use or have a dependency on opioids is reached, however only about 4% to 8% of the corresponding cannabis users (Pfeiffer-Gerschel et al. 2011).

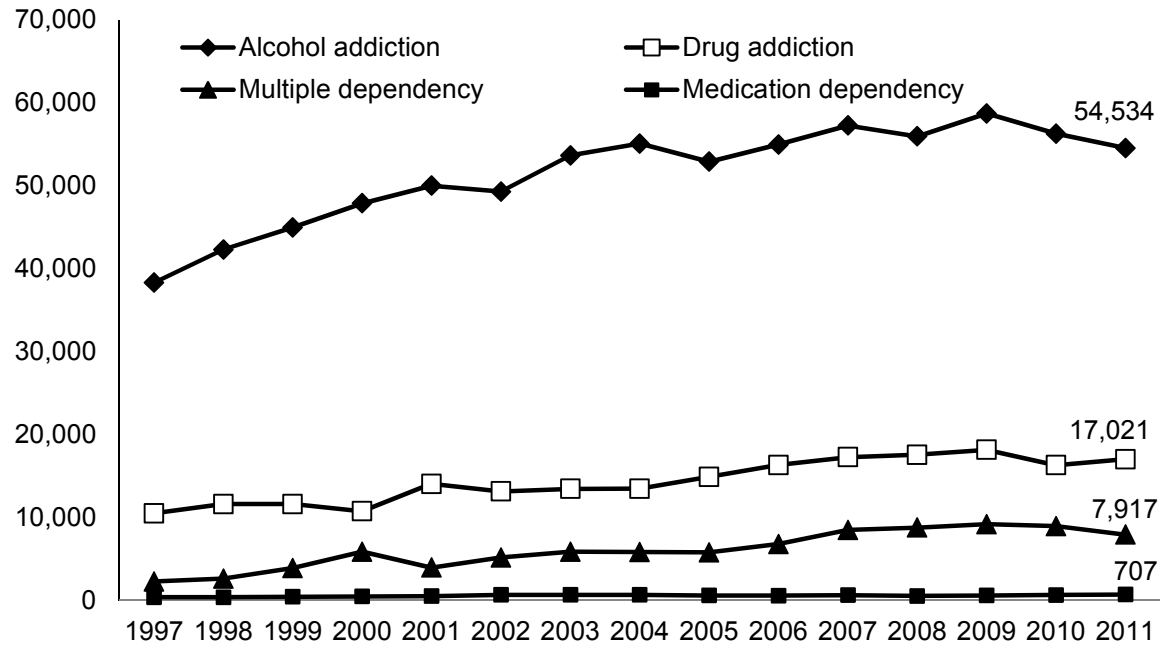
Within the framework of the facilities participating in the DSHS, the predominant share of inpatient facilities are financed by voluntary welfare agencies or other non-profit organisations with a share of 56%. 13% of inpatient facilities have a public sponsor, 3% have a commercial sponsor and 3% have a different type of sponsor (Pfeiffer-Gerschel et al. 2011). Two-thirds of the facilities participating in the DSHS also address users of illegal drugs.



DRV 2012, personal notification.

Figure 11.1 Approvals of withdrawal treatments according to the type of approved service as well as gender in 2011

In total, the number of approvals for inpatient services rose from 42,795 in 2007 by 32.6% to 56,732 approvals in 2011 (see Figure 11.1 for inpatient and outpatient approvals in 2011). The increase in approvals of outpatient services in the same period was more considerable, at 255.6% (1997: 8,653, 2011: 30,767) (DRV quoted by the Federal Government Commissioner on Narcotic Drugs 2012). In total, the number of approvals for withdrawal treatment for drug addicts between 1997 and 2011 rose by 62.2% (1997: 10,491, 2011: 17,021) (Figure 11.2).



Without integration services according to § 31 Par.1No. SGB VI with follow-up treatment followed by withdrawal treatment.

DRV-Bund quoted by Die Drogenbeauftragte der Bundesregierung 2012a.

Figure 11.2 Development of approvals for withdrawal treatment for the entire German Pension Insurance between 1997 and 2007 (itemised according to the type of dependency illness)

In 2011, the DRV-Bund provided a total of 41,733 services in inpatient withdrawal treatment, of which 27,982 were for alcohol, for the diagnostics area F10-F19 mental and behavioural disorders using psychotropic substances. Table 11.2 illustrates that approximately 47% of all services are based on polyvalent consumption. 3,404 services (24.7%) concern initial diagnoses of opioid consumption, 2,237 services (16.3%) concern cannabinoid consumption. While the average age in the F10-F19 area amounts to 40.4 years, the lowest average age in the area of illegal drugs relates to the main diagnosis of cannabinoids at 28.1 years, and the highest average age relates to sedatives/hypnotics at 44.8 years (see Table 11.2). The percentage of men who completed inpatient withdrawal treatment due to drug addiction is 83 % (DRV 2012, personal notification).

Table 11.2 Completed services provided for medical rehabilitation in the reporting year of 2011 - inpatient withdrawal treatment for adults

Main diagnosis	Services	Average age
Opioids	3404	34.8
Cannabinoids	2237	28.1
Sedatives/hypnotics	244	44.8
Cocaine	515	34.3
Stimulants	867	28.7
Hallucinogens	15	28.9
Volatile solvents	41	35.9
Multiple/other substances	6421	31.5

DRV 2012, unpublished data source.

Treatments: Psychiatry

To support the data of the DSHS and the DRV-Bund, obtaining the basic data set for addiction psychiatry can be included. The number of addiction treatments is additive due to potential overlapping with the data of DSHS or the DRV-Bund. The psychiatric addiction facilities of the psychiatric specialist clinics and psychiatric addiction wards at general hospitals and university clinics are the second major pillar for addiction care in Germany behind the facilities for consultation and rehabilitation. These facilities also conduct low-threshold qualified withdrawal treatments, however emergencies and crisis interventions are also treated and complex treatments are provided in the case of co-morbidity. In-depth diagnostics and reintegration planning are also carried out. A multi-professional team treats all types of addiction illnesses on an inpatient, part-time inpatient or outpatient basis. This guarantees all-round medical, psycho-social and psychotherapeutic treatment. Projections show that in 2010 approximately 300,000 inpatient addiction treatments took place in psychiatric clinics. This includes about 300,000 quarterly treatments that were carried out in psychiatric outpatient institutions of the clinics. 31% of inpatient psychiatric cases involved patients with dependencies. By comparison, the Federal Government performed only 150,000 treatments in facilities for internal medicine as a result of alcohol or drug addictions according to the report on health. Most patients were primarily alcohol-dependent (approx. 70 %). Disorders related to opioid consumption or consumption of multiple substances were the reason for inpatient treatment in approximately 10 to 13% in each case (DGPPN/Bundessuchtausschuss der psychiatrischen Krankenhäuser (Federal Committee for Addiction of Psychiatric Hospitals) in 2011 quoted by Die Drogenbeauftragte der Bundesregierung 2012a).

Treatments: Diagnostic statistics for hospitals

The diagnostic statistics for hospitals of the Statistisches Bundesamt (Federal Statistical Office) includes the discharge diagnoses of all patients of inpatient facilities, analogue to ICD

diagnoses (F10-F19) among others. This also involves statistics that overlap with the previously mentioned data source. Short-term treatment takes place in hospitals, for example as a result of acute intoxication. In reporting year 2010, a total of 95,844 patients with a diagnosis of addiction to illegal substances were treated in hospital on an inpatient basis (Statistisches Bundesamt 2011b; see Table 11.3). 43.2% of all acute drug cases were based on polyvalent consumption, however the declining trend of the past few years has continued (2008: 45.8 %, 2009: 43.2% An increase in acute treatment of cannabis users can be observed (2010: 8.5 %, 2009: 7.7 %). It must be assumed that in 50-80% of cases opioid consumption plays the greatest role since substance use mainly involves a combination of opioid and cocaine and/or other substances (see Pfeiffer-Gerschel et al. 2011).

Table 11.3 Patients diagnosed with addictions to illegal substances receiving inpatient care based on hospital statistics in 2010

	Hospital statistics 2010	
Main diagnosis	**Absolute**	**Percentage**
Opioids	32,538	33.9%
Cannabinoids	8,145	8.5%
Sedatives/hypnotics	9,270	9.7%
Cocaine	1,076	1.1%
Stimulants	2,805	2.9%
Hallucinogens	430	0.4%
Volatile solvents	171	0.2%
Multiple/other substances	41,449	43.2%
Total	95,884	100.0%

2011e; Statistisches Bundesamt 2011b.

11.2.2 Features of inpatient addiction treatment facilities

General approaches

Throughout the year, different treatment concepts have developed further. They are based on different theoretical foundations and are implemented in professionally run inpatient facilities. In order to guarantee quality of the facilities, uniform standards of the funding agency apply (see Chapter 3). These are located in the area of dependency illnesses, including in the “Gemeinsamer Leitfaden der Deutschen Rentenversicherung und der gesetzlichen Krankenversicherung zur Erstellung und Prüfung von Konzepten ambulanter, ganztägig ambulanter und stationärer Einrichtungen zur medizinischen Rehabilitation Abhängigkeitskranker” (“Common guidelines of the German Pension Insurance Scheme and Statutory Insurance for the Creation and Monitoring of the Concepts of Outpatient, All-day Outpatient and Inpatient Facilities for the Medical Rehabilitation of Dependency Sufferers” that came into force in 2012 (DRV 2011a). Regardless of the form of service, the same

minimum requirements apply in principle to all services for medical rehabilitation with respect to structure and quality.

A basic requirement for rehabilitation concepts are evidence-based treatment processes (e. g. in consideration of the guidelines of the Association of Scientific Medical Societies (see Chapter 3.1)), which are based on the biopsychosocial model of the International Classification of Functioning, Disability and Health (ICF). Mono-methodical use of a specific procedure did not prove successful in psychotherapy. Instead, so-called “integrative” cross-procedural therapies were utilised. This is how psychotherapy and sociotherapy are used for “psychosocial treatment” for example (Täschner et al. 2010). The most common form of psychotherapeutic measure is motivational treatment and is based on the principles of “Motivational Interviewing” (Miller & Rollnick 1999). After targeted development of motivation to change, targets and procedures are subsequently worked out. The procedure is treated as suitable particularly for drug users with minimal motivation for treatment and abstinence. Furthermore, a diversified range of measures based on behavioural therapy (including cognitive therapy, competence training, etc.) is often offered. Two focal points here are motivation according to Miller and Rollnick as well as relapse prevention (Marlatt & Gordon 1985). Furthermore, pharmacotherapy and psychotherapy are frequently linked in drug treatment. The principle holds true: no medical intervention without additional motivation (ibid.). Pharmacological treatment of opium dependency and abuse is oriented towards the guidelines of the World Federation of Societies of Biological Psychiatry (WFSBP) published in 2011 (Soyka et al. 2011a).

Excursus: The Therapeutic Community (TC)

Patients are not just “treated” in therapeutic communities. TCs are equally formed by the activity and application of patients and therapists; they are based on mutual aid and support; learning from one another and with each other is an operating principle of treatment (DHS 2008). There is only a very small number of TCs that still exists in Germany as in their original sense. They lost their monopoly on the treatment of drug addicts in the 1980s (CaSu 2007; DHS 2008).

Nevertheless, numerous specialist clinics involved with medical rehabilitation are working according to the principle of TCs. These include first and foremost the structuring of daily routines, psychodynamic procedures for promoting abstinence as well as observing specific rules for living with other drug users (Jungblut 2004 (Jungblut 2004). Medical clinics specialising in medical rehabilitation integrating the principle of the therapeutic community into their concept generally have between 25 and 50 treatment rooms and therefore belong to the smaller rehabilitation facilities (DHS 2008). TCs primarily admit young adults (including their children), who in the genesis and consequence of their dependency illness frequently are affected by profound personality disorders, serious deficits in development, distinct tendencies towards neglect and partially heavy strains in their history such as massive violence, being uprooted or forced prostitution. The concepts of specialist clinics are involved in quality assurance programmes and are recognised by the leading funding agencies.

However, facilities that invoke the operating principle of the TCs fear for their economic existence due to the shortening of treatment times, capping of standard rates or budgeting of time quotas (CaSu 2007). A statistic of specialist clinics that are specifically based on the operating principle of TCs is not available due to the low number of cases. The numbers on beds and yearly clients are even harder to determine since in some communities those affected spend their entire lives there (e. g. Synanon[134] in Berlin).

Integration of programmes

Significant components of drug treatment

The significant components of rehabilitation are described below. This description is oriented towards the Common Guidelines of the German Pension Insurance Scheme and Statutory Insurance for the Creation and Monitoring of the Concepts of Outpatient, All-day Outpatient and Inpatient Facilities for the Medical Rehabilitation of Dependency Sufferers from 23.09.2011 (DRV 2011a). There are comments on the following components:

- Admission procedures
- Rehabilitation diagnostics
- Medical treatment/rehabilitation
- Psychotherapy-oriented individual and group discussions
- Work-related interventions
- Sport and exercise therapy, relaxation therapy
- Leisure activities
- Social service
- Health education/health training and nutrition
- Care provided by family members
- Relapse management

An examination by a specialist and the *initial diagnosis* including documentation are carried out on the day of admission. The time and form of institutionalisation of the person undergoing rehabilitation are also determined on the first day (DRV 2011a).

Rehabilitation diagnostics are the basis for creating an individual rehabilitation and treatment plan. Various instruments are used here, for example, screening procedures, checklists or structured and standardised interviews (e. g. the “Action Severity Index” (EuropASI)). These are used at the start, throughout the duration and completion of medical rehabilitation and cover the present disorders, resources and possible potential for change. The diagnosis has a biopsychosocial aim and is oriented according to the ICF (DRV 2011a).

[134] www.synanon-aktuell.de

Medical rehabilitation/treatment is exclusively carried out at facilities with multi-professional teams. The facilities are under the responsibility and supervision of physicians. Health-promoting measures, physiotherapy, and smoking cessation expand the spectrum of medical services (DRV 2011a). Detoxification is not included in the services of a withdrawal treatment facility of the DRV. This is carried out in addiction-specific specialist wards in hospitals or psychiatric facilities. Although drug addicts generally should lead abstinent lives from the time they are admitted to withdrawal treatment, emergency treatment cannot be ruled out. Treating *comorbidities* is a further component. Hepatitis particularly caused by viral infections is the classical consequence of intravenous drug use that is treated in withdrawal treatment. The guidelines of the Deutsche Gesellschaft für Suchtmedizin (German Society for Addiction Medicine) (DGS e.V) published in 2006 provide orientation in the treatment of hepatitis C (DGS e. V.) (Backmund et al. 2006) published in 2006 provide orientation in the treatment of hepatitis C as well as the S3 guidelines revised in 2010 by the Deutsche Gesellschaft für Verdauungs- und Stoffwechselkrankheiten e.V. (German Society for Digestive and Metabolic Disorders) (DGVS) (Sarrazin et al. 2010). Treatment for Human Immunodeficiency Virus (HIV) and sexually transmitted diseases is also the rule at inpatient facilities for drug treatment. An additional overview of the differentiated forms of treatment is provided by Täschner et al. (2010).

Psychotherapy-oriented individual and group discussions are core components of withdrawal treatment on the basis of scientifically substantiated psychotherapy methods. As a general rule, the combination of individual and group discussions is provided for. The arrangement of the groups depends on the needs of those undergoing rehabilitation and the therapy concept. A therapeutic member is essentially responsible for a group whereby it must be made guaranteed prior to arrangement that the therapeutic member will be substituted if on holiday or in case of illness (so-called “co-therapy system”). The size of the group is 6 to 8 people undergoing rehabilitation for drug addiction. Group discussions last about 100 minutes, individual discussions normally last 50 minutes (DRV 2011a). Furthermore, gender-specific or otherwise specific group therapies are offered.

Work-related interventions are a significant component of medical rehabilitation. They are used for professional orientation and re-integration, which demonstrably represent a stabilising factor for enduring abstinence in the case of dependency illnesses and minimise the “risk of illness-related relapse”. Work-related interventions for drug addicts focus more strongly on the practice of basic competences before additional services are introduced, whereas professional education and specific professional experience are often present in the case of alcoholics and the advancement of professional reintegration is in the foreground.

Within the framework of overall responsibility of the medical and therapeutic management of treatment, the occupational therapy department of a facility is responsible for the occupational therapy that has been adjusted to the limitations, is able to support patients and has been determined within treatment management. Apart from the qualitative aspects such as diagnostics/recording of findings (supported by standardised procedures, such as “Merkmalprofile zur Eingliederung Leistungsgewandelter und Behinderter in Arbeit (MELBA)

("Feature profiles for integration of underperforming and disabled persons"), the quantitative level (duration, intensity, context) is also relevant for assuring the success of rehabilitation and supporting further target levels (improvement of symptoms on a psychosocial and somatic level, increasing awareness and insight into the disease) (Hylla & Peter-Höhner 2010). Work-related interventions include occupational therapy, ergotherapy, occupational/crafts therapy and employment-integration measures.

People undergoing rehabilitation with mental disorders, physical or mental disabilities are introduced to the basic requirements of working life as part of their *occupational therapy*. Also system-maintaining services for the facility, such as activities in the kitchen, dining area and housekeeping or repairs are partially, though not exclusively, part of occupational therapy measures (DRV 2011a). The use of occupational therapy is not mandatory. Work-related interventions can also take place through occupational integration measures such as stress tests, practical training, employment and in training or PC training courses. This also includes for example the "Problem-solving at the workplace" module in which behavioural strategies are put to the test in order to maintain employment and in order to learn and test competences for dealing with authorities, criticism, excess and insufficient workloads and in communicating.

Occupational participation: Exemplary models

The "accompanied rehabilitation" model project is directed towards people dependent on alcohol, medications and drugs with employment-related problems. Since 2007, the DRV in Rhineland Palatinate has involved 16 specialist clinics in Rhineland Palatinate and Saarland in the project. Dependency sufferers, who have been unemployed for a long time or whose professional histories are greatly disturbed and have gone through withdrawal treatment without sustained success or have not entered authorised withdrawal treatment, are assigned a rehabilitation case worker even before rehabilitation services are performed. A personal integration plan is worked out together with the case worker. This plan will then be implemented step by step accompanied by continuous monitoring. Monitoring includes targeted interventions in order to strengthen the affected person and to motivate them to use all aids until occupational reintegration. This should not only motivate those undergoing rehabilitation to enter withdrawal treatment but also contribute to guaranteeing the success of rehabilitation. This programme provides good support for the majority of those insured (Die Drogenbeauftragte der Bundesregierung 2012a).

The DRV in Rhineland Palatinate together with specialist clinics for dependency sufferers offers a specific assessment in the Southern Palatinate region. The Berufsorientierungscenter für die Rehabilitation und Integration Suchtkranker (BORIS) (Career Guidance Centre for Rehabilitation and Integration of Dependency Sufferers) addresses people undergoing rehabilitation for alcohol, prescriptions and narcotics whose employment history is seriously impaired. As long as they are in withdrawal treatment for at least eight weeks and are sufficiently motivated, a one-day stay at a career guidance centre can be made possible. To supplement the routine and standard diagnostics in specialist

clinics, work related assessment procedures and role-playing with video recordings are carried out. Standardised behavioural testing of social and communicative behaviour displays how the person behaves in daily work situations. Every year about 150 people undergoing rehabilitation take part in the project (ibid.).

"Step by step" is a project for the advancement of reintegration of people with problematic drug consumption on the general job market. The project is led by the Baden-Württembergischer Landesverband für Prävention und Rehabilitation gGmbH (Baden-Wurttemberg association for prevention and rehabilitation) (bwlv) and the Fischer-Haus specialist clinic. It is financed through the European Social Fund (ESF) and the Job Centre of the Rastatt region and the city of Baden-Baden. The target group are people receiving social security benefits (SGB II) (Basic security for people seeking employment) with placement handicaps for the general job market due to problematic substance use. The project aims to improve the reintegration of such persons into the general job market and to help stabilise their mental and physical health. Companies in the surrounding area that offer placement positions are significant cooperative partners. The concept involves the qualification of case managers/job centres, special psychosocial and occupational incentive measures for those affected (tiered programme), the inclusion of the existing "Übungswerkstatt (Exercise Workshop)" project by the Fischer-Haus and the mediation/acceptance into an employment relationship or an upstream rehabilitation measure. The initial experience shows that the dropout rate is low because of the low-threshold approach. On the other hand, a large part of the assigned clients cannot be entered into placement training promptly or at all since other primarily aids are indicated in part (e.g. inpatient treatment) or longer motivation and relationship activities are required. The high synergetic effects are underscored through direct co-operation between job centres and addiction support (Höhner 2012).

The aim of *ergotherapy* is to improve lost or still-unavailable physical, mental or psychological functions using appropriate measures in co-operation with other occupational groups. For this purpose, life skill activities, manual activities and creative processes are utilised as targeted therapeutic measures (DRV 2011a).

Playful, creative ways of handling materials and the self-awareness aspect are in the foreground of occupational and creative therapy in order to encourage expression using symbolic means. Specific topics of psychotherapy can be taken up in dealing with various materials and processed this way using a different medium (DRV 2011a).

Therapeutic exercise measures are an additional component of treatment since physical movement demonstrably improves many physical illnesses. As a result, participation-relevant aims of improved physical performance can be additionally achieved (DRV 2011a). Useful recreational activities are also part of the services for participating in social life and are decisive for maintaining abstinence as well as returning to work. People undergoing rehabilitation are encouraged to spend their free time actively and in a self-reliant manner. An appropriate qualification is required for the person running recreational activities (e. g. sports teacher or physical education instructor) (DRV 2011a).

Furthermore, treatment facilities cooperate with internal or external social services that offer accompanying help in the social environment (e. g. advice in matters of social law, measures for professional reintegration, preparation of after-care and contact with self-help groups). These co-operations are based on the joint recommendation of “Social services” (BAR 2005b).

Patient training and health education are also therapy components as the lifestyle of drug addicts is a cause of increased risk of somatic and psychological illnesses. The DRV-Bund has made available the “Promote active health” programme, which concerns the model of health promotion and offers seminars on protective factors, nutrition, exercise and stress among others (DRV 2011b).

An intact social environment is a significant prognostic factor for an abstinent life. It is essential for interventions, within the framework of working with family members, that there is a continuous relationship that requires adaptation in the view of the person undergoing rehabilitation or the therapist. This is particularly important for those undergoing rehabilitation alone. Care by family members is provided on an accompanying and supportive basis (e.g. family seminars). Proximity to home facilitates the inclusion of family members in therapeutic family care (DRV 2011a).

Relapsing or threats of relapsing are natural when dealing with dependency illness. Treatment facilities have a *relapse concept* which regulates prophylaxis and the handling of relapses. Measures include regular indication-dependent sobriety checks dependent (e. g. breath tests or ethyl glucuronide (EtG) tests) as well as prescription and illegal drug screening (DRV 2011a).

Target group-specific offers

Providing offers in the area of caring for dependency sufferers makes sense in order to allow specific topics to be processed. On the other hand, this allows employees to create competences in order to therapeutically combat special topics accordingly and to help those affected (Korsukéwitz 2010). There are a few specific inpatient offers for women, parents with children, minors or migrants. At the same time, the limits to differentiation need to be pointed out since special therapeutic services cannot be comprehensive, but rather provided only at competence centres (ibid.).

Women/ pregnant women

The DRV-Bund currently funds four inpatient facilities for drug addiction nationwide, whose treatment programmes are directed exclusively at women. Regional funding agencies fund additional facilities (Korsukéwitz 2010). Even male-specific facilities in which men's roles and their behaviours in gender-specific groups or questions are a subject of discussion have proven effective.

Parents with children

There are family therapy programmes at inpatient addiction and rehabilitation facilities for drug-using parents. In addition, seminars that promote the parenting skills of parents are

offered (as an example for offers that are directed at parents) (Pfeiffer-Gerschel et al. 2011). A good example is the specialist clinic Böddiger Berg, which offers a target-group specific programme as part of inpatient rehabilitation for drug-using parents.[135] Furthermore, the special section titled "Drogenkonsumenten mit Kindern (Abhängige Eltern und kindesbezogene Themen) (Drug users with children (Dependent Parents and Child-related topics))" of the drug and addiction report from 2011 is referenced.

Adolescents and young adults

With respect to adolescent drug users, two different help systems come into conflict with each other: youth welfare and addiction services. Interface problems or problems with financing inpatient measures result from the transition from adolescence to adulthood. According to the information of the Fachverband Drogen und Rauschmittel e.V. (Professional Association for Drugs) (fdr 2011)) youth welfare offices are increasingly refusing aid once adolescents have reached the age limit of 18. This occurs regardless of the fact that SGB VIII (Children and Youth Support) still provides a claim for first-aid services up to the age of 21 and follow-up care is guaranteed up to the age of 27. The legislator has arranged an amendment to the law here (§ 78, SGB VIII), which has the aim of establishing new age limits.

In child and youth psychiatry, inpatient post-acute treatment - the actual addiction therapy in this sense - runs for 8-10 weeks. In the case of long-term substance use, a negative environment and many pre-treatments, inpatient post-acute treatment is required as rehabilitative long-term therapy (12-18 months) in facilities specialising therein and financed by SGC V (Health Fund) and/or SGB VIII (Youth Support). If there is no social support, particularly in the case of dysfunctional families, patients can be placed in an appropriate youth welfare institution (Child and Youth Support) (Kinder- und Jugendhilfsgesetz (KJHG)) (KJHG §§ 34, 35, 35a and 41 SGB VIII) (fdr 2011).

The "Youth Addiction Network" expert's report shows an excerpt from inpatient facilities for adolescents (fdr 2011). It is a common feature for withdrawal treatment facilities (e. g. treatment stations "COME IN!" in Hamburg, "Teen Spirit Island" in Hannover, Jugendbauernhof "Freedom" in Neureichenau/Bavaria, Inizio Munich or JELLA Stuttgart) that they aim at developing maturity, identity building and reintegration into an age-appropriate social framework. This is obtained on the basis of therapeutic community, positive bonding and relationship experience, psychotherapy, combined with (curative, social and socio-) education and social programmes. The age of those supervised is between 11-18 and it can last approx. 12 months. The funding agencies are pension insurance schemes, health funds, youth and social welfare services. The youth welfare institution "Balance" in Gransee/Brandenburg is a facility that admits adolescents between the ages of 14 and 22 after detoxification treatment. The psychosocial programmes are financed by the competent youth welfare offices (§§ 34, 35a and 41 SGB VIII), and by health insurers in exceptional

[135] www.drogenhilfe.com/boeddiger_berg

cases (individual agreements) (fdr 2011). Currently the DRV-Bund is funding five inpatient specialised clinics for this group of people (Korsukéwitz 2010).

People with a migration background

Gaps in provision for people with migration backgrounds were also closed in the past few years through a variety of native-language and culturally sensitive concepts and programmes that have developed in the meantime. An example is the Landschaftsverband Westfalen-Lippe (LWL) specialist clinics in Warstein participating in the current federal pilot project "TransVer - Transkulturelle Versorgung von Suchtkranken (Transcultural Care for Addiction Sufferers). Their services are directed at drug-using migrants from Russian-speaking areas. With the help of Russian-language therapy groups, individual preparations for release and family care groups, those affected should be motivated to continue and complete treatment. At the same time, the connections to follow-up outpatient offers should be improved.

Another participant in the project is the funding agency mudra e.V., to which the treatment facility "dönus" belongs, which has existed since 1995 (mudra e.V. 2012). Drug-users from the Turkish-Oriental cultural area whose special situation as migrants is taken into account in daily therapeutic life are treated here. The team consists of native-speakers and German employees and the facility has over 22 beds. The results of the project will be presented at the end of 2012 (FOGS 2012).

Elderly persons

Studies and statistics today indicate a larger percentage of older drug users than 10 years ago. The average age has increased during this period. Alcoholics and drug addicts however are not included in the target groups in most facilities for elderly mentally ill people. In the study titled "Ältere Drogenabhängige in Deutschland (Elderly Drug Addicts in Germany)" (Vogt et al. 2010), it arose that drug and addiction services specifically target older addiction sufferers with some programmes. Nine inpatient treatment facilities in Berlin that can be used by older addiction sufferers are listed as examples (ibid.).

Complementary facilities

A long-term treatment programme is required for drug addicts with significant impairments with regard to activities and participation in particular (BAR 2005a). Social aid and programmes for providing a daily structure with the aim of having a life that is as autonomous as possible and not dependent on help are in the foreground. These aid programmes could also be taken into account for guaranteeing the success of rehabilitation as follow-up services (after-care measures, adaptation). For example, if withdrawal treatment therapy at an addiction treatment facility is insufficient in reaching the goals of rehabilitation due to the specific effects and consequences of dependency (particularly in the case of a significant risk of relapse due to homelessness and/or joblessness) when treating dependency sufferers, a test must be conducted under everyday conditions to see whether the person undergoing treatment can stand up to the requirements of working life and leading an independent lifestyle. A therapeutically indicated change of environment can be a measure for this

The adaptation phase is embedded in the medical rehabilitation system for dependency sufferers and covers the improvement in performance and strength of the person undergoing rehabilitation, support for preparation for leading an independent life as well as therapeutic services in individual and group therapy in an accompanying form that decreases in its intensity. As a general rule, the adaptation phase aligns itself seamlessly to the treatment phase (withdrawal) as a second component of medical rehabilitation services (DHS 2008).

Aftercare and adaptation facilities are either embedded in a network of inpatient addiction treatment facilities or are geographically separated facilities of inpatient addiction treatment facilities. Such care programmes are particularly available in the form of residential communities, assisted living, halfway homes and sociotherapeutic homes.

Integration of substitutions in inpatient care

As a rule, addiction rehabilitation means guiding people towards abstinence or therapy under the conditions of abstinence. Medical rehabilitation of dependency sufferers with the temporary use of methadone should be viewed as an exception. Since 2001, it has been possible to admit substituted patients to withdrawal treatment. In appendix 4 of the "dependence illnesses agreement" between health insurance companies and pension insurance companies, the Health Insurance Fund and Pension Insurance Scheme established objectives and aids to decision-making for medical rehabilitation of drug addicts at rehabilitation facilities for dependency sufferers with respect to the temporary use of a substitute substance (DRV et al. 2001b). Complete abstinence from drugs is the aim in the case of medical rehabilitation services using substitute substances as well. This also applies in reference to the substitute substance. Their use is "transitional" in this sense.

Nationally there is only a small number of inpatient programmes for substitute drug addicts. These clinics have partially established a maximum number of patients receiving substitutes while undergoing rehabilitation in order to prevent substitution from becoming the sole dominant topic (Korsukéwitz 2010). The Deutsche Rentenversicherung Bund (German Pension Insurance Association) funds two inpatient facilities in this area, namely the Psychosomatic Clinic in Bergisch Gladbach and the Specialised Facility for Psychosomatic Medicine of the Wied Clinics. Regional funding agencies fund additional facilities. In Baden-Württemberg in particular, an expansion of the programmes for this group of persons is expected since the DRV Baden-Württemberg has supported appropriate concept modifications in special facilities (Korsukéwitz 2010).

One of these for example is the SURE project (Substitutionsgestützte Rehabilitation) (substitution rehabilitation). Since January 2011, the three-year project has been carried out in the Fachklinik Drogenhilfe (Specialised Addiction Clinic) in Tübingen on an inpatient basis and in the "Tagwerk" rehabilitation facility in Stuttgart on an all-day outpatient basis. The target group are opiate addicts, who in principle are eligible for rehabilitation but cannot begin abstinence-oriented treatment without a substitute. The attempt is made for these people to reintegrate on a professional level and to participate in society and social life. The readiness to reduce dosage and abstinence is a requirement for being admitted. The substitute

substance is reduced step-by-step under the supervision of authorised substitution physicians and then discontinued entirely. The patients undergoing rehabilitation are integrated into the conventional treatment programme of both facilities. Eleven admissions were made up to February 2012, of which 5 people were still undergoing treatment, therefore only a few results can be reported. At the time of reporting, a patient had reduced dosing over eight weeks as scheduled and completed treatment normally and successfully after a total of 24 weeks (Drogenhilfe Tübingen & Tagwerk Stuttgart 2012).

Cooperation and networking

According to the SGB IX ("Rehabilitation und Teilhabe behinderter Menschen - Rehabilitation and participation of disabled persons"), rehabilitation is not a closed sector of the health care system or of an individual funding agency. The legislative authority calls for joint planning and coordination of different rehabilitation agencies, services and facilities in the interest of those affected. Therefore SGB IX stands for a new form of rendering services in the sense of comprehensive participation that goes beyond the specific demands of SGB V and SGB VI (DHS 2008). The aim is to join participation services as seamlessly as possible in order to offer aid measures that have been aligned as individually and specifically as possible to the needs and resources of those affected.[136] In its guidelines on concept assessment, (DRV 2011a) the DRV-Bund requests rehabilitation facilities to provide support through and in cooperation with companies, particularly in the areas of alcohol, prescription medication, drugs, tobacco and gambling. The DHS shows the current status and the optimal arrangement of forms of association in the document titled "Suchthilfe im regionalen Behandlungsverbund (Addiction assistance in the regional treatment association)" (DHS 2010b). Specifically the document illustrates the linking of the support segments of acute treatment, monitoring and consultation in the integrated system of addiction service, in health care and in social security as well as in the support segments for promoting participation and treatment. Selected examples for regional integrated systems give an impression of the status of implementation as well as advantages and disadvantages of regional integrated systems.

The increasing combination treatments can be named for the inpatient sector in particular. The flexible design of outpatient, all-day outpatient and inpatient treatment possibilities in the form of modules allows for customised aid programmes for dependency sufferers. Furthermore, interface problems are being reduced through closer cooperation between service providers in order to raise the effectiveness and efficiency of the measures as a result.

Combined models: Regional examples

The DRV in Braunschweig-Hannover, the DRV in Oldenburg-Bremen and the DRV Nord together have been running "Kombi-Nord", a combined treatment facility for dependency

[136] See for example the project titled 'Step by Step", Chapter 2.2.2, in which cooperation between job centres and addiction services is described.

sufferers in Northern Germany since 2009/2010. 2012 will bring an improvement whereby handover discussions will be able to take place between the facilities involved via video conference. In addition, there will be a uniform release report in the future (Federal Government Commissioner on Narcotic Drugs 2012a).

An additional model for combined treatment, the Kombi Saar, can be found in Saarland. The model by SHG Specialised Clinic for Dependency Illnesses in Tiefental and the IANUA Gesellschaft für Prävention und Sozialtherapie mbH (association for prevention and social therapy) addresses insured persons with alcohol, prescription medication and drug addictions, with the exception of heroin addicts and people participating in substitution programmes. At the start there is an outpatient preliminary talk with IANUA in order to determine whether abstinence was achieved during previous detoxification. If not, qualified detoxification measures must be initially carried out before a treatment agreement can be concluded. Combined treatment is approved as an overall service with established inpatient and outpatient phases. As a rule they should not exceed one year. Inpatient treatment takes place in the Tiefental Specialised Clinic and lasts eight weeks. During the outpatient phase, the person undergoing rehabilitation attempts to make steps towards changes and deepen them. This generally includes 80 therapy sessions (TS) as well as eight TSs for family members (ibid.).

The DRV in South Bavaria has recognised a combination therapy for cannabis dependency in the Grafrath therapy centre as a supplementary programme. Rehabilitation begins on an inpatient basis, which lasts twelve weeks as a rule. This is followed by 40 outpatient therapy units in the cooperating outpatient places of treatment (ibid.).

11.3 Quality management

11.3.1 Guidelines and standards for inpatient addiction assistance

The effort to provide medical, psychotherapy and psychosocial interventions for people with substance-related disorders at the highest level of quality possible was promoted with lasting effect by the standards of the “Recommendation agreements for addiction” from 1978.

Current foundations for providing services for inpatient medical rehabilitation are firstly the agreement titled “Dependency illnesses” (DRV et al. 2001c) Secondly, the BAR[137]work assistance for rehabilitation and participation of people with dependency illnesses is a basis for work in the inpatient addiction assistance sector (BAR 2005a). Work assistance provides an overview of the general principles and foundations for services for rehabilitation and

[137] The Bundesarbeitsgemeinschaft für Rehabilitation e.V. (Federal Working Committee for Rehabilitation) (BAR) promotes and coordinates the rehabilitation and participation of disabled persons. In accordance with the statutes, it pursues the primary target to work towards providing rehabilitation services according to the same principles for the benefit of the disabled and the chronically ill. It represents funding agencies of the statutory health insurance, statutory accident insurance, statutory pension insurance and the Federal Employment Agency. Additional members include the Federal States, the Federal Association of German Employers’ Associations, the German Trade Union Confederation, the Federal Association of Integration Offices and Main Welfare Associates, the Federal Task Force on Supra-Local Welfare Agencies as well as the National Association of Statutory Health Insurance Physicians (www.bar-frankfurt.de).

participation, substance-related disorders and dependency illnesses (incl. diagnostics, rehabilitation aims, treatment principles, indications), the arrangement and organisation of the addiction assistance system for people with dependencies, the available rehabilitation programmes and the basis for claims from a social law point of view.

An additional basic requirement of inpatient treatment facilities is the orientation of the therapy concept towards the guidelines of the Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) (Association of Scientific Medical Societies). Currently the guidelines on “Cannabis-related disorders”, “Opioid-related disorders” (Acute treatment and post-acute treatment), “Psychological and behaviour-related disorders resulting from cocaine, amphetamines, ecstasy and hallucinogens” and “Medication dependency (sedatives, hypnotics, analgesics, psychostimulants)” as well as on the substances of alcohol, tobacco are being revised (see Special section of the REITOX report 2011, Pfeiffer-Gerschel et al. 2011).

In order to guarantee uniform documentation in psychosocial counselling centres and inpatient facilities for people with substance-related disorders, eating disorders and pathological gambling behaviour, the Deutsche Kerndatensatz (KDS) (German Core Data Set) has been utilised in the current version nation-wide since January 2007 for documentation in the area of addiction help. It was created in 1998 as a common minimum statistical data set in the scope of a consensus process between many involved institutions and persons, which took place in the Fachausschuss Statistik (Trade Statistics Committee) (previously Statistik-AG) of the DHS. Since 2002, the core set of data has been determined as a nation-wide uniform data set for documenting addiction treatment by Working Group for the Statistical Report on Substance Abuse Treatment in Germany (AG Deutsche Suchthilfestatistik, AG DSHS), in which federal, *Laender*, pension insurance and statutory health insurance are represented in addition to the service providers. The data collected using the KDS of the individual facilities are sent using different software solutions in aggregated form to the Institute for Therapy Research where they are bundled and evaluated in the DSHS project funded by BMG. Significant aims of the German Addiction Statistics (Deutsche Suchthilfestatistik, DSHS) are to present and analyse the quality of the health care system, early detection of new problem areas as well as to prepare suggestions for improvement in order to optimise care for consumers with (primarily) substance-related disorders. Furthermore it is used as a monitoring system on a federal state, association and consumer level. The DSHS has developed into a recognised and highly valued monitoring instrument in the area of German addiction treatment, which also enables trend analyses of data for care research (DHS 2010a).

In order to promote cooperation among rehabilitation agencies in quality assurance, a joint declaration was made for the first time in 1999 by the association of pension, health and accident insurance companies on cooperation on quality assurance. This applies to facilities of outpatient and inpatient rehabilitation and inpatient preventative treatment. In the process, specific requirements, aims and content of external quality assurance and internal quality management were established. In accordance with § 135a SGB V, providers of preventative

services or rehabilitation measures as well as facilities with which a preventative care agreement has been signed in accordance with § 111a are obligated to do the following:

- participate in measures of quality assurance across facilities, which particularly aim at improving the quality of results and
- introduce quality management and further develop it internally.

The contents of the agreement take into account the rules of the Common Recommendation in accordance with § 20 par. 1 SGB IX. Since October 2009, a quality management procedure is mandatory for all providers of inpatient services for medical rehabilitation. To complete this statutory task, the "Vereinbarung zum internen Qualitätsmanagement nach § 20 Abs. 2a SGB IX (Agreement on internal quality management according to § 20 par. 2a SGB IX)" was worked out on the level of the Bundesarbeitsgemeinschaft für Rehabilitation (Federal Working Group for Rehabilitation) (BAR 2009), in which the fundamental requirements of a quality management procedure are regulated. Additionally, it defines a uniform, independent certification procedure.

Requirements of internal quality management (BAR 2005a)

- Participation-oriented model
- Facility concept
- Indication-specific rehabilitation concepts
- Responsibility of quality management at the facility
- Basic elements of a quality management system
- Relations with those undergoing rehabilitation/reference persons/relatives, clinicians, service providers, self-help
- Friendly management of complaints
- External quality assurance
- Internal results measurement and analysis (procedure)
- Error management
- Internal communication and personnel development

Inpatient rehabilitation facilities are required by law to conduct a quality management procedure that is recognised by the BAR. Most quality management systems (QM systems) in medical rehabilitation are based on DIN EN ISO 9001:2000 (DHS 2008). The Deutsche Gesellschaft für Qualitätsmanagement in der Suchttherapie e.V. "deQus" (German Society for Quality Management in Addiction Treatment), founded in 2001, supports addiction treatment facilities in the introduction and certification of QM (deQus 2000). The rehabilitation facility must issue a release report based on the "Leitfaden zum einheitlichen Entlassungsbericht in der medizinischen Rehabilitation der gesetzlichen

Rentenversicherung" (Guidelines on uniform release reports in medical rehabilitation of statutory pension insurance) after every service rendered for medical rehabilitation (DRV 2009). The guidelines provide information on how reporting in medical rehabilitation is to be structured in terms of content and which rules apply to social medicine documentation. Further guidelines are additionally used[138]. Extensive information on development, methods and implementation of national treatment guidelines can be found in the REITOX Report 2010 (Pfeiffer-Gerschel et al. 2010a).

The pension insurance companies' quality assurance programme for medical rehabilitation is based on a system of structure, process and results quality. The survey of persons undergoing rehabilitation, the peer-review procedure, evaluations of the rehabilitation performance data as part of the classification of therapeutic services (KTL) and the rehabilitation treatment standards for alcohol dependency are part of the practiced procedure of rehabilitation quality assurance (DRV 2012a; Klosterhuis et al. 2011). Rehabilitation quality assurance of pension insurance is initially supported by routine data, which are documented during the application process, decision-making and implementation of rehabilitation measures. Features such as age, gender, severity of addiction and social situation are fundamental for assessing the person undergoing rehabilitation. (Klosterhuis et al. 2011). The continuous survey of persons undergoing rehabilitation concerns the satisfaction of rehabilitation patients with treatments and consultations carried out as well as the assessment of the success of rehabilitation from the patient's point of view (ibid.). The figures are calculated according to the principle of optimum quality (=100 quality points). In the process, the individual results are converted to quality points. In 2011, 76% of all patients undergoing rehabilitation with dependency illnesses rated the rehabilitation measures carried out as successful on average, which consequently corresponds to 76 of 100 quality points. 74 quality points were achieved for satisfaction by patients undergoing rehabilitation, which corresponds to an average mark of "2" on a scale of "1" (very good) to "5" (bad). In the assessment of individual rehabilitation processes in the peer-review procedure, the addiction facilities received 74 quality points in 2011, which corresponds to the results of the previous year (DRV quoted by the Federal Government Commissioner on Narcotic Drugs 2012a). Furthermore, the therapeutic range of services is rated and compared by evaluating the routine documentation of the treatments performed according to the release reports. Looking at the services provided by 66 addiction treatment facilities, you get an average of 74 out of 100 possible quality points. The best facility had 82 and the worst 68 quality points (ibid.).

Personnel

Only professionals with relevant training can work in addiction treatment. The German Pension Insurance enacted guidelines on advanced training of professionals for individual and group therapy within the framework of medical rehabilitation of addiction sufferers, in which advanced training courses can receive a "recommendation for recognition". As part of restructuring the education system in Germany according to European guidelines

[138] Clear presentation found at http://www.suchthilfe.de/themen/basis.php.

(introducing Master's and Bachelor's degrees at universities and colleges) the requirements for therapeutic employees of addiction support are also defined and designed anew. Postgraduate educations play a particularly important role when redesigning training courses for social workers, psychologists and physicians. Cooperation between different professional groups from social work/education, psychology, psychiatry and other fields of medicine is one of the significant standards of treatment when dealing with drug addiction (Pfeiffer-Gerschel et al. 2011).

The description of the establishment plan of the DRV-Bund is largely based on the "Abhängigkeitserkrankungen" (Dependency Illnesses) agreement (DRV et al. 2001c), which stipulates different group sizes in psychotherapy for people dependent on alcohol, prescription drugs and those dependent on illegal drugs. A therapist with suitable qualifications should be available for group and individual therapy for drug addicts with 6 to 8 patients each (either physician, psychotherapist, social worker/educator or ergotherapist). Furthermore, additional generally-active therapists should be available in sufficient numbers including medical personnel if necessary (ibid.). Personnel assessment is generally directed at the latest structural requirements. It is individually established in connection with the therapy concept of treatment facilities (DRV 2010a).

When comparing across indications, it makes sense to refer employee numbers to a uniform number of patients undergoing rehabilitation. With respect to personnel assessment, the DRV-Bund has selected such a ratio where the number of employees required for a facility with an average occupancy of 100 rehabilitation patients is listed (DRV 2010b). The specifics of smaller ward sizes must be taken into account precisely for facilities dealing with dependency illnesses. Table 11.4 brings together the required professional groups in function groups in order to make meeting personnel requirements more flexible. Assessment of the number of required employees takes place on the level of function groups. In this respect, it should be noted, particularly in the case of dependency illnesses, that graduate social educators and workers in addition to physicians and graduate psychologists could also be employed on a psychotherapeutic or addiction treatment level as long as they also have completed recognised additional therapeutic training. The group of social workers, however, is also responsible for the duties part of clinical social work.

Table 11.4 Personnel requirements – Number / 100 people in rehabilitation

	Dependency illnesses			
	Alcohol / prescription medication		Illegal drugs	
Professional groups	**Number / 100**	**Functional group**	**Number / 100**	**Functional group**
Physicians	3	3	3	3
Graduate psychologists	5		5	
Graduate social workers / graduate social ed. pedagogues	5*	10	9*	14
Care workers	6	6	6	6
Physiotherapists				
Graduate phys. ed. teachers	2.5	2.5	2.5	2.5
Phys. ed. teachers / Gymnastics teachers				
Diet assistants / Ecotrophologists	0.5	0.5	0.5	0.5
Ergotherapists				
Occupational therapists				
Vocational therapists	4.5	4.5	4.5	4.5
Creative therapists				
Gestalt therapists, art therapists				

* including 1 graduate social worker for clinical social work.

abridged according to DRV 2010b, p. 21.

Regular advanced training of employees must be guaranteed according to the requirements of the “Dependency illnesses” agreement from 2001 (see appendix 1, number 7, attachment 2 number 8). Facilities that are public and non-profit organisations are generally bound to the respective tariff schemes. The Working Hours Act must also be taken into consideration when organising the employment of staff. Employment costs are 70% of the total costs of a specialised addiction clinic. In the past few years it has become more and more difficult to occupy positions at facilities due to the lack of skilled professionals and the strict requirements of funding agencies. The situation with respect to this and to physicians is problematic, and especially for small facilities (DHS 2008). The problem concerns assistant and medical specialist positions as well as medical director positions.

Link between funding and effect

Particularly in times of limited resources, funding agencies demand quality certificates from facilities. Nonetheless, there are only a few evaluation studies available on the issue examining the extent to which the measures of inpatient rehabilitation contribute to

abstinence and social and professional integration of drug addicts. Catamnestic studies show a limited response rate due to a lack of agreement to participation in follow-up reports, invalid addresses of the patients listed or because of people who refuse, people who are unavailable or have died or patients who are incapable of being interviewed. Fischer et al. (2007a, b) examined two abstinence-oriented drug rehabilitation facilities in Rhineland-Palatinate within the drug catamnesis research project in a prospective study. Among the 429 patients involved, data was gathered at four measurement times (Start/end of treatment, 6 and 12-month follow-up history). The rate of response for the 6-month follow-up history was 55.3% and 41.5% for the 12-month follow-up history. Due to methodical difficulties, "success records" hover between conservative and optimistic. If one were to follow conservative estimates in this study, the rate of success hovers between 21.5% and 25%. Optimistic estimates are between 41% and 55%. Sonntag und Künzel (2000) documented a response rate between 30% and 60% as well as abstinence rates between 23% and 37% for 12-month follow-up histories in their review of different catamnesis studies. They state that approx. one quarter of drug addicts remain abstinent one year after their inpatient treatment (ibid.). Overall, treating drug addicts is more successful catamnestically if the end of treatment goes according to plan, the length of treatment is 16 weeks, patients undergo treatment voluntarily and display a rather short length of dependency of a maximum of 10 years. Other beneficial factors include being female and a rather young age when entering treatment (Fischer et al. 2007b).

Studies on cost-effectiveness with respect to illegal drugs are rare in Germany. As part of the German model project on heroin-assisted treatment of opiate addicts,[139] general information on treatment costs was also gathered in the accompanying research in addition to the specific costs and benefits of heroin-assisted treatment (v.d.Schulenburg & Claes 2006). The costs of drug treatment, outpatient and inpatient (psychiatric) treatments per week are listed in Table 11.5. These are fundamentally applicable not only to the project itself, but toward the addiction support system in general. Inpatient drug-free treatment is estimated at €3,047 per patient per week, staying at a therapeutic community is listed at €700 and €1,048 for psychiatric clinics. Most of the information is based on estimates or calculations using secondary data (e. g. DSHS, Bundesarbeitsgemeinschaft der Träger psychiatrischer Krankenhäuser (Federal Working Committee for Psychiatric Hospital Agencies). The percentages for staff or material costs cannot be estimated.

[139] The German Federal Model Project on heroin prescription deals with a scientific drug investigation study that took place between 2002 and 2004 in seven cities with a total of 1,015 study participants. As part of this, serious addicts received injectable heroin as medication. A control group received the replacement drug in parallel.

Table 11.5 Costs of various treatments per week

	Costs of treatment per week
Outpatient detoxification treatment	€ 32
Inpatient detoxification	€ 2,469
Outpatient substitution (without costs of the substitute)	€ 32
Psychosocial monitoring	€ 37
Outpatient drug-free treatment	€ 52
Inpatient drug-free treatment	€ 3,047
Therapeutic community (complementary)	€ 700
Day clinic	€ 700
Psychiatric clinic	€ 1,048
Outpatient psychiatric clinic (complementary)	€ 50
Other clinics/stations	€ 3,047
Other treatment	€ 700

v.d.Schulenburg & Claes 2006.

11.4 Discussion and outlook

Inpatient treatment of drug addicts is a significant component of the differentiated and effective addiction support system in Germany. Not only scientific results and experience-oriented knowledge based on practice have led to continuous further development, modification and innovation of service programmes. Also, increasing economisation and rationalisation entail expanded organisational requirements for inpatient facilities for drug addicts (DHS 2008). Finally, the effects of demographic change lead to challenges for inpatient addiction treatment.

From the point of view of the DRV-Bund, the question arises with great urgency as to how the few resources can be applied with greater efficiency and even better individual accuracy (Hebrant 2011). It is stressed that despite the general scarcity of financial resources, the DRV-Bund's policy of "no rehabilitation based on cash situation!" still remains and therefore every application is reviewed according to the guidelines and no reduction in the approval rate can be seen (Hebrant 2011). Nevertheless, experts are talking about a "financial crisis for rehabilitation" (Koch 2011). Professional addiction associations warn that the addiction rehabilitation system is coming under massive pressure (see buss et al. 2011). The resources for medical rehabilitation are scarce due to the capped budget for rehabilitation of the German Pension Insurance Scheme and the implementation of austerity measures. The effects of the austerity measures are visible in the decision titled "Anpassung und Harmonisierung der Richtwerte für die Verweildauern (Adjustment and harmonisation of the reference values for length of stay" of 21 September.2010 (Koch 2011)). As part of these austerity measures, the tendency to shorten the length of stay for inpatient facilities treating drug addictions or increasing outpatient or combined treatments as well as stricter controls

for approving rehabilitation measures is becoming evident (Koch 2011; Zellner 2011). As a result, specialised clinics in particular that work according to the principle of therapeutic communities have been placed in a precarious situation (DHS 2008). In the past few years it has become clear that the budgetary situation for rehabilitation remains tense and no clear relief is expected in the coming years. Increasing the budget for rehabilitation is advocated by many sides, however it seems unlikely that the legal framework will be changed in the near future (Koch 2011).

Improved flexibility in the programme structure becomes evident primarily in the expansion of part-time inpatient and outpatient treatment programmes. Starting in 2012, the DRV-Bund has allowed patients undergoing rehabilitation to switch from inpatient to all-day outpatient facilities in their proximity as a so-called “extended all-day outpatient release form”. Previously this was possible only in individual cases if the insured person happened to be living close to the respective inpatient rehabilitation facility (Hebrant 2011). Four of the 35 all-day outpatient rehabilitation facilities funded by the DRV-Bund (Status as of: February 2010) are exclusively specialised in rehabilitation of drug addicts, 22 treat only alcohol and prescription medication dependency and seven rehabilitate all three indications together (Korsukéwitz 2010). A regular combination of inpatient and all-day outpatient rehabilitation is targeted as an alternative and supplement for the market (Hebrant 2011). The definition of short-term and long-term treatment is thus broken down and the length of treatment is made more flexible.

The Kombi-Nord model represents good practice. The previous model for combination treatment “inpatient/outpatient” provides only an inpatient start to the procedure in principle. Flexible handling of outpatient and inpatient elements that allows for need-based entry into and transfer between rehabilitation treatments is needed (DHS 2008).

The fact that patients with increasingly worse health conditions are entering inpatient rehabilitation must be taken into account (Fachverband Sucht e.V. 2012). Furthermore, it is also clear that the detoxification phase has become significantly shorter due to the flat-rate system and austerity measures. Patients cannot be motivated sufficiently in such a short time span of the detoxification phase and prepared for inpatient withdrawal treatment. As a result, the withdrawal phase is more difficult or the cost of care increases (Fachverband Sucht e.V. 2012; Zellner 2011). Seamless integration between acute care and rehabilitation facilities is important to avoid a possible "revolving door" effect in the field of detoxification. However, the time after rehabilitation must not be ignored in the networking structure. Rehabilitation after-care as well as the inclusion in a self-help group, assist in securing sustained success of the treatment (DHS 2008).

The on-going development of quality assurance and review of effectiveness, particularly against the background of scarce financial means will continue to remain a central topic in inpatient addiction treatment. The significance of certifications will increase due to legal requirements. This leads to significant improvement of treatment quality (DHS 2008). The use of new technologies will also enter the field of rehabilitation treatment (Fachverband Sucht e.V. 2012). This includes for example online applications, improved data exchange or

clinic information systems. However, sufficient and above all qualified staff must be available for this. Since neither fair or customary salaries can be paid using grants, allowances or cost rates, there are signs of a lack of skilled professionals in all professional groups for addiction treatment (Leune 2012). The situation appears problematic especially in the case of physicians particularly in this respect and for small facilities (DHS 2008).

Work-related measures are an indispensable component of rehabilitation with the aim of restoring the ability to work. More attention will also have to be paid in the future so that professional rehabilitation services for the transition to working life is secured during and at the end of medical rehabilitation for the transition to working life (DHS 2008). Finally, even more intensive cooperation is required between individual treatment facilities and companies that take SGB IX into account due to the increasing flexibilisation and differentiation of services.

The observation and analysis of trends and changes among clientele is of great importance for the development of the programmes. The total population of addicts portrays an increasingly heterogeneous image: people with multiple dependencies or additionally diagnosed with psychiatric disorders, people with a migration background, the homeless or the long-term unemployed (DHS 2008). The consumption of multiple psychoactive substances in particular is more frequently described as “normal” (Zellner 2011). In the case of drug addictions, double diagnoses can be seen in up to 70% of cases depending on the examination (DHS 2008). A tendency can be observed whereby the leading diagnosis for multiple dependencies turns the balance and decides on the patient’s allocation, appearing as a result as the only diagnosis statistically (Hebrant 2011). Depending on the severity of the disorder, different requirements arise for the profile of the rehabilitation facilities, such as the treatment of lesser comorbid disorders, combined treatment or specialised treatment with a particular focus on the comorbid disorder (DHS 2008). In addition, the size of the facility must be adjusted to the needs of the clientele. Longer duration of treatment must be made possible particularly in individual cases. A modified cost structure arises from this even with respect to equipment. Patients with comorbidities require not only a specially qualified staff, but oftentimes higher expenditures on supplies (medication) as well (DHS 2008). Rehabilitation and the measures used in individual cases will be increasingly adapted to individual needs and person-related aims with respect to the type, compactness and scheduling of services (DHS 2008).