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Treatment

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Contents

0 Summary (T0)

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

41.5% of outpatient clients who visit addiction counselling facilities due to a drug problem are cannabis users (54.6% of first time clients). One third of outpatients are treated for harmful opioid use (32.2%). 16% of all patients submit themselves to treatment due to stimulant use.

The proportion of cannabis and stimulant users among clients in inpatient treatment also continues to grow. Over the last 5 years, the number of people who admitted themselves to inpatient hospital treatment due to simulant use has increased by 264%, followed by cocaine and cannabis users' hospital admissions, which have each more than doubled. The proportion of those who seek inpatient treatment due to opiate use, however, is continuously falling.

From 2002, when reporting became obligatory, the number of substitution patients reported continuously increased until 2010. In recent years the number has remained largely stable. On the reporting date (1 July 2016), the number was 78,500. A total of 2,590 doctors providing substitution treatment reported patients to the substitution register in 2016.

Due to regional increases in methamphetamine use in recent years, the need for qualified specific treatment has also increased. For this reason, the German Medical Association (Bundesärztekammer, BÄK) and addiction societies, supported by the German Federal Ministry of Health (Bundesministerium für Gesundheit, BMG) and the German Federal Government Commissioner on Narcotic Drugs publish S3 treatment guidelines under the title "Methamphetamine-related disorders".

In the context of the migration and refugee issue, questions are still being raised as to the prevalence of use of addictive substances and refugees' support needs, as well as suitable treatment options for persons with migration backgrounds. In spite of many new measures, there are still numerous barriers which prevent migrants from making use of addiction support.

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

With the German Act Amending the Narcotics Regulations and Other Provisions (Gesetz zur Änderung betäubungsmittelrechtlicher und anderer Vorschriften), which came into force on

10 March 2017, the possibilities for prescribing cannabis-based pharmaceuticals were expanded. The German Federal Institute for Drugs and Medical Devices (Bundesinstitut für Arzneimittel und Medizinprodukte, BfArM), which has been commissioned to carry out non-interventional data collection on the use of cannabis-based pharmaceuticals, is assessing how treatment, for example, of patients suffering from pain, will be changed through Cannabis as medicine.

Falling application numbers for medical rehabilitation treatments have prompted service providers and funding agencies to develop joint solutions to simplify the procedure for referring into inpatient treatment and thus facilitate clients' admission to therapy.

National and international studies show a high prevalence of psychiatric comorbidity for addiction disorders. Only around 37% of those treated in Germany for drug addiction and 33% of those with multiple substance use reported no further psychiatric comorbidity, according to the health insurance providers' data.

1 National profile (T1)

1.1 Policies and coordination (T1.1)

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

The National Strategy on Drug and Addiction Policy, announced in 2012 by the Federal Government Commissioner on Narcotic Drugs (Drogenbeauftragte der Bundesregierung) at the time, and which is still in effect, places a particular focus on addiction prevention and early intervention but also stresses the necessity of counselling and treatment services in Germany (Drogenbeauftragte der Bundesregierung 2012).

In the current Drug and Addiction Report (Drogen- und Suchtbericht), the German Drugs Commissioner named crystal meth and new psychoactive substances (NPS) as a focus of her work in the current legislative period (Drogenbeauftragte der Bundesregierung, 2016). In addition, children of addicts play an important role in drug policy. The Associations of Addiction Professionals (Bundesärztekammer, BÄK) and the German Society for Psychiatry, Psychotherapy and Neuropsychiatry (Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde, DGPPN) developed, with support from the Drugs Commissioner and the BMG, S3 guidelines in 2016 for the treatment of methamphetamine-related disorders (Drogenbeauftragte et al. 2016). It came into force in 2016. Furthermore, the German Federal Cabinet (Bundeskabinett) concluded the Third Amending Regulation of the German Regulation on the Prescription of Narcotic Drugs (3. Verordnung zur Änderung der Betäubungsmittelverschreibungsverordnung, BtMVVÄndV) (BMG 2017). It regulates the legal requirements for providing substitution treatment to people who have become dependent through their misuse of opioids. The development of an evidence-based guideline to implement substitution therapy was assigned to the authority of the BÄK. The amendment of the German Regulation on the Prescription of Narcotic Drugs

and the new guidelines have come into force as from 2 October 2017 (c.f. Legal Framework workbook). The German New Psychoactive Substances Act (Neue-psychoaktive-Stoffe-Gesetz, NpSG) came into force on 26 November 2016 (BMJV 21 November 2016). It provides for a far-reaching ban on purchasing, possessing and dealing NPS and the imposition of criminal penalties for supplying NPS to others (c.f. Legal Framework workbook).

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

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

The federal ministries, particularly the BMG, fulfil a cross-departmental and cross-institutional coordinating role at a federal level. They prepare and amend federal laws (e.g. the narcotics law and the social welfare legislation, which also affect treatment). Other than that, the BMG, just like the Federal Drugs Commissioner, can only issue recommendations to the *Laender* and responsible institutions.

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

The municipalities are involved in the governance of acute treatment within the scope of hospital planning. Furthermore, they support the funding of counselling facilities, which as a rule are provided by non-profit organisations contributing high levels of their own resources. Substitution treatment is a service provided by the statutory health insurance providers. The BÄK plays a leading role in this context because the development of medical guidelines for substitution treatment is assigned to its authority, subject to the German Regulation on the Prescription of Narcotic Drugs (Betäubungsmittelverschreibungsverordnung, BtMVV). The standards for psychosocial care (PSC) provided as a complement to substitution treatment are developed by the relevant service providers in the *Laender*, in consultation with the municipalities or *Laender*. The funding for PSC is dealt with in varying ways by the *Laender*,

however funding usually comes from the municipalities, either as a flat rate support for counselling facilities in the scope of the municipal services of general interest or as individual support in the scope of integration support (German Code of Social Law, Sozialgesetzbuch, Volume 12 (SGB XII)).

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

Information on the organisation and governance of treatment in the scope of the penal system can be found in the Prison workbook. The political foundations and organisation of harm reduction measures are explained in the Harms and Harm Reduction workbook.

A detailed description of the addiction care system in Germany, its legal basis, qualities and challenges can be found in the DHS's Addiction Yearbook 2017 (Jahrbuch Sucht) (Bartsch 2017)

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

The legal basis for the treatment of those with dependency disorders is provided in Germany by various German Codes of Social Law (Sozialgesetzbücher, SGB), the German Public Health Service Act (Gesetz über den öffentlichen Gesundheitsdienst, ÖGDG) as well as the municipal services of general interest. The latter is anchored in constitutional law in the Social State Principle (Sozialstaatsprinzip) as per Art. 20 (1) German Constitution (Bürkle & Harter 2011). As far as the law governing the provision of care is concerned, the following Codes of Social Law are relevant to the treatment of dependence disorders:

- SGB II: basic social protection for job seekers - support in taking up or maintaining employment and securing their livelihood
- SGB III: employment support
- SGB V and VI: statutory health and pension insurance - treatment of illness; rehabilitation to re-establish the ability to work
- SGB VIII: child and youth support
- SGB IX: Rehabilitation and participation of disabled people - self-determination and equal participation
- SGB XII: social welfare - living a life with human dignity

Dependent persons can use this support for the most part free of charge, however in some cases approval for costs is required from the social funding agencies defined in the German social laws. Family doctors play a special role as they are often the first point of contact for addicts and at-risk persons. However, no systematically evaluated data is available on their addiction treatments. The core element of the addiction support system, in addition to care from family doctors, consists of 1,500 addiction counselling and treatment centres. Furthermore, treatment and care are provided in over 320 outpatient and inpatient therapy facilities, in 84 psychiatric outpatient institutes as well as in over 1,000 facilities for integration support (IFT 2016). The 409 specialist psychiatric departments (97 of which are exclusively

for the treatment of addiction disorders) with a total of 4,487 beds for addicts (Destatis 2015) are of great importance: they are not only responsible for detoxification, but also for crisis intervention and the treatment of psychiatric comorbities.

The majority of the support facilities are funded by free, charitable bodies. Public and commercial organisations are also active, in particular in the area of inpatient treatment.

The heavily differentiated and compartmentalised support system enables the provision of especially person-centred counselling and treatment. The large number of responsible entities and funding agencies, however, makes cooperation between the various facilities, authorities and institutions involved in treatments difficult. The management of numerous interfaces requires a high degree of willingness to cooperate on the part of service providers and funding agencies as well as substantial management skills (DHS 2010; Bartsch 2017a).

In order to counter this problem, agencies have joined various services together into combined systems. They coordinate their treatment and support concepts with each other, offer complementary or alternative services from a single source, enable tailored planning and delivery of treatment and can react flexibly to unforeseen crises and other problems. In this context, they agree to maintain collective quality standards and binding rules of communication (Bartsch 2017).

In several *Laender*, such as Baden-Württemberg, Schleswig-Holstein, Hesse and North Rhine-Westphalia, addiction support has been municipalised: all bodies within a municipality which are involved in the care and treatment of persons with dependency disorders agree mandatory governance processes; financial and organisational responsibility as well as addiction specific competence are pooled. This method offers both opportunities as well as risks for addiction support. Processes can be organised more effectively thus improving interface management. The spectrum of services for people with substance related disorders is, however, mostly more extensive than is believed and its effectiveness as well as its significance for the wider community are often underestimated. Therefore, a lack of specialist knowledge among those responsible in the municipalities can lead to them viewing addiction support as a source of potential savings (Bürkle 2015).

Many addiction support agencies, above all in the larger cities, provide a variety of services for drug addicts, from low-threshold services, through counselling and treatment, psychosocial care of substituting patients up to rehabilitation and residential projects. However, there is currently no systematic data collection on the geographical degree of coverage or the extent to which people in need of treatment receive it from the various addiction support organisations.

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

Counselling, promotion of motivation and outpatient treatment are primarily offered in the outpatient counselling and treatment centres as well as in specialist walk-in clinics. They are often the first port of call for clients with addiction problems, to the extent that they are not treated by the family doctor. As with low-threshold support services, they are, in part, funded

from public resources. However, a relevant portion of the costs of the outpatient facilities is borne by the providers themselves. With the exception of outpatient medical rehabilitation, outpatient addiction support is, in varying degrees, voluntarily funded by the *Laender* and municipalities on the basis of municipal services of general interest. This is anchored under constitutional law in the Social State Principle (Sozialstaatsprinzip) as per Art. 20 (1) German Constitution (Bürkle & Harter 2011). The fact that the funding of outpatient services is only partially guaranteed under the law, leads time and again to financing problems. Generally counselling is carried out free of charge.

Table 1 Network of outpatient addiction support (number of facilities and people treated)*

Type of facility designated as per the DBDD	Type of facility according to national definition	Total number of units	Total number of clients
Specialised drug treatment centres	**Counselling and treatment facilities**	1,500	> 500,000
Low-threshold agencies	**Low-threshold facilities (emergency overnight accommodation, consumption room, street work, etc.)**	268	no data
General primary health care (e.g. GPs)	**Substitution doctors**	2,590**/8,416***	78,500
General mental health care	**Psychiatric practices**	no data	no data
Other outpatient units	**Psychiatric outpatient institutes**	84	91,800
Prisons (in-reach or transferred)	**External services for counselling/treatment in prison**	84	no data
Other outpatient units	**(Whole day) outpatient rehabilitation**	88	> 1,000
Other outpatient units	**Outpatient assisted living**	571	> 12,000
Other outpatient units	**Employment projects/qualification measures**	102	> 4,800
Other outpatient units	**Self-help groups**	8,700	no data

Source: Standard table 24.

* Facilities which exclusively or primarily treat users of illicit drugs are in the minority. In the vast majority of cases, alcohol problems are (also) treated.

** In 2015 2.613 substitution doctors reported to the substitution register (BOPST 2016).

*** The number of doctors qualified to administer addiction therapy reported by the medical associations is higher than the number of doctors actually performing substitution treatment. In 2012, 8,416 doctors qualified to treat addiction were registered (BOPST 2013).This number is not updated.

IFT 2016; BOPST 2017;

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

With regard to the availability and provision of individual treatment and support services, there are differences to be found between the *Laender*. In rural regions especially, particularly in the eastern *Laender*, there are difficulties in providing region-wide care to patients (who wish to receive substitution treatment). All in all, the situation with regard to support services available has not changed significantly in recent years or, if anything, it has

rather deteriorated. While municipal financing is falling, the profile of requirements is expanding at the same time. Non-profit organisations are increasingly lacking the financial basis to contribute their own resources. It is mostly based on church taxes, however these are falling year on year. This has not yet led to a reduction in counselling and treatment services. Referrals from addiction counselling and treatment centres continue to make up the largest share of all referrals into medical rehabilitation. Maintaining the services is, however, becoming increasingly difficult (Bürkle 2015, GVS 2017).

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

No additional information is currently available on this.

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

The addiction psychiatry facilities within the specialist psychiatric clinics and the addiction psychiatry departments of general hospitals and university clinics play a role in addict care which is often underestimated by the public. Annually, they carry out almost 440,000 addict treatments altogether. These are understood as including: detoxification, qualified withdrawal, crisis intervention and comorbidity treatment. The costs for these treatments are borne by the statutory health insurance providers.

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

Valid data on qualified withdrawal has to date not been published, since the clinics' accounting system is being changed. Some clinics are using the new system and some are still using the old system. A precise allocation of types of treatment can not be carried out due to different data collection methods.

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

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

Type of facility designated as per EMCDDA	Type of facility according to national definition	Total number of units	Number of persons treated
Hospital-based residential drug treatment **	**Specialised psychiatric hospitals ****	274 clinics/ 4,478 beds	approx. 440,000
	of which: departments, which exclusively treat users of psychotropic substances (without alcohol, tobacco, sedatives)		> 100,000
Residential drug treatment (non-hospital based)	**Inpatient rehabilitation facilities**	24 ***	32,132****
	of which: facilities for users of illicit drugs		12,703 ****
Therapeutic communities***	**Therapeutic communities*****	no data	no data
Prisons	**Secure psychiatric units**	31 ***	no data
Other inpatient units	**Transition facilities**	102 ***	no data
Other inpatient units	**Social therapy inpatient facilities**	414 ***	no data
Other inpatient units	**Social therapy day care facilities**	81 ***	no data

Source: Standard table 24.

* Facilities which exclusively or primarily treat users of illicit drugs are in the minority. In the vast majority of cases, alcohol problems are treated (as well).

** Destatis 2016, 2016a

*** IFT 2016

**** DRV 2017

***** In Germany, there is no statistical data on therapeutic communities within the meaning of the term as understood on an EU level. There are only isolated facilities which work according to that concept. It is even more difficult to identify numbers of clients or places as some clients remain in a facility their whole life (e. g. Synanon, www.synanon.de [accessed: 28 Aug. 2017]). The problem was already addressed in the REITOX Report 2012.

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

No additional information is currently available on this.

1.2.6 Further aspects of inpatient drug treatment provision and utilisation (T1.2.6)

Rehabilitation

In recent years we have seen increased flexibility in the structure of treatment services and this has enabled clients to combine outpatient and inpatient rehabilitation (combination

treatment) or to make use of other, needs specific treatment services, including day care and outpatient treatment options.

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

Similar to outpatient counselling centres and specialist walk-in clinics, the inpatient addiction support facilities are also fighting for survival. Although the need for treatment continues to be high, many inpatient withdrawal facilities have had to close in recent years for economic reasons. Between 2013 and 2016 for example, the Federal Association for Inpatient Addiction Support (Bundesverband für stationäre Suchtkrankenhilfe, buss) lost 15 member facilities with around 7,000 treatment places (corresponding to approximately ten percent). In the last three years, the National Association for Addiction Support (Gesamtverband für Suchthilfe, GVS) has also been affected, with the loss of around 200 treatment places as a result of clinic closures. The *Laender* Bavaria and North Rhine-Westphalia (NRW) have been particularly affected (Koch & Wessel 2016). The background to this development is the creeping divergence in costs and remuneration rates with simultaneously increasing quality requirements: almost all structural and personnel conditions are stipulated by the funding agency.

Only around 10% of facilities which provide inpatient rehabilitation, have developed concepts to offer rehabilitation also to substitution patients, although the requirements for this were created in Annex 4 of the Agreement on Addiction Disorders (between health insurance providers and pension insurance providers) (Vereinbarung Abhängigkeitserkrankungen) (Kuhlmann 2015, Spitzenverbände der Krankenkassen und VDR 2001) (c.f. also section 4.3).

1.3 Key data (T1.3)

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

Outpatient Treatment

In 2016, data from a total of 342,393 treatments (not including one-off contacts) carried out in 863 outpatient facilities was collected within the framework of the Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS)[1] (Braun, et al. 2017a). For the following remarks, however, only those clients who were primarily treated for illicit substance use (including sedatives/hypnotics and volatile solvents) were taken into account. Clients treated for a primarily alcohol-related disorder accounted for 43.5% of all recorded cases in 2016. For 2016, the DSHS contains data on the main diagnoses from a total of 72,433 treatments from 861 facilities that were started or completed in outpatient

[1] The DSHS is a national documenting and monitoring system in the area of addiction support in Germany. The documented data is based on the KDS. C.f. sections 1.4.5 and 5.

psychosocial counselling centres within the addiction support system due to problems with illicit drugs. If one looks only at the data from the DSHS pertaining to illicit substances, only 32.2% of cases today (2015: 33.4%; 2014: 35.3%; 2013: 37.6%) concerned clients who had sought treatment or counselling primarily due to dependence on or harmful use of opioids. More than a third of the cases (41.5%; 2015: 41.2%; 2014: 40.2%; 2013: 38.7%; 2012: 36.5%) concerned clients primarily with cannabis problems (Braun et al. 2017b).

Amongst persons who were in addiction specific treatment for the first time, cannabis was again in first place, at 54.6% (2015: 59.8%; 2014: 60.8%; 2013: 59.5% of all clients). The second largest group, after a considerable margin, is, as in the previous year, first-time clients with the primary diagnosis stimulants (17.5%; 2015: 19%; 2014: 19.1%; 2013: 18.7%; 2012: 16.6%) followed by first-time clients with opioid related disorders (11.7%; 2015: 13%; 2014: 11.9%; 2013: 12.7%). The proportion of first-time clients with cocaine related disorders (5.8%; 2015: 5.5%; 2014: 5.1%; 2013: 5.5%), as well as of all other substance groups (Table 3), have remained practically unchanged in size compared to the previous year.

Table 3 Primary diagnosis in outpatient therapy (DSHS ambulant, 2016)

Primary diagnosis harmful use of/dependence on	**All patients treated (%)**			**Persons treated for the first time (%)**		
(ICD10: F1x.1/F1x.2x)	**Males**	**Females**	**Total All clients entering treatment**	**Males**	**Females**	**Total All clients entering treatment**
Opioids	31.3	35.2	32.2	12.0	10.8	11.7
Cannabinoids	44.1	31.7	41.5	60.0	36.9	54.6
Sedatives/Hypnotics	1.1	4.9	1.9	0.9	3.8	1.6
Cocaine	7.0	4.5	6.5	6.4	3.8	5.8
Stimulants	14.5	21.8	16.0	15.7	23.3	17.5
Hallucinogens	0.2	0.1	0.1	0.2	0.1	0.2
Volatile substances	0.0	0.1	0.1	0.1	0.2	0.1
Multiple/other substances	1.8	1.6	1.8	1.5	1.2	1.4
Total (Number)	57,207	15,185	72,433	19,754	5,933	25,694

Braun, B. et al. 2017b; Braun, B. et al. 2017c

Data on socio-demographic information in an outpatient setting can be found in section 1.3.2.

Inpatient treatment

In general, inpatient treatment in Germany is carried out under drug-free conditions. Since documentation standards are determined by the respective source of funding and not by the type of treatment, all inpatient treatments carried out for persons with main diagnoses F11-F16 and F18-F19 are presented in the following with a differentiation by acute hospital treatment (Statistical Report on Hospital Diagnoses, Krankenhausdiagnosestatistik), and rehabilitation therapy (Statistical Report of the German Statutory Pension Insurance Scheme, Statistik der Deutschen Rentenversicherung). Furthermore, there is data from the DSHS which provides data for a selection of specialist clinics and facilities in accordance with the German Core Data Set on Documentation in the area of Addict Support (Deutscher Kerndatensatz zur Dokumentation im Bereich der Suchtkrankenhilfe, KDS).

Out of the total of 47,777 inpatient treatments of substance-related disorders in 211 facilities documented by the DSHS in 2016, 11,736 were related to illicit substances (including sedatives/hypnotics and volatile solvents) (Braun, B et al. 2017d). Of the treatments with primary drug problems recorded by the DSHS, the proportion of those with a primary diagnosis based on dependence or harmful use of cannabis, at 33% (2015: 33%; 2014: 30.7%; 2013: 28.3%) has not risen any further compared to the previous year, whilst the proportion of treatments due to opioids, at 19% (2015: 22%; 2014: 27.0%; 2013: 27.1%) continued to fall. Treatments due to cannabis thus continue to represent the largest single group in the inpatient setting (without primary diagnosis alcohol). The proportion of treatments which were due to stimulant use (25%) continues to rise (2015: 23%; 2014: 20%; 2013: 18.3%) and since the previous year has been above the proportion accounted for by opioid-related treatments (see Table 4).

Table 4 Inpatients broken down by addiction diagnosis

	Hospital	DRV	DSHS			
	2015 %	2016 %	2015 %	2016 %		
primary diagnosis	Total	Total	Total	Total	Males	Females
Opioids	31	18	22	19	19	20
Cannabinoids	15	26	33	33	35	26
Sedatives or Hypnotics	9	3	3	3	2	9
Cocaine	2	5	7	8	9	4
Stimulants incl. caffeine	9	17	23	25	23	30
Hallucinogens	1	0	0	0	0	0
Volatile substances	0	0	0	0	0	0
Multiple substance use & use of other psychotropic substances	32	31	12	12	12	10
Total (Number)	111,522	9,761	11,738	11,736	9,331	2,405

Destatis 2015; DRV 2017; Braun et al. 2017d

Overall treatment

Table 5 Summary table - clients in treatment

	Number of clients
Total clients in treatment	According to the DSHS 2015 with primary diagnosis illicit drugs: 72,433 outpatient 11,736 inpatient
Total OST clients	78,500
Total	Not specified*

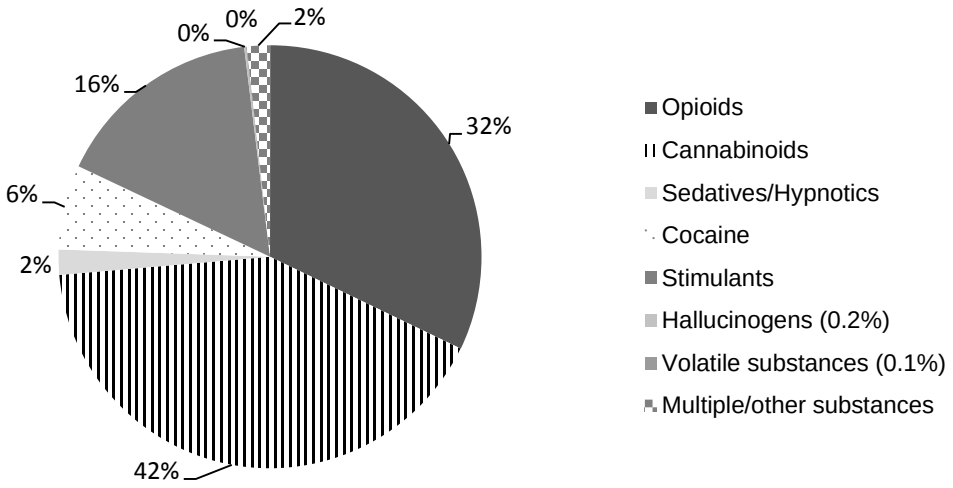
* The available data sets cannot be seen as cumulative, rather they overlap in part with the same groups of persons within outpatient and/or inpatient care. Therefore, it is impossible to derive overall estimates from the routine data, in particular when one takes into account family doctors.

Braun et al. 2017b; Braun et al. 2017d; BOPST 2017.

No national data is currently available on the distribution of methamphetamine use. However, the Saxon State Office for addiction questions (Sächsische Landesstelle für Suchtfragen, SLS) does publish statistical reports from local counselling facilities and specialist walk-in clinics on counselling and referral into treatment, for Saxony. According to those reports, for the first time since the peak level in 2014, no further increase in the percentage share of crystal meth related counselling could be established in 2015. However, the proportion does

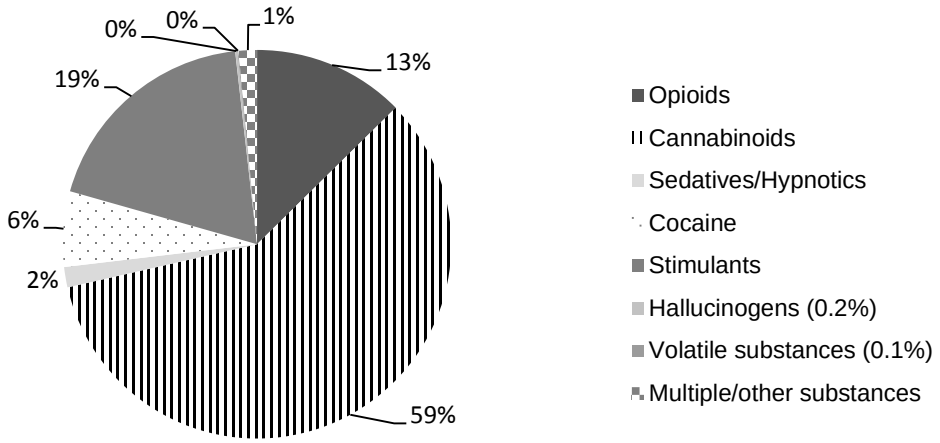
still account for around a quarter of all counselling due to substances (2015: 24.3%, 2014: 24.9%) (SLS 2016). Reports from the field in other *Laender* have shown an increased mixed use with amphetamines and NPS among young people (c.f. section 3.1).

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



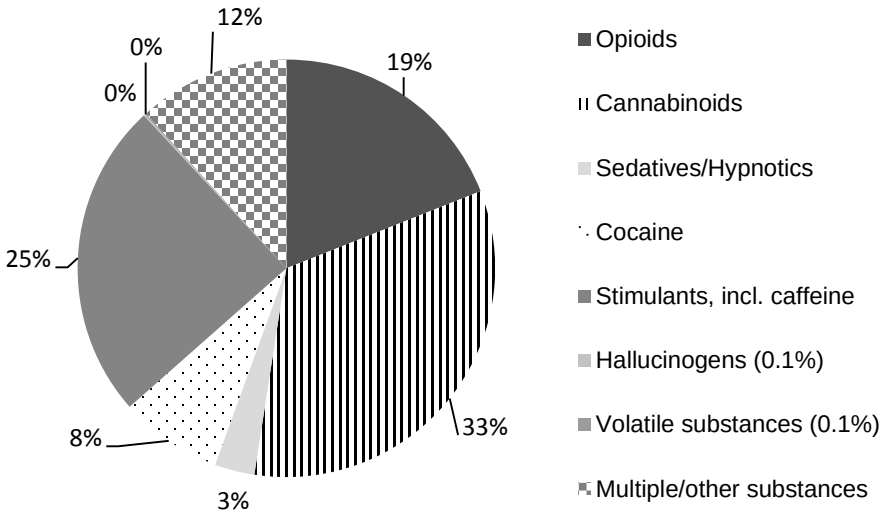
Braun et al. 2017b

Figure 1 Proportion of treatment demands by primary drug (outpatient)



Braun et al. 2017c

Figure 2 Proportion of first-time treatment demands by primary drug (outpatient)



Braun et al. 2017d

Figure 3 Proportion of treatment demands by primary drug (inpatient)

1.3.3 Further methodological comments on the Key Treatment-related data (T1.3.3)

No additional information is available on this.

1.3.4 Characteristics of clients in treatment (T1.3.4)

Outpatient Treatment

Table 6 shows an overview of the socio-demographic data of patients treated in outpatient addiction support.

Table 6 Socio-demographic data by primary diagnosis (DSHS ambulant, 2016)

	primary diagnosis			
Characteristics	**Opioids**	**Cannabinoids**	**Cocaine**	**Stimulants**
Age when starting treatment in years (m)	38.5	24.9	34.3	29.1
Age of first drug use in years (m)	21.5	15.4	21.9	18.8
Gender (ratio males)	77.0%	83.9%	85.5%	71.4%
Living alone	53.3%	62.4%	45.6%	54.2%
Employment status				
Unemployed	58.6%	32.4%	36.8%	48.6%
School pupil/ In training	2.0%	33.0%	4.9%	10.5%
Homeless	3.8%	1.0%	1.6%	1.7%

Braun et al. 2017b

In an explorative study, Schneider (2016)investigated the patterns of use and negative impacts of 194 cannabis users who were being cared for or treated in outpatient counselling facilities. The main question was what distinguished the "typical", highly impacted, cannabis client. The results support the assumption that cannabis users who seek out a counselling facility exhibit intensive patterns of use and suffer from many varied problems. In addition to addiction specific problems there is a higher need for social and legal support. Almost half of these users have already come to the attention of judicial authorities. The multi-layered need for counselling was also apparent from the type of counselling requested: the most frequent counselling objective was stated as "Support in social and legal matters". The absolute majority report having already experienced manifest effects of use. Symptoms such as panic, fear of persecution etc. are also often experienced. These symptoms correlate strongly with the negative effects in the social environment. In this context, there are differences with respect to age and use habits between "urban" and "rural" areas.

Inpatient treatment

Table 7 gives an overview of the socio-demographic data of clients treated in inpatient addiction support.

Table 7 Socio-demographic data by primary drug (DSHS stationär, 2016)

	primary diagnosis			
Characteristics	**Opioids**	**Cannabinoids**	**Cocaine**	**Stimulants**
Age when starting treatment in years	36.4	28.4	34.8	30.0
Age of first drug use in years (m)	21.1	15.2	20.8	18.6
Gender (ratio males)	78.1%	84.1%	88.5%	75.2%
Living alone	57.1%	63.0%	54.6%	61.0%
Employment status				
Unemployed	69.1%	63.2%	62.2%	69.9%
School pupil/ In training	0.9%	6.3%	1.1%	2.6%
Homeless	3.9%	2.7%	3.1%	2.9%

Braun et al. 2017d

Since 2011, in addition to the standard analyses of the DSHS, information on selected treatment groups has been compiled, in annually changing special analyses, and presented over a few pages in the form of brief reports. Of note here is the report on clients/patients from different living situations in outpatient and inpatient addiction treatment (Künzel et al. 2014). In that report, client/patient groups with different living situations were observed in respect of their characteristics prior to the start of, during, and at the end of the support/treatment.

The German Statutory Pension Insurance Scheme (Deutsche Rentenversicherung) provides comprehensive statistics of their medical rehabilitation services, the type, duration and results of the service as well as an overview of the income and expenses and the number of beds in their own facilities (DRV 2017).

In total, 9,761 people (7,891 males, 1,870 females) who have utilised the services of the statutory pension insurance providers received the diagnosis "Mental and behavioural disorders due to medicinal drugs/illicit drugs". Of those, 1,011 were foreign nationals. On average, 92 days of care were utilised. The average age at the end of the treatment was 33.8 years old and is the lowest age in comparison to other rehabilitation services which are used (for the purposes of comparison, alcohol rehabilitation: 46.5 years old) (DRV 2017).

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

- Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS) 2016
- Statistical Report on Rehabilitation from the German Pension Insurance Scheme 2016
- Statistical Report on Hospital Diagnoses (Krankenhausdiagnosestatistik) 2016 and 2017

- Regional monitoring systems, such as BADO in Hamburg (Martens & Neumann-Runde 2016)

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

1.4 Treatment modalities (T1.4)

1.4.1 Outpatient drug treatment services (T1.4.1)

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

The central task of these facilities is the counselling and treatment of persons with dependency disorders. The specialists encourage affected persons to accept help, they create support plans and refer patients into further services (social, occupational, medical rehabilitation). Addiction support and treatment facilities as well as specialist walk-in clinics also often assume the psychosocial support for substitution patients, they support self-help projects and are specialist facilities for prevention. The legal basis is the municipal services of general interest according to Art. 20 (1) German Constitution. In the municipalities, there are, in addition, socio-psychiatric services available on the basis of the ÖGDG, which are also responsible for addicts (c.f. 4.3).

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

Low-threshold facilities are a service which help patients into the support system. In addition to contact and conversation services, they offer further support such as medical and hygienic primary care, street work, infection prophylaxis or legal advice. There are also consumption rooms in several major cities. The services are financed through voluntary public services and projects planned by the municipalities and also in part by the *Laender*. Further information can be found in the 2017 Harms and Harm Reduction workbook.

Practice-based doctors

Practice based doctors are frequently the first point of contact for people with an addiction problem. It is their responsibility, in the scope of the diagnosis and treatment, to talk about a drug abuse or dependency problem and its consequences. They should encourage patients to use suitable support services and refer them to counselling centres. Across Germany, there are approx. 120,000 practice-based doctors (BÄK 2016) who have around 20% patients with addiction disorders. The legal basis of this is the SGB V. The outpatient medical treatment is planned by the associations of SHI-accredited doctors. Information on substitution can be found in sections 1.4.7 to 1.4.10.

External services for counselling/treatment in prisons

Correctional institutions (Justizvollzugsanstalten, JVA) cooperate on a regional level with outpatient addiction support facilities. External social workers advise and refer to therapy where necessary according to Sec. 35 German Narcotic Drugs Act (Betäubungsmittelgesetz,

BtMG) (suspending prosecution upon admission into therapy). In some prisons, substitution treatment is possible.

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

Psychiatric outpatient institutes

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

Outpatient medical rehabilitation

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

Outpatient assisted living

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

Employment projects/qualification measures

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

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

Outpatient psychotherapeutic treatment

Psychotherapy can be performed by practice based, licensed psychological psychotherapists, according to the German Psychotherapy Act (Psychotherapeutengesetz, PsychThG). Specialist doctors for psychiatry and psychotherapy, specialist doctors for psychotherapeutic medicine and doctors with the additional designation "psychotherapy" are also qualified to carry this out. Overall, there are 28,631 psychotherapists and 6,737 specialist doctors involved in the outpatient care of children, adolescents and adults with psychological disorders. Of the psychotherapists, 6,084 are medical psychotherapists and

22,547 are psychological psychotherapists (DGPPN 2017). Data from the German Federal Health Monitoring (Gesundheitsberichtserstattung, GBE) reveals even higher numbers. According to that data, there are 32,309 psychological psychotherapists and child and youth therapists working in outpatient facilities. The number of therapists has continually increased since 2009 (gbe-bund.de). The legal basis is SGB V. Planning occurs through the chambers of psychotherapists.

1.4.3 Inpatient drug treatment services (T1.4.3)

Detoxification

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

Qualified withdrawal facilities/specialist hospital departments

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

Inpatient facilities for medical rehabilitation

Medical rehabilitation is performed in specialist clinics and includes group therapy, individual therapy, family work in the form of couple and family sessions or seminars as well as non-verbal forms of therapy (design and music therapy). This is complemented by work and occupational therapy, sports and exercise therapy and other indicated treatment services. Social counselling and preparation for the subsequent support services (e.g. "after-care") always form a part of withdrawal treatment. The spectrum of medical rehabilitation also includes employment related services. Medical rehabilitation has a time limit. The treatment time of the different forms of treatment is set individually. The legal basis is primarily the SGB VI and subordinately the SGB V. Planning and quality assurance are provided by the pension insurance providers and statutory health insurance providers. Outpatient and inpatient rehabilitation are, as far as possible, abstinence oriented (Weinbrenner & Köhler 2015).

Therapeutic communities (TCs)

There are only a few therapeutic communities left in Germany as in the original meaning of the term. However, numerous specialist clinics within the medical addiction rehabilitation system work according to the principles of TCs. Specialist clinics for medical rehabilitation,

which integrate the principle of TCs into their concept, generally have a capacity of between 25 and 50 treatment places and are thus amongst the smaller rehabilitation facilities. Further information can be found in the Selected Issue Chapter "Inpatient Treatment of Drug Addicts in Germany" of the REITOX Report 2012 (Pfeiffer-Gerschel et al. 2012).

Treatment in prisons

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

Psychiatric clinics

The services available range from detoxification and "qualified" withdrawal treatment, through crisis intervention to treatments for addicts with additional mental disorders. Nationwide, 440,000 addiction patients are treated annually in psychiatric clinics or specialist departments. The legal basis is the SGB V. The *Laender* are responsible for planning.

Transition facilities

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

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

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

Inpatient social therapy facility

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

1.4.4 Further aspects of available inpatient treatment services (T1.4.4)

No additional information is available on this.

1.4.5 Treatment outcomes and recovery from problem drug use (T1.4.5)

Care, treatment and early intervention

In the counselling and treatment centres as well as in the specialist walk-in clinics, which make their data available to the DSHS[2], the scheduled termination of care/treatment is classified as an indicator of treatment success, in addition to the assessment of counselling and therapeutic staff. Around 60% of outpatient clients finish their care as planned; among inpatient clients the proportion is roughly 70%. Differences are seen both in substance classes as well as between outpatient and inpatient care. In inpatient care, the rates of ending treatment as planned are higher than those of outpatients for all substance groups. These results are particularly pronounced for clients with the primary diagnosis "alcohol" and "pathological gambling". Opioid users are the group with the largest proportion which stops treatment prematurely (outpatient 48%, inpatient 46%). This is followed by persons with stimulant-related problems (outpatient 42%, inpatient 31%), then cocaine (outpatient 40%, inpatient 32%) as well as cannabis (outpatient 36%, inpatient 35%). The group with the highest proportion of clients who finish treatment as planned is alcohol dependent clients (outpatient 68%, inpatient 84%). In order to assess performance, in the KDS used until now, from 2010, a differentiation is made between a positive ("successful", "improved") and a negative outcome ("unchanged", "worsened") (DHS 2010a). It can be seen that finishing treatment as planned is associated with a higher treatment outcome across all main diagnoses: 80% of outpatients and 92% of inpatients who finished a treatment as planned had a positive outcome. In contrast, only 34% of outpatient and 27% of inpatient treated persons with unplanned terminations had a positive outcome (Dauber et al. 2016).

The extension of the FreD programme to include problems caused by amphetamine-type stimulants (ATS), should enable ATS users to be reached at an early stage. The term "FreD" stands for "Frühintervention bei erstauffälligen Drogenkonsumenten" (Early Intervention with Drug Users Coming to the Attention of Law Enforcement for the First Time). After cannabis, ATS are the most frequently used primary substance among project participants, in particular in facilities in the new *Laender* (i.e. the former East German *Laender*). The FreD programme was for 75% of project participants the first time they had availed themselves of drug-related support; 25% had already previously visited outpatient addiction counselling or a family doctor or had taken part in a qualified withdrawal or therapy service. A total of 77 contact conversations were carried out in the evaluation time period with drug users who had come to the attention of law enforcement for the first time. Of those, 70 (90.1%) actually participated in a FreD course. Three quarters of participants completed the course as

2 The DSHS is a national documenting and monitoring system in the area of addiction support in Germany. The documented data is based on the KDS. C.f. sections 1.3 and 5.

planned, which can be taken as a good result considering the age range of the adolescents involved. In particular, course participants found that their expectations in terms of the advice they would receive on legal consequences and possible risks of drug use were largely fulfilled. As is well-known from other studies, however, a positive experience from a course is not a direct path to a change in attitudes and behaviour. Whilst a quarter of adolescents and young adults reported having learned something during the course, which will change their behaviour in future, a comparatively large proportion was still uncertain at the end of the course whether their behaviour will be changed (FOGS 2017; LWL 2017).

Rehabilitation

The DRV statistics portal shows a total of 44,452 medical rehabilitation treatments for 2016, of which 32,132 were inpatient treatments (DRV 2017). A total of 12,703 addiction rehabilitation services for drug addicts were provided (DRV 2017a). To date, DRV data on treatment outcomes is only available for the year 2014. According to that data, the treatment outcome is described for 28% of withdrawal treatments as unchanged, for 67% as improved, for 0.6% as worsened while for 4.6% no conclusion was possible (DRV 2015).

Catamnestic surveys are regularly carried out by the addiction rehabilitation clinics. However, the samples are small, in particularly in drug rehabilitation. For this reason, rehabilitation facilities merge their results in order to obtain more meaningful results. An example for this, is the clinics which belong to the quality circle of the FVS. The current catamnesis of clients discharged from treatment in 2013 (Fischer et al. 2016) evaluates data from 1,535 patients. The aforementioned 1-year catamnesis is produced on the basis of the "standards for implementing catamneses of persons suffering from dependence" of the German Society for Addiction Research and Addiction Treatment (Deutsche Gesellschaft für Suchtforschung und Suchttherapie, DGSS) (DG-Sucht 1985, 1992, 2001). According to the DGSS method of calculation 4, which obtains the percentage success rates of all patients in the reference period, the catamnestic success rate amounted to 24.9% (for the year 2012: 21.2%). All non-respondents are defined as having relapsed. The total figure for relapses, including patients who are reported to have relapsed, is 75.1% (for the 2012 cohort: 78.8%). Among non-respondents, there are fewer patients who finished treatment as planned (60.9%), a higher number of those who dropped out of treatment (25.5%) as well as shorter treatment times. The abstinence rates as per the DGSS 4 were as follows for the following primary drugs: heroin 26.8%, cannabis 26.2%, cocaine 27.3%, amphetamine 28.8% and for multiple drug use 25.3%. In addition to the status of addictive substance use (abstinent, abstinent following relapse, relapsing), an assessment of changes in the central areas of life of catamnesis participants is recorded. The following variables are taken into account: partner relationship, parents/siblings/relatives, own children, acquaintances/friends, leisure activities, employment status, physical health, mental state, financial situation, living situation, criminal activity/offences, addictive substance use, ability to cope with everyday life. On a scale of 1 = "much better" to 7 = "much worse", respondents who have remained abstinent assess themselves as being between 1 and 3 in all points. The assessment is particularly positive with respect to crimes and addictive substance use (between 1 and 2). Employment status,

financial situation and living situation are assessed as being between 2 and 3. The assessments from those who are abstinent following a relapse is somewhat lower. However, the situation in respect of addictive substance use is still positively assessed (between 2 and 3) as are relationships with partners, relatives and children (between 2 and 3). Among respondents who describe themselves as relapsing, the level of satisfaction with different areas of their everyday lives is less positive (mostly between 3 and 4). However, even those respondents find that their level of satisfaction in relation to their addictive substance use is relatively high (3) (Fischer et al. 2016).

Two large addiction support agencies - the German Caritas Association (Deutsche Caritasverband) and the GVS have jointly produced a further catamnesis study, in order to evaluate the results of the Outpatient Rehabilitation Support (Ambulanten Rehabilitation Sucht, ARS). The data on those who finished treatment in the years 2011 to 2014 is recorded by the ARS (Walter-Hamann & Wessel 2016). A special analysis is dedicated to people undergoing rehabilitation with the primary diagnosis "illicit drugs". The catamnesis response rate was around 30%. Of the 630 ARS cases of "illicit drugs" recorded, 65% were without and 35% with inpatient involvement. The primary diagnosis cannabis (F12) accounted for a proportion of around 40%, opioids (F11) for 20-30% and cocaine (F14) for 12-14%. Overall, rehabilitation measures were finished as planned in 70-80% of cases. The abstinence rate for ARS according to DGSS 4 was 38% without inpatient participation and 30% with inpatient participation. The group of "defined relapses" according to DGSS 4 (not reached) made up 34% and 37% respectively. The proportion of those who were unemployed fell by the end of treatment in comparison to the start of treatment by 7-12%; the proportion of those able to work increased by 8-12%. At the time of the catamnesis (1 year after the end of ARS) the proportion of those who were unemployed reduced by a further 3% and 10% respectively (GVS & Caritas 2016).

The effectiveness of inpatient and outpatient withdrawal treatments has been demonstrated in numerous catamnesis studies. To date, however, specific data on the treatment of methamphetamine addicted patients has been lacking. In one withdrawal clinic, methamphetamine addicts were compared to addicts dependent on other drugs in a 1-year catamnesis. They performed just as well in the survey as the group of other drug addicts. A comparison of the groups shows that the age of methamphetamine addicts was on average 3 years younger and the time in treatment was longer. The proportion of women with primary diagnosis "methamphetamine" was twice as high (46.5%) as the "other drugs" group (22.1%). Both groups had on average more than two addiction diagnoses per patient and approx. 70% had another psychiatric diagnosis (excluding addiction disorders). In the group of methamphetamine addicts, the proportion of those who finished treatment as planned was significantly higher (66.7%) than in the "other drugs" group (48.2%). According to the calculation method DGSS 4, abstinence rates in all groups were between 11% and 15%. In this context, it should be noted that in addition to drug use, any alcohol consumption was also deemed to be a relapse (Hamdorf et al. 2015).

1.4.6 Social reintegration services (employment/housing/education) for people in drug treatment and other relevant populations (T1.4.6)

Information on social reintegration services can be found in the DSHS brief reports, No. 2/2014: Clients/patients from different living situations in outpatient and inpatient addiction treatment (Künzel et al. 2014) and No. 2/2015: Clients/patients in sociotherapeutic addiction support facilities (Künzel et al. 2015).

Opioid substitution treatment (OST)

1.4.7 Main providers/organisations providing opioid substitution treatment (T1.4.7)

A total of 2,590 doctors providing substitution treatment reported patients to the substitution register in 2016. This number of actually substituting patients represents another reduction from previous years and is the lowest level in the last ten years. In 2016, 524 doctors - thus approx. 20% of substituting doctors - availed themselves of the colleague consultation rule: according to this rule, doctors without an addiction therapy qualification can treat up to three substitution patients simultaneously if they involve a suitably qualified doctor as a consultant in the treatment (BOPST 2017). In the "Third Amending Regulation of the German Regulation on the Prescription of Narcotic Drugs (3. BtMVVÄndV)" the number of patients is increased to ten and the official catalogue of institutions that may deliver substitution substances for immediate use was considerably extended (BMG 2017).

As of the reference date of 1 July 2016, the number of substitution patients was 78,500.

In 2016, around 93,000 registrations, de-registrations or changed registrations of patient codes were recorded in the substitution register. This high number is, amongst other reasons, due to the same people being registered and deregistered multiple times. Across Germany, around 150 double treatments were reported to the substitution register and ended by the doctors concerned accordingly. In 2015, the number was 120 double treatments (BOPST 2017).

The nationwide average number of reported substitution patients per substitution doctor is 30, however there are huge variations between *Laender* (Hamburg: 45.9; Brandenburg: 6.9). Access to substitution treatment is subject to strong regional differences. Firstly, the proportion of substitution patients in the total population is much higher in the city states (especially Bremen, Hamburg and Berlin), possibly because of the surrounding environment effect, than in the larger area states. Secondly, the proportion is significantly higher in the western *Laender* than in the eastern *Laender*.

The share of substances used in substitution treatment has shifted in the past few years away from methadone (42.5%) and towards levomethadone (33.0%) as well as buprenorphine, which, in 2016, was used in roughly one in five substitution treatments (23.1%) (Table 8). The proportion of persons receiving substitution treatment with methadone or levomethadone has fallen since 2005 from 82.0% to the current level of 75.5%.

Table 8 Type and proportion (%) of substances reported to the substitution register (2005-2016)

Substitution drug	2005	2010	2011	2012	2013	2014	2015	2016
Methadone	66.2	57.7	54.8	51.6	49.3	46.1	44.0	42.5
Levomethadone	15.8	23.0	25.4	27.0	28.6	30.3	31.8	33.0
Buprenorphine	17.2	18.6	19.2	20.4	21.3	22.6	23.0	23.1
Dihydrocodeine	0.7	0.3	0.2	0.2	0.2	0.2	0.2	0.2
Codeine	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Diamorphine		0.3	0.4	0.7	0.5	0.7	0.8	0.8

BOPST 2017.

1.4.8 Characteristics of clients in OST (T1.4.9)

No new information is currently available on this. Data from the PREMOS Study can be used as an information source (Wittchen et al. 2011a). Compare also the REITOX reports 2011 and 2012.

1.4.9 Further aspects on organisation, access and availability of OST (T1.4.10)

A cabinet decision on the 3. BtMÄndVV has existed since 15 March 2017. On 12 May, the Bundesrat approved that decision (Bundesrat 2017). Large parts of the existing BtMVV were revised and modified in line with current legal requirements and scientific knowledge. In the scope of this amendment, the BÄK treatment guidelines for substitution treatment of opioid addicts were also rewritten (c.f. Legal Framework workbooks).

Since 1992, substitution based therapy has been regulated in detail in narcotics law and is today a medically recognised treatment method. The BtMVV has been changed multiple times since then, most recently in March 2017 (cabinet decision) and on 12 May 2017 (Bundesrat approval) and has come into force as from 2 October 2017. The state of medical science in opioid substitution treatment (OST) was set out for the first times in guidelines in 2002. The guidelines were updated in the scope of the Third Amending Regulation of the German Regulation on the Prescription of Narcotic Drugs (3. BtMVVÄndV) on the basis of new scientific evidence (Bundesanzeiger 2. Oktober 2017). The statutory health insurance providers recognised substitution treatment in 2003 and therefore cover the costs of this for those with statutory health insurance.

According to the Third Amending of the BtMVV, the following substances are approved for substitution in Germany:

1. an approved substitution medicine, which does not contact the substance diamorphine,

2. a levomethadone, methadone or buprenorphine preparation or

3. in justified, exceptional cases, a preparation of codein or dihydrocodein

Substitution with diamorphine has also been regulated under § 5a BtMVV since July 2009 (c.f. Chapter 1.2.2 in the REITOX Report 2009; (Pfeiffer-Gerschel et al. 2009)

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

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

The provision of substitution treatment has been a cause for concern for many years, in particular in rural regions (c.f. REITOX Report 2014, Chapter 5.5.2). Ever increasing numbers of older doctors are retiring with hardly any younger doctors coming through to take their place. As a result, the gap in the provision of care is growing, leading to many opioid dependent persons in small towns or rural areas only being reached to a limited extent. In the Third Amendment of the BtMVV medical and therapeutical issues are assigned to the authority of the BÄK in order, among other things, to improve the situation of substitution doctors and to further develop the regulation of substitution treatment overall (vgl. 1.4.7 and legal framework workbook).

Furthermore, the support system is facing the challenge of providing care for long term substitution patients or aging drug addicts with accompanying health limitations up to and including nursing care (c.f. REITOX Report 2014, Chapter 5.5.3). Regional studies on substitution treatment support the review and optimisation of support concepts locally. For example, the city of Karlsruhe offers an overview of the living situation as well as of the current and expected needs of substitution patients over 50 years old. Those questioned expressed a clear desire for support in coping with everyday tasks, support with social contacts and support in the area of leisure time. In answering the question on a future need for support due to increased nursing care needs, admission to a nursing home was rejected by respondents. One alternative is an assisted living community (Stadt Karlsruhe 2015), see also section 4.3.

1.5 Quality assurance of drug treatment services (T1.5)

1.5.1 Quality assurance in drug treatment (T1.5.1)

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

- In the scope of the Third Amendment of the BtMVV, guidelines will also be updated for substitution treatment according to the available evidence. They are expected to be adopted in autumn 2017. (BMG 2017; communication BÄK, publication expected in September 2017).
- The S3 guidelines on methamphetamine related disorders has been in force since September 2016 (Drogenbeauftragte der Bundesregierung et al. 2016a).
- Furthermore, in 2016 the Joint Addiction Commission (Gemeinsame Suchtkommission) of the Professional Society of Child and Youth Psychiatrists and the specialist associations presented a position paper on the requirements on qualified withdrawal treatment for children and young persons (Thomasius et al. 2016).
- The proposals for enhancing employment measures within medical rehabilitation of persons with dependency disorders came into force on 1 March 2015. They were drawn up by the joint working group "Focus on employment in medical rehabilitation of persons suffering from dependence" (Berufliche Orientierung in der medizinischen Rehabilitation, BORA) (Müller-Simon & Weissinger 2015).
- At the beginning of 2014, the DGS approved the final version of the guidelines, "Therapy for opiate dependence - Part 1: substitution treatment" (Backmund et al. 2014).
- Also in 2014, the German Pain Society (Deutsche Schmerzgesellschaft), in collaboration with other medical expert organisations developed an S3-Guideline on "Long term use of opioids for non-tumour related pain" (Langzeitanwendung von Opioiden bei nicht tumorbedingten Schmerzen - "LONTS") (Deutsche Schmerzgesellschaft 2014).
- The revised version of the 2004 S3-Guideline on "Prophylaxis, diagnostics and treatment of the hepatitis C virus (HCV) infection, AWMF-Register No. 021/012" from the German Society for Digestion and Metabolic Diseases (Deutsche Gesellschaft für Verdauungs- und Stoffwechselkrankheiten e.V., DGVS) was published in 2010 (Sarrazin et al. 2010).
- In 2006, the Association of the Scientific Medical Societies (Arbeitsgemeinschaft der medizinisch-wissenschaftlichen Fachgesellschaften, AWMF) published the AWMF-guidelines on diagnostics and treatment of substance-related disorders under the title "Evidence-based addiction medicine – treatment guidelines for substance-related disorders" ("Evidenzbasierte Suchtmedizin – Behandlungsleitlinie substanzbezogene Störungen") (Lutz et al. 2006).

- Also in 2006, at a consensus conference, the guidelines of the DGS for the treatment of chronic hepatitis C in injecting drug users were approved (Backmund et al. 2006).
- The AWMF guidelines on cannabis related disorders was published in 2004 (Bonnet et al. 2004) as well as
- the guidelines on mental and behavioural disorders due to cocaine, amphetamine, ecstasy and hallucinogens (DG-Sucht & DGPPN 2004).

In addition to the treatment guidelines, the funding agencies also have other quality assurance instruments. The German Pension Fund (Deutsche Rentenversicherung Bund, DRV) carries out annual evaluations of medical rehabilitation of persons with dependence disorders: firstly, the facilities supported by the DRV are examined in a peer review process and the quality of the rehabilitation process is recorded. Anonymised medical discharge reports as well as rehabilitation clients' therapy plans are selected at random by experienced and specially trained rehabilitation doctors of the relevant specialist area. The assessment is based on an indication-specific checklist of quality-relevant characteristics of rehabilitation and a handbook. Both inpatient and outpatient withdrawal rehabilitation services are included in the process and assessed according to the same criteria (DRV homepage[3]). In addition, the persons undergoing rehabilitation treatment are questioned on the subjective treatment success and their satisfaction with the treatment overall as well as on the different treatment modules/elements (Naumann & Bonn 2017).

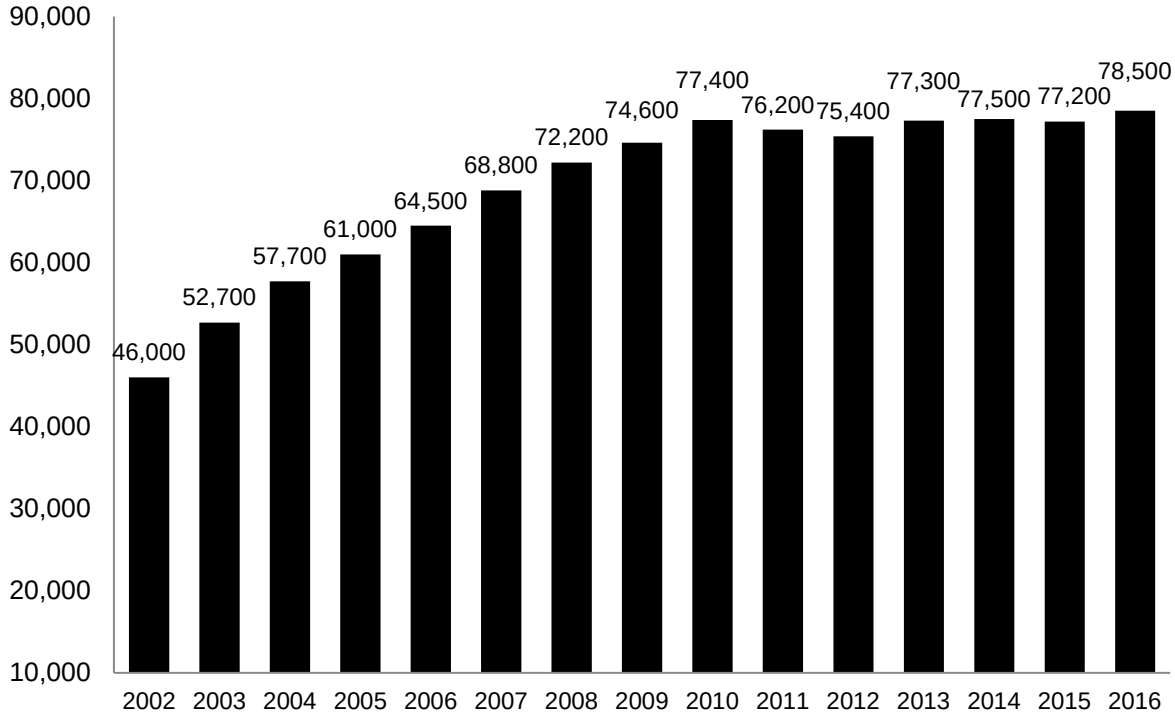
Furthermore, the medical rehabilitation of people with dependence disorders may only be provided by specialist staff with the relevant further training. In this context, the German Statutory Pension Insurance Scheme has produced guidelines for the supplementary training of specialist staff working in individual and group therapy within the framework of the medical rehabilitation of drug addicts, in which supplementary training courses can receive a "recommendation for recognition". Cooperation between different professional groups from social work, psychology, psychiatry and other medical fields forms an essential part of the treatment standards in the case of drug dependence. As for outpatient options (in particular counselling centres), quality assurance and professional monitoring are mainly in the hands of the organisations that provide these facilities, or the *Laender* and municipalities. The responsibility for detoxification and rehabilitation, however, lies with the respective funding agency (statutory health insurance providers (Gesetzliche Krankenversicherung, GKV) and pension insurance providers (Rentenversicherung, RV)) (c.f. also Chapter 11.3 of the REITOX Report 2012).

[3] www.deutsche-rentenversicherung.de

2 Trends (T2)

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

From 2002, when reporting became obligatory, the number of substitution patients reported continuously increased until 2010. After a stable trend in recent years, the number of substitution patents has increased by 1.7% in the last year and on the reference date of 1 July 2016 was at 78,500 persons. There are still considerable regional differences regarding the supply of and demand for substitution treatments.



BOPST 2017

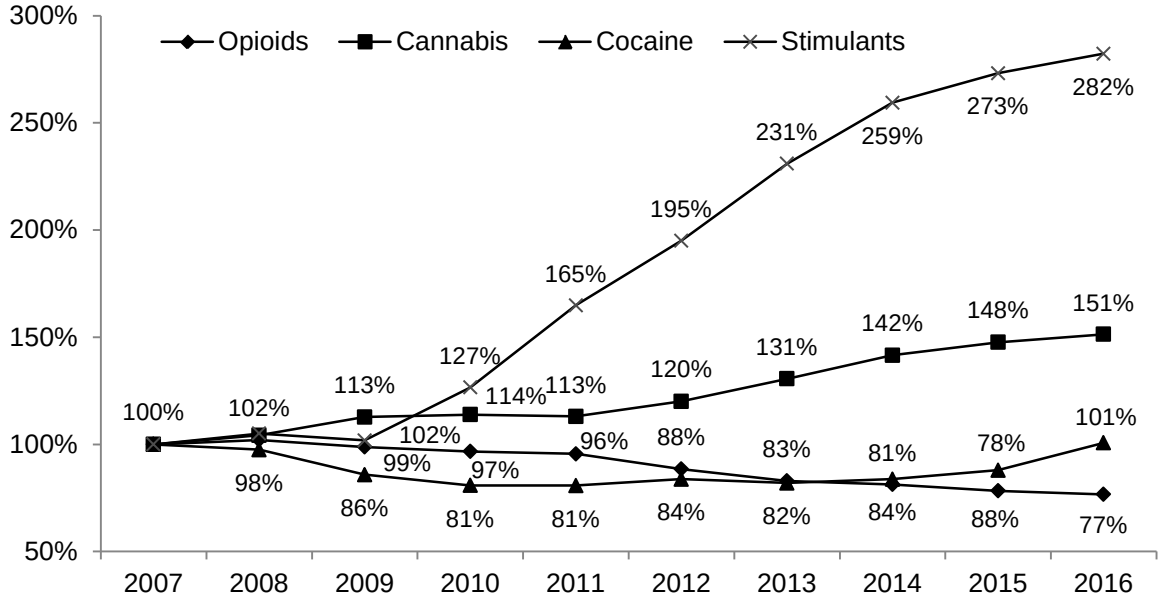
Figure 4 Number of reported substitution patients in Germany (reference date 1 July)

Changes in admissions to outpatient treatment

In the area of health care, according to the DSHS data the problems in inpatient and outpatient facilities continue to be dominated, as far as illicit drugs are concerned, by disorders caused by the use of heroin, cannabinoids and stimulants (see section 1.3.1).

Furthermore, cannabis is in clear first place in terms of requests for treatment, when it comes to persons seeking outpatient therapy for the first time (first time patients), whereas opioids are, in this group, increasingly rarely the reason for making contact with a treatment facility. In 2013, the proportion of clients with the primary diagnosis cannabis exceeded for the first time the proportion with the primary diagnosis opioids amongst admissions to outpatient treatment and thereby comprised the largest single population within that subgroup (Braun et

al. 2016). If one calculates the changes in client admissions to the outpatient setting, according to the proportions of various primary diagnoses since the introduction of the new KDS in 2007 (index=100%), one finds a 51% increase in the share of clients with primary diagnosis cannabis since 2007, a slight decline in clients with opioid problems (-23%). In the last three reporting years there has been a slight increase in clients with cocaine problems as well as an almost tripling of the proportion of clients with the primary diagnosis stimulants (Figure 5).



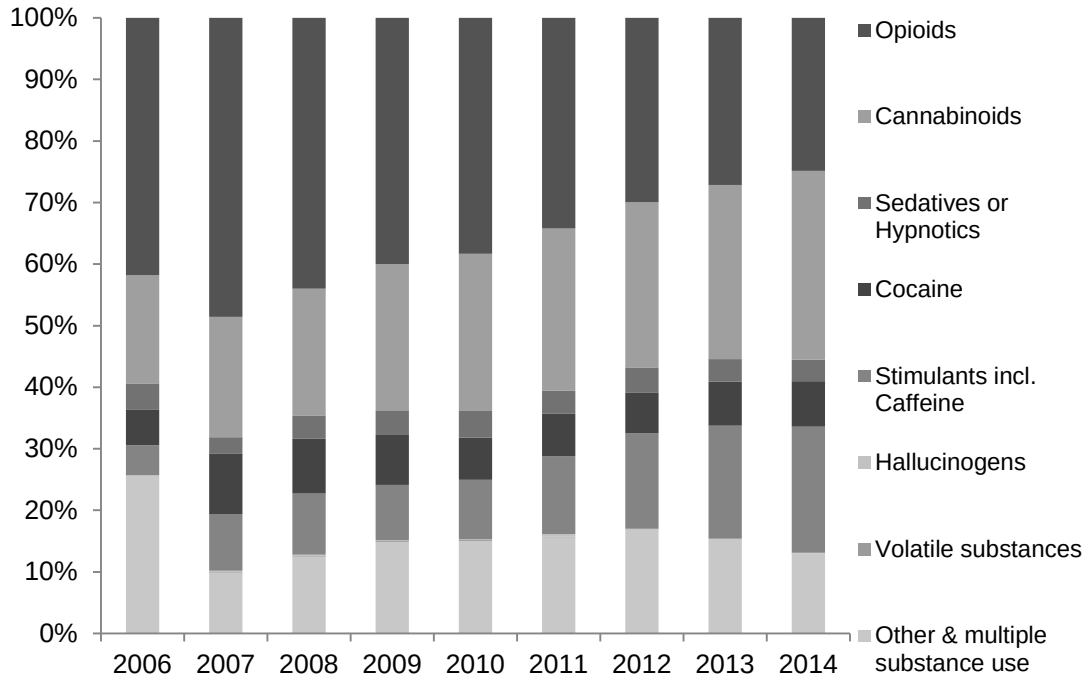
Braun et al. 2017b

Figure 5 Changes in admissions to outpatient addiction counselling for various primary diagnoses since 2007 (DSHS ambulant)

Changes in admissions to inpatient treatment

In the area of inpatient treatment, the proportion of patients with a primary diagnosis based on a dependence on or harmful use of cannabis (33.5%; 2015: 33.4%; 2014: 30.7%; 2013: 28.3%) has, since 2013, exceeded the proportion of treatments based on opioids (19.0%; 2015: 22.0%; 2014: 24.9%; 2013: 27.1%) (Braun et al. 2017d

Figure 6). Those treated with a primary diagnosis due to stimulants last year overtook the proportion of those treated for opioids and is now, with 24.6%, (2015: 23.1%; 2014: 20.5%) in second place (Braun, B. et al. 2017d).



Braun et al. 2017d

Figure 6 Changes in admissions to inpatient addiction treatment for various primary diagnoses (DSHS stationär)

The total number of rehabilitation services funded by the RV in the area of addiction rose by over 10% between 2003 (51,123) and 2009 (57,456) and has since then been continually decreasing (2010: 56,997; 2016: 38,780) (Note: No data available for 2014.

DRV 2017

Figure 7). Changes of the data collecting method explain a part of this decrease since the reporting year 2015. The majority of the rehabilitation services (70.3%) is provided for alcohol related disorders. Disorders due to the use of illicit drugs and multiple drug use together comprise around 28.4% of the treatments provided (medicinal drugs: 1.3%). This proportion has increased by approximately four percent since 2003 (24.3%). In contrast, while the proportion of services due to alcohol related disorders since 2003 (74.8%) has fallen, it has now remained largely unchanged since 2007 (70.6%) (DRV 2017).

The ratio of inpatient to outpatient rehabilitation in 2016 (across all services) is 4.8:1. (In 2003 this ratio was still 3.7:1). In comparison to the previous year 2015 it has fallen somewhat (2015: 5:1). Looking only at the rehabilitation services for drugs and multiple substance use, one finds that the ratio between inpatient and outpatient treatment has, at 8.3:1, shifted even more markedly towards inpatient interventions and, following an increase in the previous year (2015: 9.4:1), has once again slightly fallen. Between 2003 and 2009 (according to the data of the DRV), the numbers of rehabilitation cases for drug patients (drugs/multiple use) in inpatient treatment continuously increased before falling since then. In the area of outpatient treatment, the respective numbers of cases continuously increased until 2007, then remained stable until 2010 before falling again since then (Note: No data available for 2014.

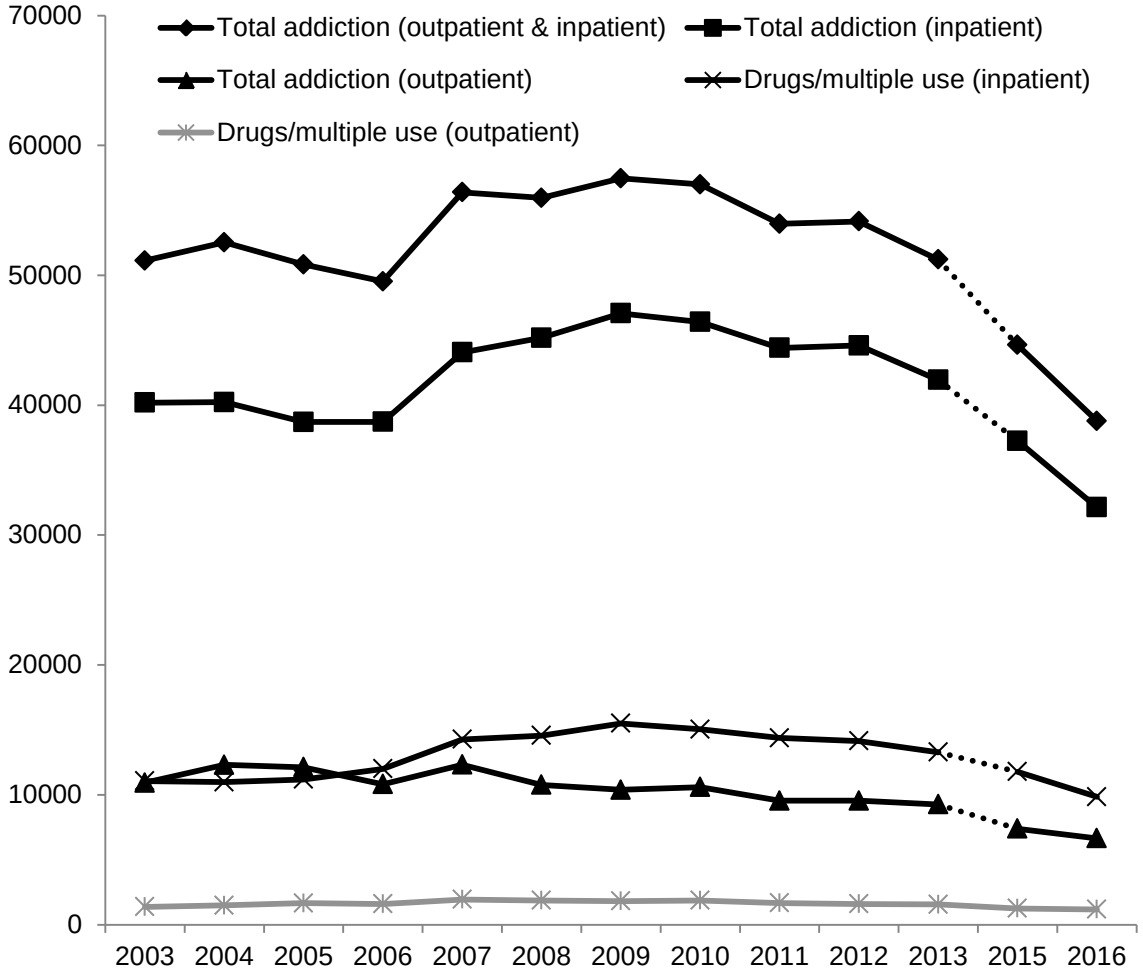
DRV 2017

Figure 7).

Since the reporting year 2015, the available statistics from the DRV for day care treatments have been listed separately. This new breakdown as well as the fact that after-care cases are no longer present, means that the data can no longer be compared to previous years and now seem to be lower (see the hatched line in Note: No data available for 2014.

DRV 2017

Figure 7 as well as Table 9).



Note: No data available for 2014.

DRV 2017

Figure 7 Changes in outpatient and inpatient rehabilitation treatments

Table 9 Change to the encryption of DRV treatment data

	2012		2013	
	inpatient	**outpatient**	**inpatient**	**outpatient**
Alcohol	29,990	7,865	28,199	7,618
Drugs	12,242	1,322	13,225	1,535
Medicines	461	83	467	87
Multiple	1,907	272	51	29
Total All clients entering treatment	44,600	9,542	41,942	9,269

	2015			2016		
	inpatient	**day care***	**outpatient**	**inpatient**	**day care***	**outpatient**
Alcohol	25,047	1,916	6,072	21,848	1,762	5,401
Drugs	11,764	412	1,258	9,824	355	1,181
Medicines	423	21	58	441	22	63
Multiple	15			19		3
Total All clients entering treatment	37,249	2,349	7,388	32,132	2,139	6,648

* all day outpatient.

DRV 2017

The total number of acute addiction or drug treatments in hospital has increased a little since 2010, with slight fluctuations (Destatis 2017). The largest increase recorded this year was no longer in stimulants (+29%; 2014: +48%), but with hallucinogens (+29%, 2014: +16%). In third place are treatments due to the use of cannabinoids (+13%, 2014: +29%). The sharp increase in opioid treatments in 2014 (+20%) slowed slightly this year (2016: +4%).

Taking a longer view, the 264% increase in treatments for stimulants use since 2010 is considerable, followed by a 126% rise in cocaine related treatments. The use of cannabinoids also resulted in 111% more hospital treatments than in 2010 (Table 10).

Table 10 Inpatient treatment of drug problems in hospitals

Primary diagnosis substance	Year						Change	
	2010	2011	2012	2013	2014	2015	2015 - 2014	2015 - 2010
Alcohol	333,357	338,355	345,034	338,204	340,500	326,971	-4%	-2%
Opioids	32,538	28,956	26,512	27,962	33,686	34,916	4%	7%
Cannabinoids	8,145	9,094	10,142	11,708	15,153	17,148	13%	111%
Sedatives/Hypnotics	9,270	10,241	9,999	9,707	10,082	10,134	1%	9%
Cocaine	1,076	1,222	1,417	1,702	2,200	2,435	11%	126%
Stimulants	2,805	3,878	4,519	5,810	8,627	10,216	18%	264%
Hallucinogens	430	574	472	526	610	789	29%	83%
Tobacco	310	269	225	238	190	213	12%	-31%
Volatile substances	171	198	155	135	159	153	-4%	-11%
Multiple use/other substances	41,449	41,777	43,063	43,826	35,798	35,731	0%	-14%
Total addiction	429,551	434,564	441,538	439,818	447,005	438,706	-2%	2%
Total drugs	95,884	95,940	96,279	101,376	106,315	111,522	5%	16%

Destatis 2017.

2.2 Additional trends in drug treatment (T2.2)

No additional information is currently available on this topic.

3 New developments (T3)

3.1 New developments (T3.1)

Methamphetamine

The topics of "New developments" in the 2016 workbook are still current and continue to occupy both drug policy and addiction support. This applies in particular for methamphetamine problems, for which nationwide data from the DSHS will be available for the first time from 2017 onwards.

The evaluation of the target group specific online self-help portal for methamphetamine users announced in the 2016 Treatments workbook is now available. The project was developed by the Centre for Interdisciplinary Addiction Research (Zentrum für Interdisziplinäre Suchtforschung, ZIS) of the University of Hamburg. The service was launched as planned, however several modifications to the moderation and operation concept were necessary in the initial project phase, in order to achieve sufficient appeal and accuracy of fit. The targeted number of active users of the portal was successfully reached several months before the end of the project. Since then, the service is being used by an ever-growing number of registered

members with increasing activity. In addition, the portal resonated with therapists and employees in the areas of outpatient and inpatient addiction support, social work, youth work, aftercare and prevention. In addition to analyses of registered users and further optimisation of the portal, the needs of the above mentioned groups who will introduce those concerned to the portal are the most important in the further operation and completion of the research. To this end, comprehensive surveys as well as the development of specific information and training material are appropriate and planned (Milin & Schäfer July 2016).

Furthermore, the results of the "FreD-ATS"[4] project are available, which is directed specifically at young people (LWL-Koordinationsstelle Sucht 2017). Referral or assignment in this project takes place by the police, the public prosecutor or the courts. At the time of the start of the project in July 2015, there was an inconsistent assessment of the crystal meth problem in Germany. There were indications of very differing rates of distribution regionally. Saxony, Thuringia and parts of Bavaria were especially affected. However, practitioners from other *Laender* also reported an increased mixed use with amphetamines and NPS among young people. The evaluation of the project shows:

- In addition to cannabis, ATS are the most frequently used primary substance among course participants, in particular in facilities in the new *Laender*.
- For 83% of participants, the FreD course is their first contact with the (addiction) support system.
- The adolescents feel better informed, reflect on their interaction with substances and their use behaviour and strive to change it.
- The FreD trainers assess the FreD-ATS supplement as current, comprehensive and aligned to the needs of the young people.
- The referrals continue to come mainly from law enforcement authorities (LWL-Koordinationsstelle Sucht 2017).

A project which targets drug using, usually crystal meth using, pregnant women is "Mama, denk an mich" (Mama, think of me). In this, clinics for child and youth medicine, gynaecology and for psychiatry and psychotherapy collaborate interdisciplinarily, in order to enable women to stop using drugs during or after pregnancy and to improve the prospects of the new born babies being able to remain with, and be looked after by, their mothers. In the first 10 months of the project, the percentage of children who were able to remain with their birth families increased from one third to two thirds (Pressestelle Universitätsklinikums Carl Gustav Carus Dresden 29 November 2016).

As was announced in the previous year, the globally used treatment manual MATRIX, for people dependent on stimulants, has been translated into German and adapted for clients dependent on methamphetamines. Therefore, it is now also available for the German-speaking world (suprat.de).

[4] ATS = Amphetamine Type Stimulants

Migration and addiction support

The topic of addiction support and migration or refugees continues to be relevant. Questions are still not being satisfactorily answered about the prevalence of use of addictive substances and the need of support by refugees, as well as suitable treatment options for persons with migration backgrounds. The following points were diagnosed as obstacles to treatment by an expert group (Ameskamp et al. 2026):

- Many refugees, in particular those who have only developed a substance disorder during or after their flight, are not aware of the symptoms of their disorder or can not interpret them as such. Usually, dependence is regarded not as an illness but as a moral failing or stroke of fate. Knowledge about social and medical support options does not exist.
- For refugees (and migrants in earlier years), the available treatment options are only available to a limited extent. A so-called emergency slip (certificate to cover 24 hours of costs) only authorises the holder to withdrawal treatment for dependence on opioids, alcohol and other substances. After withdrawal, there is no opportunity for abstinence-based treatment. Outpatient abstinence-based treatment or substitution treatment is only possible for asylum seekers once they have a health card for asylum seekers (in NRW, Bremen, Hamburg and Berlin). Addiction medicine rehabilitation treatments (inpatient withdrawal treatments) are generally not available, neither are day structuring and stabilising support.
- Mostly, interpreters are not available for anamneses, examinations and follow-up sessions, or are not paid for by the funding agencies. Language mediators with the necessary (sub) culture and refugee-specific knowledge are not only necessary for visits to doctors but also for preparatory and accompanying motivational work in order to design treatment in a meaningful manner.
- Information material available in native languages for the main user groups affected is lacking as is material for illiterate people, and a platform enabling access to native language publications, announce events and facilitate training.
- Economic compulsive crime in connection with opioid dependence, and the use in itself, can be grounds for deportation.
- Many refugees are located in rural regions where addiction related support is not available in sufficient capacity.

In addition to the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA) and the DHS, many *Land* bodies for addiction issues, specialist addiction prevention centres or addiction support agencies deal with the subject of migration and refugee flight. They produce illustrated, written native language informational materials, in order at least to counteract the above named information deficit (e. g. Hesse, Berlin, Hamburg). Counselling and group sessions, early intervention and referral to further support will are also offered, e. g. by the project "Guidance" of the drug emergency service in Berlin. The project started in October 2016. 135 counselling meetings were provided between

January to April 2016. The project works with native speaking language mediators (Arabic and Farsi), and is funded by the Berlin Senate[5].

New Psychoactive Substances

NPS were also the subject of intense discussion within the addiction support system, in the approval process for the NpSG - which came into force in November 2016. This has been reflected i.a. in the revision of the KDS (KDS 3.0) (DHS 2016). The KDS is an addiction support specific data gathering tool, which is widely used in both outpatient and inpatient addiction support (see section 5 Sources and methodology). In KDS 3.0 "other and synthetic cannabinoids," "synthetic cathinones," "GHB/GBL," "ketamine" and "other NPS" have been included from 2017 onwards. Specific treatment programmes for NPS users still have not been introduced in Germany. Simon and Colleagues (2016) recommend, on the basis of reporting by the EMCDDA, the use of elements of good clinical and acute medical practice, tailored to the individual conditions and supplemented by specific elements where this is possible. Further information can also be found in the 2016 and 2017 Drug Policy and Drugs workbooks.

Three further developments in recent years have led to intense discussions:

Improvement in the access routes to treatment

Due to falling requests for medical withdrawal treatments in recent years, funding agencies (DRV and GKV), specialist addiction associations and clinic operators consulted on how this development could be reversed. Among other possible reasons for the fall in requests, the access routes and "non-admission rates" for approved treatments were examined. As a minimal compromise between the DRV, GKV and the German Hospital Association (Deutschen Krankenhausgesellschaft, DKG e.V.), basic recommendations were developed for the improvement of access to qualified withdrawal in the medical rehabilitation of persons with dependency disorders (seamless process for qualified withdrawal/addiction rehabilitation) (DRV, GKV & DKG 2017). This was generally welcomed by the specialist addiction associations and their member associations as well as by clinic operators, however it was criticised as not having gone far enough.

The Heidelberg Congress 2016 "Addiction moves - broadening routes to access" was also concerned with the issue of access routes, as did a series of lectures of the Bavarian Academy for Addiction and Health Questions (Bayerischen Akademie für Sucht- und Gesundheitsfragen, BAS) (BAS 5 July 2017).

The prescription of medicinal drugs containing opioids for chronic, non tumour related pain.

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

[5] drogennotdienst.org

related pain received, according to data by Barmer GEK in 2010, around three quarters of all prescribed opioids, in part despite existing contraindications (Just et al. 2016). In Germany, the proportion of those covered by statutory health insurance with at least one opioid prescription per year increased from 3.3 to 4.5% between 2000 and 2010, which corresponds to an increase of 37% (Schubert et al. 2013).

In order to be able to better assess the prescribing behaviour, the Federal Ministry of Education and Research (Bundesministerium für Bildung und Forschung, BMBF) is funding a 27-month project entitled "Extent and trends of the problem medicating with benzodiazepine, Z-substances, opioid analgesics and anti-depressants among statutory health insurance patients (ProMeKa)". The objective is to obtain new, comprehensive and representative knowledge on the distribution and trends of long-term prescriptions as well as possibly anti-guideline prescribing behaviour for medicinal drugs with addictive potential as well as anti-depressants among patients insured under the GKV. It also aims to identify at-risk groups with conspicuous and high-risk prescribing patterns of these substances (ZIS homepage).

Cannabis as medicine

With the Amending Act on Narcotic Drugs and other Regulations, which came into force on 10 March 2017, the legislature expanded the possibilities for prescribing cannabis-based pharmaceuticals. The act stipulates, among other things, the introduction of a state body (Cannabis Agency). That body controls and polices the cultivation of cannabis for medicinal purposes in Germany. Furthermore, the BfArM has been tasked with conducting non-interventionist data collection on the use of cannabis-based pharmaceuticals. The data collected will be evaluated in 2022 (BfArM Homepage). More detailed information can be found in the Legal Framework workbook.

In Germany in recent years only a few hundred patients (2014: 382 persons) have received permission for the legal use of cannabis as a painkiller. North Rhine-Westphalia was in first place with 93 patients. Bavaria was second with 84, followed by Baden-Württemberg with 62 cannabis patients. According to the news magazine Spiegel online[6] this is evident from a BfArM list. In 2016, the number of permissions granted for the use of cannabis and its use for the purposes of medically-assisted self-therapy increased to 1,061 (BfArM, personal communication). The extent to which changes are the result of the new Act will be apparent from 2018 onwards in the health insurance providers' data, as well as from 2022 onwards in the results of the data collection set out in the Act.

4 Additional information (T4)

4.1 Additional sources of information (T4.1)

No additional sources of information are currently available on this.

[6] 04.03.2015

4.2 Further aspects of drug treatment (T4.2)

No further information on further aspects is currently available.

4.3 Psychiatric comorbidity (T4.3)

The term psychiatric comorbidity is understood in the scope of addiction disorders to mean that patients are suffering from a dependence disorder and exhibiting one or several further disorders from the area of psychiatric diagnoses. The scientific examination of this topic has only been undertaken since the 1990s (Kraus et al. 1998, Kuntze et al 1998, Wittchen et al. 1999, Frei & Rehm 2002, Frei & Rehm 2002a). The discussion helped to draw attention to the frequency and significance of the simultaneous appearance of different psychiatric clinical pictures and their mutual interaction. Comorbid disorders are a some of the greatest challenges in the scope of drug treatment.

The distribution of psychiatric comorbidity among dependence disorders is, according to an evaluation of health insurance providers' data from 2007, very high. Only 37.3% of those treated in Germany for drug addiction and 33.5% of those with multiple substance use report no further psychiatric comorbidity according to the health insurance funds' data (Marschall 2010).

Dependent on the consumed substance and the respective further psychological disorder, very different prevalences are present among drug addicts. The connections between alcohol dependence and psychological disorders (mostly depression) are the best-studied in Germany, as well as those between opioid dependence and psychological disorders.

Persons dependent on opiates exhibit, apart from frequent dependencies on additional psychotropic substances, additional psychological disorders, such as affective disorders and anxiety disorders, personality disorders and post traumatic stress disorders. The disorders can partly be explained as a side effect or consequence of opiate dependence. For the development of a dependence however, pre-existing psychological burdens and early manifesting disorders are seen as significant factors (Scherbaum & Specka 2014).

The Cobra Study (Cost Benefit and Risk Appraisal of Substitution Treatments) with 2,694 opiate dependent patients in substitution treatment (Wittchen et al. 2008) demonstrates the considerable extent of accompanying psychological disorders. In this respect, 57% of study participants were diagnosed with depressive disorders, 25% with anxiety disorders, 31% personality disorders, 21% sleep disorders, 12% posttraumatic stress disorder or acute stress reaction and 5% were diagnosed with psychoses. In the follow-up after 12 months, a significant improvement in the somatic disorders was observed, while among psychological stress no such clear improvement was apparent.

A long term study of opioid dependent persons in substitution treatment, the PREMOS Study (Predictors, Moderators and Outcomes of Substitution Treatment) (Wittchen et al. 2011), expanded on the results of the COBRA study. In the PREMOS Study, no serious psychological disorder was present, according to a doctor's assessment, among 35.4% of study participants. In this study also, the 6-year follow-up did not show any substantial

improvements in the psychological disorders. The most frequent individual diagnoses at the 6-year follow up were depression (38.4%), personality disorders (20.2%), anxiety disorders (16.9%) and sleep disorders (13.5%). The results of the PREMOS study were illustrated in detail in the REITOX Reports 2011 and 2012.

A high incidence of comorbid psychological disorders was also seen in the treatment of methamphetamine addicts. Hamdorf and colleagues found a high need for disorder-specific treatment services in withdrawal as well as the need for outpatient psychotherapy for the further improvement and consolidation of the achievements of withdrawal (Hamdorf et al. 2015).

Among patients diagnosed with schizophrenia, the proportion with lifetime prevalence of abuse or dependence is very high, in particular for the substances nicotine (70-90%), alcohol (20-60%), cocaine (15-50%) and cannabis (12-42%). The proportion is lower among amphetamine dependent persons, however it is at 2-25% (Kauffeldt 2016).

Dependent patients with comorbid psychological disorders exhibit a less favourable development than patients without comorbid disorders (Scherbaum & Specka 2014). This is also reflected in a higher intensity of addiction disorders, worse social integration, a lower retention rate in treatment, more legal problems, a higher suicide rate and more frequent emergency admissions.

The treatment of dependence paired with one or more psychiatric disorders thus, among other reasons, represents a great challenge, since the approaches of the respective treatment are characterised by opposing elements. For example, the focus of psychosis treatment is on protective, shielding interventions, avoidance of stress and overloading and medication-based support. Dependence in itself is not addressed. In contrast, addiction treatment focuses on clarifying, sometimes confrontational interventions, actively addressing deficits and not administering medicinal drugs. Relationships with others is more strongly taken into account - for example, there are group interventions. Finally, the simultaneous treatment of dependence and psychosis is more strongly focussed on dealing with the problem than maintaining the idea of a cure (Kauffeldt 2016).

Addiction support tries to counteract the problem of different treatment approaches through a combination of initial services. Different clinics in a region with different focuses, e. g. acute treatment, crisis intervention, withdrawal, aftercare, follow-up treatment and vocational rehabilitation, work together and have a so-called clearing team at their disposal, which takes on the case management. These services are so far the exception, however (Kauffeldt 2016). In general, there are only a few integrated treatment concepts.

A need for and capacity to undergo rehabilitation as well as a positive rehabilitation prognosis are prerequisites of a normal medical withdrawal treatment. These conditions mean that for certain target groups, such as drug addicts with psychological comorbidity, the utilisation of a withdrawal treatment is made more difficult: abstinence, completely forgoing the use of drugs (including substitutes), is fraught with anxiety and is very unsettling. For most drug addicts, including those without psychological comorbidity, abstinence presents an

uncertain outlook. This outlook is even more precarious if a patient, who has been stabilised physically, psychologically and socially with the help of substitution, has this support taken away. Thus, the possibility of beginning a withdrawal treatment even during substitution is an important option specifically for those patients with comorbid disorders (Kuhlmann 2015). It enables and improves the chance of achieving a considerably higher degree of social integration and quality of life. However, only around 10% of institutions that offer inpatient withdrawal treatment provide concepts for patients who are in substitution treatment when commencing any measures they offer (c.f. section 1.2.6). An internet service from the associations of addiction professionals, the "digital substitution map" ("Digitale Substitutionslandkarte), helps substituting opioid addicts in finding clinics which offer substitution-based withdrawal treatments. The intention is to improve access to withdrawal treatments and opportunities for participation. (buss et al. 2016)

Further services for people suffering from addiction with one or more other psychiatric diagnoses are provided by sociotherapeutic residential facilities. There are however only a few facilities which are specially aimed at this target group. Hence, waiting times are long as a result.

For parents of drug addicted children, adolescents and young adults with a psychological comorbidity, the situation is often difficult to bear. They feel inadequately informed, and left all alone in crisis situations. Not infrequently, they are seen as a part of the addict's problem. Families in which a family member suffers from a dependence disorder are quickly stigmatised through prejudices and fears in society about drugs and dependence. The child's addiction disorder is often believed to be a consequence of parent's lack of skills in bringing up their children and a lack of parental care. If a psychological disorder is also present, this means exclusion, abnormality and even more prejudices in society (BVEK 2008, Berberich-Haiser 2016). The Federal German Association of Parent Circles for at risk of addiction and addicted sons and daughters e. V. (Bundesverband der Elternkreise suchtgefährdeter und suchtkranker Söhne und Töchter e.V., BVEK) tries to support concerned parents and relatives by providing information and assistance in the sense of self-help - parents supporting parents.

The ÖGD provides social psychiatric services (Sozialpsychiatrische Dienste, SPD). These are also utilised by addicts. In 2016, a joint conference of experts from addiction support, psychiatry and ÖGD was intended to encourage a more intensive and better collaboration between the various support systems. Examples of good practice were presented, such as Träger gGmbH in Berlin. It brings together, under one roof, services for people with a psychological disorder, for people with an intellectual disability and for those with addiction disorders. The institutions work closely with the Community Psychiatric Association (Gemeindepsychiatrischen Verbund), the Association for Psychiatry and Mental Health (Verein für Psychiatrie und seelische Gesundheit e.V.), the Paritätische Wohlfahrtsverband Berlin, the umbrella organisation Community Psychiatry (Gemeindepsychiatrie e.V.), the federal initiative Outpatient Psychiatric Care (Ambulante Psychiatrische Pflege e.V.) and the Transparent Civil Society Initiative (Initiative Transparente Zivilgesellschaft).

5 Sources and methodology (T5)

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

The main sources for the Treatment workbook are:

- Statistical Report on Substance Abuse Treatment in Germany (Deutsche Suchthilfestatistik, DSHS) (Base: German Core Data Set, Deutscher Kerndatensatz)
- Statistical Report on Hospital Diagnoses (Krankenhausdiagnosestatistik)
- German Hospital Directory (Deutsches Krankenhausverzeichnis)
- Statistical Report of the German Pension Insurance Scheme (Statistik der Deutschen Rentenversicherung)
- Statistical Report of the Statutory Health Insurance Providers (Statistik der Gesetzlichen Krankenversicherungen)
- Regional monitoring systems
- Substitution register
- Addiction Yearbook 2017 from the DHS

5.1 Sources (T5.1)

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5.2 Methodology (T5.2)

Outpatient care

Based on the KDS, the DSHS provides extensive data on clients treated on an outpatient basis for the majority of outpatient facilities funded by the *Laender* and municipalities (Braun et al. 2017ab). In most addiction support facilities in Germany, the current KDS (DHS 2010a) is used. The KDS was revised in 2007 and a new version will be released in 2017. Due to these revisions, the comparability of data from different time periods will always be limited.

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

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

Inpatient care

In the area of inpatient treatment, 211 facilities participated in the federal analysis of the DSHS in 2016 (in 2015 it was 212 facilities) (Braun et al. 2017d).

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

The KDS, produced by the German Federal Statistical Office, documents the diagnosis on discharge of all patients leaving inpatient facilities as well as the main diagnoses, age and gender. Though complete, the KDS is not specific to the topic of addiction and thus offers little detailed information in this area. It does however allow a differentiation in the number of cases in line with the ICD-classification (F10-F19). Apart from accounting information on services provided by hospitals, there is no systematic collection of comprehensive statistical data on hospital treatments. However, general documentation standards do exist, for example for psychiatric clinics and facilities for child or youth psychiatry. These contain, amongst other things, information on the treatment of patients with addiction problems. So

far, no systematic analysis has been carried out for the transfer of this information to the standard of the KDS.

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

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

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

Substitution treatment

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

6 Tables

7 Figures