



European Monitoring Centre
for Drugs and Drug Addiction



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2011 National Report to the EMCDDA by the Reitox National Focal Point

GERMANY

New Developments, Trends and In-Depth Information on Selected Issues

Drug Situation 2010/2011

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In its function as national focal point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the DBDD assigns national experts to the five epidemiological key indicators. Serving as contact persons for the EMCDDA, these experts take part in the experts' conferences held yearly at European and national level with a view to further harmonize and develop the key indicators. They moreover contribute to the creation of this annual Report by writing texts on specific topics and giving feedback to the draft versions of the individual chapters.

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Note: For better legibility, the present report refrains from using female grammatical forms that are instead subsumed under the respective male gender.

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ABBREVIATIONS

Abbreviation	German	English
ADHD	Aufmerksamkeitsdefizit- /Hyperaktivitaetsstoerung (ADHS)	Attention deficit hyperactivity disorder
AIDA	Assistierte Integration substituierter Drogenabhaengiger in den Arbeitsmarkt	Assisted integration of drug users undergoing substitution therapy into the labour market
AJSD	ambulanter Justizsozialdienst	
AMNOG	Arzneimittelmarkt- Neuordnungsgesetz	Act on the new Regulation of the Medicinal Drugs Market
APA		American Psychiatric Association
ASD	Allgemeine Soziale Dienste	
AVerCa	Aufbau einer effektiven Versorgungsstruktur zur Frueherkennung und Fruehintervention jugendlichen Cannabismissbrauchs	Development of an effective care structure for the early recognition and early intervention in adolescent cannabis abuse
AWMF	Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften	Association of the Scientific Medical Societies in Germany
BÄK	Bundesaerztekammer	German Medical Association
BAMF	Bundesamt fuer Migration und Fluechtlinge	Federal Agency for Migration and Refugees
BAS e.V.	Bayerische Akademie fuer Suchtfragen in Forschung und Praxis	Bavarian Academy for Addiction Issues in Research and Practice
BayStVollzG	Bayerisches Strafvollzugsgesetz	Bavarian Prison Law
BfArM	Bundesinstitut fuer Arzneimittel und Medizinprodukte	Federal Institute for Drugs and Medical Devices
BGH	Bundesgerichtshof	Federal High Court of Justice
BKA	Bundeskriminalamt	Federal Criminal Police Office
BkiSchG	Bundeskinderschutzgesetz	Federal Child-Protection Act
BMAS	Bundesministerium fuer Arbeit und Soziales	Federal Ministry for Employment and Social Affaires
BMBF	Bundesministerium fuer Bildung und Forschung	Federal Ministry for Education and Research
BMFSFJ	Bundesministerium fuer Familie, Senioren, Frauen und Jugend	Federal Ministry for Family, Senior Citizens, Women and Youth
BMG	Bundesministerium fuer Gesundheit	Federal Ministry for Health
BMI	Bundesministerium des Innern	Federal Ministry of the Interior
BMJ	Bundesministerium der Justiz	Federal Ministry of Justice
BMVBS	Bundesministerium fuer Verkehr, Bau und Stadtentwicklung	Federal Ministry for Transport, Building and Urban Development
BOPST	Bundesopiumstelle (innerhalb des BfArM; s.o.)	Federal Opium Agency (one of the 13 departments at the Federal Institute for Drugs and Medical Devices)
BSG	Behoerde fuer Soziales, Familie, Gesundheit und Verbraucherschutz	Agency for Social Affaires, Family, Health and Customer Protection
BtM	Betaeubungsmittel	Narcotic drugs
BtM-AendV	Betaeubungsmittelrechts- Aenderungs-verordnung	Amending regulation on narcotic drugs

Abbreviation	German	English
BtMG	Betaeubungsmittelgesetz	Narcotics Act
BtMG-AendG	Gesetz zur Aenderung des Betaeubungsmittelgesetzes	Amending Narcotics Act
BtMVV	Betaeubungsmittelverschreibungsverordnung	Narcotics Prescription Regulation
BUB-Richtlinien	Richtlinien ueber die Bewertung von aertzlichen Untersuchungs- und Behandlungsmethoden	Guidelines on the evaluation of medical examination and treatment methods
buss	Der Bundesverband fuer stationaere Suchtkrankenhilfe e.V.	Federal Association for inpatient addiction help
BZgA	Bundeszentrale fuer gesundheitliche Aufklaerung	Federal Centre for Health Education
CaBS	Casemanagement und Beratung fuer cannabiskonsumierende Schueler	Case management and counselling for cannabis using school children
CBD	Cannabidiol	cannabidiol
CDR		Centre for Drug Research
CND	Suchtstoffkommission der Vereinten Nationen	Commission on Narcotic Drugs of the United Nations
COBRA		Cost Benefit and Risk Appraisal of Substitution Treatments
COFOG	Klassifikation der Ausgaben des Staates nach dem Verwendungszweck	Classification of the Functions of Government
COMBASS	Computergestuetzte Basisdokumentation der Suchthilfe in Hessen	Computer-assisted basic documentation of the addiction help system in Hessen
CPT	Europaeisches Komitee zur Verhuetung von Folter und unmenschlicher oder erniedrigender Behandlung oder Strafe	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
DAH	Deutsche Aidshilfe	German Aids Help Organisation
DAS	Drogenaffinitaetsstudie der BZgA	Drug affinity study of the Federal Centre for Health Education
DBDD	Deutsche Referenzstelle fuer die Europaeische Beobachtungsstelle fuer Drogen und Drogensucht	German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction
DBT	Dialektisch-Behaviorale Therapie	Dialectic behavioral therapy
DeStatis	Statistisches Bundesamt Deutschland	Federal Statistics Office
DFB	Deutscher Fußball-Bund	German Football Association
DFG	Deutsche Forschungsgemeinschaft	German Research Network
DGS e.V.	Deutsche Gesellschaft fuer Suchtmedizin	German Society for Addiction Medicine
DGVS	Deutsche Gesellschaft fuer Verdauungs- und Stoffwechselkrankheiten	German Society for Digestive and Metabolic Diseases
DHS	Deutsche Hauptstelle fuer Suchtfragen	German Centre for Addiction Issues
DHV	Deutscher Hanfverband	German Hemp Association
DifU	Dt. Institut fuer Urbanistik gGmbH	German Institute for Urbanistics

Abbreviation	German	English
DISuP	Deutsches Institut fuer Sucht- und Praeventionsforschung	German Institute for Addiction and Prevention Research
DJI	Deutsches Jugendinstitut	German Youth Institute
DJK	Deutsche Jugendkraft	German Youth Power Sports Association
DOSB	Deutscher Olympischer Sportbund	German Olympic Sports Association
Dot.sys	Dokumentationssystem fuer Maßnahmen der Suchtpraevention	Documentation system for addiction prevention measures
DPIP	Drogenpraeventions- und informationsprogramm	Drug Prevention and Information Programme
DRUID	Fahren unter dem Einfluss von Drogen, Alkohol und Medikamenten	Driving under the Influence of Drugs, Alcohol and Medicines
DRV	Deutsche Rentenversicherung Bund	German National Statutory Pension Insurance
DSHS	Deutsche Suchthilfestatistik	German Statistical Report on Treatment Centres for Substance Use Disorders
DSM	Diagnostisches und statistisches Manual psychischer Stoerungen	Diagnostic and Statistical Manual of Mental Disorders
DSR	Drogen- und Suchtrat	National Board on Drugs and Addiction
DVW	Deutschen Verkehrswacht	German Road Safety Organisation
DZSKJ	Deutsches Zentrum fuer Suchtfragen des Kindes- und Jugendalters	German Centre for Addiction Research in Childhood and Adolescence
EBDD / EMCDDA	Europaeische Beobachtungsstelle fuer Drogen und Drogensucht	European Monitoring Centre for Drugs and Drug Addiction
EDSP		Early Developmental Stages of Psychopathology
EkhD	Erstauffaellige Konsumenten harter Drogen	Users of hard drugs who have come to the notice of the police for the first time
EDDRA	Austausch ueber Aktivitaeten zur Reduzierung der Drogennachfrage	Exchange on Drug Demand Reduction Action
ENCARE		European Network for Children Affected by Risky Environments within the Family
ENDIPP		European Network on Drugs and Infections Prevention in Prison
ESA	Europaeische Suchtstudie (frueher Bundesstudie)	Epidemiological Survey on Addiction
ESPAD	Europaeische Schuelerstudie zu Alkohol und anderen Drogen	European School Survey Project on Alcohol and other Drugs
EU	Europaeische Union	European Union
FAIRE	Fachstelle fuer Arbeitsmarktintegration und Reintegration Suchtkranker	Agency for labour market integration and reintegration of addicted people
fdr	Fachverband Drogen und Rauschmittel e.V.	fdr – Federation of drug help organisations
FDR	Falldatei Rauschgift	Drugs Data File
FeV	Fahrerlaubnisverordnung	Driving license regulation
FOGS	Koelner Gesellschaft fuer Forschung und Beratung im Gesundheits- und Sozialbereich	Cologne Society for Research and Counselling in Health and Social Affairs
FP7	7. Forschungsrahmenprogramm	7th Research Framework Programme

Abbreviation	German	English
FreD	Fruehintervention bei erstauffaelligen Drogenkonsumenten	Early intervention in drug users who came to the notice of the police for the first time
FTK	Fortbildung Transkulturell	Society for transcultural further education
G-BA	Gemeinsamer Bundesausschuss	Common Federal Committee
GG	Grundgesetz	German Constitution
GKV	Gesetzliche Krankenversicherung	SHI -Statutory Health Insurance Scheme
GRV	Gesetzliche Rentenversicherungen	Statutory Social and Pension Insurances
HaLT-Projekt	Hart am Limit-Projekt	HaLT – alcohol prevention project
HAV	Hepatitis A-Virus	Hepatitis A virus
HBSC		Health Behaviour in School-aged Children
HBV	Hepatitis B Virus	Hepatitis B Virus
HCV	Hepatitis C Virus	Hepatitis C Virus
HDG	Horizontale Drogengruppe	Horizontal Drug Group
HmbStVollzG	Hamburgisches Strafvollzugsgesetz	Hamburg Prison Law
HRQOL		Health-Related Quality of Life
HStVollzG	Hessisches Strafvollzugsgesetz	Hessian Prison Law
ICD		International Classification of Diseases
IDIAL	Intensivbetreuung substituierter Drogenabhaengiger zur Integration in den Arbeitsmarkt und unterstuetzten Lebensfuehrung	Intensive care for drug users for labour market integration and assisted living
IFT	Institut fuer Therapieforchung	Institute of Therapy Research
IfSG	Infektionsschutzgesetz	Infectious Diseases Control Law
IDU	IVD -Intravenoes applizierender Drogenkonsument	Injecting drug user
IKUSH	Interkulturelle Suchthilfe in Leipzig vom Ehrenamt zur Profession	Intercultural addiction help in Leipzig from voluntary work to profession
INDRO e.V.	Institut zur Foerderung qualitativer Drogenforschung, akzeptierender Drogenarbeit und rationaler Drogenpolitik e.V.	Institute for the Furtherance of Qualitative Drug Research, Acceptance-Oriented Drug Work and Rational Drug Policy
JVA	Justivollzugsanstalt	Detention facility
JVollzGB	Justizvollzugsgesetzbuch	Prison Code
KDS	Deutscher Kerndatensatz zur Dokumentation im Bereich der Suchtkrankenhilfe	German Core Data Set for Addiction Help
KFM	Kurzfragebogen zum Medikamentengebrauch	Short questionnaire on medical drug abuse
KiD	Hilfe fuer drogenabhaengige Eltern und ihre Kinder	KiD - Help project for drug dependent parents and their children
KiGGS	Kinder- und Jugendgesundheitssurvey	Health Interview and Examination Survey for Children and Adolescents
KKG	Gesetz zur Kooperation und Information im Kinderschutz	Act on Cooperation and Information in the area of Child Protection
KOALA e.V.	Kinder ohne den schaedlichen Einfluss von Alkohol und anderen Drogen e.V.	Children without the harmful influence of alcohol and other drugs - Help association for children from families with addiction problems

Abbreviation	German	English
KOLIBRI	Konsum aller leistungsbeeinflussenden Mittel in Alltag und Freizeit	Use of performance enhancing drugs for everyday and recreational purposes
KV	Kassenaerztliche Vereinigung	Association of SHI-accredited physicians
LKA / LKÄ	Landeskriminalamt / Landeskriminalaemter	Land Criminal Police Office/s
LMS	Local Monitoring System	LMS
LWL	Landschaftsverband Westfalen-Lippe	Land association Westfalen Lippe
LWL-KS	Landschaftsverband Westfalen-Lippe Koordinationsstelle Sucht	Land association Westfalen-Lippe Coordination Centre Addiction
MATE-ICN		Measurements in the Addictions for Triage and Evaluations – ICF-Core-Set and Needs for Care
MDFT	Multidimensionalen Familientherapie	Multi-dimensional family therapy
MoSyD	Frankfurter Monitoring System Drogen	Frankfurt Monitoring System Drugs
NACOA Deutschland	Interessenvertretung fuer Kinder aus Suchtfamilien e. V.	National Association for Children of families with addiction problems
NACOA		National Association for Children of Alcoholics
NJVollzG	Niedersaechsisches Justizvollzugsgesetz	Lower-Saxon Prison Law
NUB	Neue Untersuchungs- und Behandlungsmethoden	New examination and treatment methods
NZFH	Nationales Zentrum Fruehe Hilfen	National Centre for Early Aid
ODAS		Opiate Dosage Adequacy Scale
OST	Opioid-Substitutionstherapie	Opioid substitution therapy
PDU		Problem Drug Use
PEG-IFN- α	pegyliertes Interferon- α	Pegylated Interferon- α
PERMIT		Psycho-education reaches methadone / buprenorphine substituted patients in antiviral treatment
PHP		Public Health Program
PKS	Polizeiliche Kriminalstatistik	Police criminal statistics
PREMOS-Studie		Predictors, Moderators and Outcomes of Substitution Treatment - Study
Prev@WORK	Praevention in der Ausbildung	Prevention in vocational training
ProPK	Programm Polizeiliche Kriminalpraevention der Laender und des Bundes	Program Police Criminal Prevention of the <i>Laender</i> and the Federal Government
QIP	Qualitaet in der Praevention	Quality in prevention
RBV	Ribavirin	Ribavirin
RC		Research Chemicals
REITOX	Europaeisches Informationsnetzwerk zu Drogen und Sucht	REITOX- European Information Network on Drugs and Addiction
RKI	Robert Koch Institut	RKI - Robert Koch Institute
RV	Rentenversicherung	Pension Insurance

Abbreviation	German	English
SAPV	spezialisierte ambulante Palliativversorgung	Specialized outpatient palliative care
SDS	Skala zur Erfassung des Schweregrades der Abhaengigkeit	Severity of Dependence Scale
SGB	Sozialgesetzbuch	Social Security Codes
SKH	Suchtkrankenhilfe	Addiction help
SKOLL	Selbstkontrolltraining	Self-control training
SQ	Strukturierter Fragebogen	Standard Questionnaire
ST	Standardtabelle	Standard Table
StBA	Statistisches Bundesamt (Destatis)	Federal Statistics Office
StGB	Strafgesetzbuch	Penal Code
StVG	Straßenverkehrsgesetz	Road Traffic Act
StVO	Straßenverkehrsordnung	Road Traffic Regulations
StVollzG	Strafvollzugsgesetz	Prison Law
TDI		Treatment Demand Indicator
THC	Tetrahydrocannabinol	Tetrahydrocannabinol
transVer	transkulturelle Versorgung von Suchtkranken	Transcultural care of addicted people
TREAT		Treatment systems Research on European Addiction Treatment
TTM	Transtheoretisches Modell	Transtheoretical model
UKE	Universitaetsklinikum Hamburg-Eppendorf	University Clinic Hamburg-Eppendorf
UN	Vereinte Nationen	United Nations
WFSBP		World Federation of Societies of Biological Psychiatry
WHO	Weltgesundheitsorganisation	World Health Organization
WIAD	Wissenschaftliches Institut der Aerzte Deutschlands	Scientific Institute of the German Medical Association
ZIS	Zentrum fuer interdisziplinaere Suchtforschung	Centre for interdisciplinary addiction research

Introduction

One of the major tasks of the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (Deutschen Beobachtungsstelle fuer Drogen und Drogensucht, DBDD)¹ is to report yearly to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) on the drug situation in Germany, serving as a contact partner for the latter in its function as the so-called German REITOX¹ focal point.

The DBDD produced the German REITOX Report 2010/2011 in accordance with the standard European guidelines issued by the EMCDDA, taking into account the quality report's feedback on previous reports. The report is mainly based on the data from the year 2010, but also includes findings from the year 2011 as far as available until completion of the report.

Each chapter of the report has an introductory passage presenting the most important and updated background information – e.g. on the structure of the health care system or the available data sources. These parts have only been revised according to the requirements and updated. They describe the most important fundamentals such as methodological aspects of regularly carried out surveys. The introductory passages are to help to see the updated information on the drug situation in context and comprehend it without having to resort to supplementary literature. For the first time in 2009, these parts of the report have been marked (framed and highlighted in grey colour) so that readers, familiar with the framework conditions of the German reporting system, may, while reading, concentrate on the new developments.

The other sections of the individual chapters provide exclusively new data and findings from the reporting year. Older data are only used for comparative purposes where appropriate. Otherwise, the report refers to earlier publications or to pertaining standard tables (ST) and structured questionnaires (SQ) of the EMCDDA that contain a multitude of information. They are available from the statistical bulletin released by the EMCDDA (www.emcdda.europa.eu/stats11), but can, of course, also be electronically supplied by the DBDD on request.

In this year's Report, the two Selected Issues are devoted to the topics "Drug-related health policies and services in prison" and "Drugs users with children". These Selected Issues highlight two areas of topics that have increasingly moved into the centre of experts' discussions in Germany. The provision of services to drug using detainees form a considerable part of the work performed by the health services in prisons. Without having an insight into the available resources and special offers made in this area, reporting would be even more fragmentary than it already is as a result of missing federal standards for the documentation of services provided. For this reason, the DBDD carried out its own survey among all ministries of justice of the *Laender* in cooperation with the drug and addiction

¹ Réseau Européen d'Information sur les Drogues et les Toxicomanies.

commissioners of the federal states to flesh out the Selected Issue “Drug-related health policies and services in prison“. The great willingness of most of the ministries of justice to provide large amounts of data and information on this complex of topics has considerably helped to complement the existing information that mainly stems from scientific studies. This is – following the workshop run in November 2010 by the DBDD in cooperation with the Ministry of Health on the topic of “Drugs in prison“ - another example within a short period of time for the excellent cooperation with our partners from the judiciary that made the comprehensive reporting on this year’s Selected Issue possible in the first place.

Many drug users and people with drug-related disorders have children. Therefore, the correlates of drug use do not only impact the drug users themselves but also many areas of the lives of their children. The impact of drug use of parents is manifold, reaching from manifest health risks to considerable problems in the psychological and social area. Thanks to the changes made to the help system (in particular in connection with the substitution treatment of opioid addicts) a larger number of addicted people are nowadays able to live in family structures and to better master their tasks as parents. Drug users with children need particular support from the help system that attends both to the problems of the drug using parents and children, requiring cooperations with partners outside of the traditional addiction help system.

In the year 2012, the EMCDDA, too, will bring out publications that will complement the Selected Issues of the national focal points, approaching them from a European perspective.

On behalf of the German Reitox Reference Centre I would like to express my special thanks to all experts for their cooperation, their support and the host of valuable information they have provided us with in the reporting year. It is only thanks to the existence of such an extensive network that cross-sectional reporting within the framework of the Reitox Report is made possible.

Finally, I would like to draw your attention to the new and re-designed website of the DBDD on which you find further information on the DBDD and on the national report (www.dbdd.de). Information on the EMCDDA, data from other EU-countries and on the European report can be found at www.emcdda.europa.eu.

Munich, October 2011

Tim Pfeiffer-Gerschel
Head of the DBDD

Summary

The present report on the drug situation in Germany has been prepared on behalf of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), which is an agency of the European Union. The report is the result of joint work performed by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (Deutsche Beobachtungsstelle fuer Drogen und Drogensucht, DBDD), the Institute for Therapy Research (Institut fuer Therapieforschung, IFT), the Federal Centre for Health Education (Bundeszentrale fuer gesundheitliche Aufklaerung, BZgA) and the German Centre for Addiction Issues (Deutsche Hauptstelle fuer Suchtfragen, DHS). The DBDD is funded by the Federal Ministry for Health and Social Affairs and the EMCDDA. The overall report is structured according to the EMCDDA guidelines and is available for download at www.dbdd.de.

Drug policy: legislation, strategies and economic analysis

Isolated “drug” concepts have meanwhile been replaced by a cross-substance “addiction” policy that increasingly sets the focus on common aspects of the whole range of psychotropic substances. As a reaction to the new challenges posed to addiction and drug policy and current developments, the Federal Government Commissioner on Narcotic Drugs has developed a “national strategy on drug and addiction policy“ that is currently coordinated with the departments of the Federal Government. The National Board on Drugs and Addiction (Drogen- und Suchtrat, DSR) of the 17th legislative period set to work at its constituent meeting on 10 November 2010. Within the framework of the 25th amending regulation on narcotic drugs (25. BtMAendV) it has been stipulated among others that it is possible for proprietary medicinal drugs containing cannabis to be manufactured and prescribed by doctors after clinical testing and licensing by the Federal Institute for Drugs and Medical Devices (Bundesinstitut fuer Arzneimittel und Medizinprodukte, BfArM) for the first time in German history. New psychotropic substances have been observed for some time to make a stronger appearance at the national, European and international level. Mostly manufactured for recreational purposes, these substances are generally synthetic derivatives that do not fall anymore under the Narcotics Act but have a similar or even stronger effect than their precursor substances (“designer drugs“). With this, legal bans and controls under the Narcotics Act are bypassed and new markets created or respectively maintained as a result of the legal grey zone that exists until the respective substance gets placed on the list of controlled substances. An expert opinion assessed the feasibility of the introduction of a defined substance group to the Narcotics Act to prevent regulations of the Narcotics Act from being bypassed. Moreover, numerous projects have been carried out at regional, federal and international level in the area of drugs especially in cooperation with the Federal Health Ministry.

Drug use in the population and specific targeted groups

The results of the last Epidemiological Survey on Substance Abuse (ESA) carried out in 2009 were already presented in the Reitox Report 2010. They corroborate the findings of earlier surveys, showing that about a quarter of the adult population in Germany has experience with drugs. The portion of adults who took drugs in the last 12 months still was at 5%; less than 3% used drugs in the last 30 days. Cannabis remains the by far most commonly used illicit drug. Noteworthy figures were only reached by cocaine, amphetamines, ecstasy and mushrooms. The use of heroin, LSD and crack remains limited to a specific group that is clearly smaller in numbers.

In 2011, the Federal Centre for Health Education published the results of a recent representative survey conducted on the cannabis use of teenagers and young adults in Germany. According to this survey, 7.4% of the teenagers aged between 12 and 17 years and 35.0% of the young adults aged between 18 and 25 years have used cannabis at least once in their life (life time prevalence). 5.0% of the 12- to 17-year olds and 12.7% of the 18- to 25 year olds also used cannabis in the last 12 months before the survey (12-month prevalence). In the last 30 days before the survey, 1.7% of the adolescents and 5.3% of the young adults used cannabis (30-day prevalence). After having significantly increased in the 1990's, life time prevalences for cannabis use are currently on the decline in all age and gender groups. The 12-month prevalence and the 30-day prevalence found by the recent survey are lower on a statistically significant scale in almost all surveyed groups.

The findings of a recent school survey conducted within the framework of the Frankfurt MoSyD complement the results of the federal study. Moreover, MoSyD also provides information on a recent scene survey as well as the trend scout and expert panel.

Prevention

Despite the continuous decline in cannabis use among adolescents and young adults in Germany, it remains important to have the illicit substance cannabis addressed by suitable preventive measures. As in the previous years, the still too high and - in part - excessive use of alcohol among children and adolescents continues to be intensely discussed by the expert public and press in Germany. Since the use of alcohol in combination with an illicit drug represents a widely spread risk behaviour, prevention specialists have reacted with a high number of substance-related prevention measures in order to promote low-risk consumption of alcohol and to reduce the use of licit and illicit substances in all age groups of the population. Substance-related prevention activities and cross-substance measures like for example the promotion of health and life skill competences as well as the formation of critical views are about equally spread in Germany.

Within the framework of universal prevention measures, parents – in addition to children and teenagers – form an important target group especially for cross-substance measures. Parents are often embedded in the school setting or are directly addressed as a target group of life skill training measures of family-based prevention. Next to improving child rearing skills

and harmonious interaction within the family, parents are to become aware of the importance of the role model function they assume for their children with regard to substance use.

With the use of the “new media” increasingly gaining in importance in the prevention of addiction, new ways of access for different target groups – especially for children and adolescents but also for example for people with a migration background continue to be further developed. Information on help, counselling and treatment possibilities is provided in the Internet as low-threshold information offers. These information channels help to give access to people who so far could not be reached by prevention measures.

Problem drug use

Based on the figures from treatment facilities, police contacts and records of drug-related fatalities, estimates venturing the prevalence of problem (i.e. risky, harmful and dependent) drug use make the number of problematic users of heroin range between 81,000 and 171,000 persons (1.5 to 3.2 persons per 1,000 inhabitants) in the age group of 15-64 years. Since 2008, the estimates for the multipliers treatment demand and police contacts are on the decline. The same applies to the multiplier drug-related deaths for the previous years. In 2010, this value remained relatively stable but within a larger interval. All in all, these (rough) estimates indicate a continuous decline of the number of heroin/opioid users since the year 2008. This chapter represents moreover the findings of the recent survey carried out by the Federal Centre for Health Education on the “regular” use of cannabis among adolescents and young adults. Partly based on the data of ESA (cf. chapter 2), specific calculations on the trend of problem cannabis use were made. Here, the portions of people with cannabis dependence do not show any significant changes between 2006 and 2009 according to the SDS. Moreover, a follow-up study will be presented on the misuse of substitution substances in Germany complete with surveys carried out in and around the scenes and substitution practices and ambulatories in ten cities.

Drug-related treatment: treatment demand and availability

About half (46.3%; 2009: 47.5%) of the clients who sought help from outpatient drug counselling facilities in connection with illicit drugs in 2010, had primary opioid-related problems; about a third (35.6%; 2009: 35.4%) suffered primarily from problems with cannabis use. Cannabis-related cases accounted for 59.8% (2010: 61.0%) of the patients who underwent therapy for the first time, while opioids played a minor role among this population (17.7%; 2009: 18.3%). In about one case out of ten, stimulants were the reason for contacting an outpatient addiction counselling centre for the first time; they accounted for about 8% of all newly admitted and discharged patients. In the inpatient setting, opioids continued to play a predominant role in the area of illicit drugs. As for acute (hospital) treatments, toxicoses caused by sedatives/hypnotics (excluding alcohol) were the reason for admittance in about one case out of ten. Cocaine was the main reason for treatment in 6.8% of the cases and stimulants in 9.7% of the cases treated in the specialized clinics that participate in the German Statistical Report on Treatment Centres for Substance Use Disorders. The number of substitution treatments continued to increase also in 2010 and

currently (2010) lies at 77,400. There are still considerable regional divergences regarding the offer of and demand for substitution treatments.

Health correlates and consequences

By 1 March 2011, a total of 2,918 new cases of HIV-infections were reported for the year 2010. The portion of people who contracted HIV probably through injecting drug use (IDU) was at 3.7%. With 93 cases in the year 2010, the number of newly diagnosed HIV infections in IDUs fell to its lowest level since the start of discriminating recording in the year 1993.

For the year 2010, a total of 5,283 cases of newly diagnosed hepatitis C infections were reported. With this, the incidence continued to decline. Injecting drug use, which in all probability has a causal link with the diagnosed hepatitis C infection, was reported for 1,267 cases (32.6%). While hepatitis C infection among drug users has shown a slightly declining trend over the last years, it still remains one of the central issues in this group of persons.

In 2010, the total figure of drug-related deaths published by the Federal Criminal Office fell again by 7% with respect to the previous year. In total, 1,237 people died of the use of illicit drugs. Overdose of heroin (including use of heroin in combination with other drugs) is still the most common cause of death.

Response to health correlates and consequences

A variety of measures such as drug consumption rooms, syringe exchange programmes and other prevention programmes are to contribute to preventing drug-related deaths and infectious diseases. Presently, a total of 28 drug consumption rooms are operating in six federal states in Germany. According to a recent study conducted on the availability of syringe exchange programmes, at least 26.6% of the rural districts make corresponding offers. Many experts still see considerable possibilities for improvement in the prevention and treatment of infectious diseases and other health correlates in drug users.

Social correlates and social reintegration

The social situation of many patients in the help system, especially in low-threshold facilities, is still precarious. The life of many addicts continues to be strongly marked by homelessness, lack of regular employment and low income that is not least caused by a low level of education.

Several demonstration projects are run in various regions of Germany to tackle this problem and promote the cooperation between the addiction help system and the working groups formed by the employment agencies and the municipalities (the so-called "ARGEn") with a view to motivate unemployed drug users to undergo therapy at an early stage, to counteract chronification and to bring as many clients as possible back into regular employment.

Drug-related crime, prevention of drug-related crime and prison

In the year 2009, a total of around 231,000 drug law offences were recorded. Out of them about 165,000 were general offences committed against the Narcotics Act

(BtMG) and little less than 50,000 were dealing/trafficking crimes. With this, the number of dealing/trafficking crimes declined by 2.1%, following the trend of the previous year.

The number of convictions rendered under the Narcotics Act fell by 3% between 2008 and 2009. The slight decline was found in all age groups, i.e. in adult, young adult and juvenile offenders. As regards the type of crimes, the decline in the overall figure is to be equally attributed to the lower case figures recorded for the unspecific consumption-related offences (§29 alinea 1 BtMG), dealing/trafficking crimes and crimes in respect of §30 alinea 1 no. 4.

Drug markets

All in all, there was little change in the development of purity, prices and number of seizures of illicit drugs between 2009 and 2010. The quantity of the drugs seized is subject to fluctuations depending on larger individual seizures. As a result of a few seizures of large quantities of cocaine running into the three- and four-digit kilogram range, the quantity of cocaine seized reached a record level in 2010. However, since 2010 did not see seizures of larger quantities of amphetamines and heroin that could compare to the ones of the year 2009, the overall quantity of drugs seized declined respectively in comparison with the previous year.

The number of seizures declined on the whole by 3.5% between 2009 and 2010 which is a result of the declines in all types of narcotic drugs except for amphetamines and for the comparatively low case figures for methamphetamine, mushrooms and khat.

The average concentration of active ingredients of the analyzed illicit drugs was subject to very different developments in the comparison between the years 2009 and 2010. While the concentration of active ingredients in cocaine and cannabis products have basically stayed stable over the last 14 years, considerable changes were found for amphetamines and heroin in comparison to the previous year: The concentration of active ingredient in amphetamines went up again for the first time since 2004 (2010: 6.6%; 2009: 4.8%); after having continually increased in the previous years to a record level of 60.3% in 2009, the concentration of active ingredient in heroin at wholesale level almost dropped by half (2010: 34.1%), falling back to the levels of the years 2005 and 2006. The concentration of active ingredient of heroin at retail level, by way of contrast, continued to increase and seems to stabilize above the 20%-level (2010: 24.6%).

Prices paid for the various types of drugs either slightly increased between 2009 and 2010 or basically remained unchanged. Significant changes were found for prices paid at retail level for amphetamines (+19%) and marijuana (+10%) as well as for crack (-15%). Wholesale prices paid in 2010 tended to be somewhat higher for all types of drugs in comparison with 2009 except for cocaine.

Drug-related health policies and services in prison

The execution of criminal justice was transferred into the hands of the federal states in 2006. Since then a few *Laender* have introduced their own prison laws. For the rest of the *Laender*,

the general prison law applies. Not at least as a result of this legal situation, Germany does not have a national system for regular data collection to survey the health situation in prisons. Instead, there are mainly regional studies available that only allow restricted comparisons to be made since statistics are not interlinked and methods of data collection and classification not standardized (ICD-diagnoses are only made very seldom). Only very few data can be directly linked, sequencing or comparative analyses are hardly possible at all. Experts estimate however that about 30% of all male and more than 50% of all female detainees are intravenous drug users. With this, the rates of drug using detainees are by far higher than among the general population, requiring a comprehensive therapy offer behind prison walls. The lack of binding federal guidelines in the area of drug-related health care in prison leads to differences between the federal states in terms of type and availability of therapy offers. There are still divergences between offers of intra- and extramural treatment of drug users or addicted persons. Apart from other difficulties, a problem is posed by the lack of sufficiently qualified medical personnel in some prisons when it comes to the provision of treatment and therapy services.

Drug users with children (addicted parents, child care and related issues)

Estimates assume that between 30,000 and 60,000 children of drug addicts live in Germany. Hard data are available on drug users who are undergoing treatment or receive counselling from an outpatient or inpatient drug aid facility. The German statistical report on treatment centres for substance use disorders also provides information on how many of the clients have their own children or live together with children in a household.

The addiction of one parent poses different risks and hazards to the family as a whole and to individual family members. The living circumstances of addicted parents are often marked by poverty and social disadvantage. This poses additional health risks and psychological stress both for parents and children.

Germany has a complex network of players, facilities and institutions that work to provide support and aid to families with addiction problems and carry out activities, events and projects. Those working with the parents, children, families or family members are often closely linked with each other. A special role is assigned to cooperation between different institutions. An important objective is to strengthen and expand existing structures at the local and community level as well as to create uniform national standards for binding cooperation structures.

PART A: NEW DEVELOPMENTS AND TRENDS

1 Drug policy: legislation, strategies and economic analysis

1.1 Introduction

1.1.1 Definitions

In Germany, the term 'drug policy' is undergoing a gradual change of meaning. Until the end of the last century, it was exclusively related to illicit drugs that were at the centre of the political interest. There was no comparable conception neither for an alcohol or tobacco policy nor for an 'addiction'² policy, comprising the whole range of addictive substances. Since a few years however, (1) disorders resulting from licit psychotropic substances and (2) common aspects of all substances (e.g. in universal prevention or in patients with multiple abuse) as well as non-substance-related forms of addiction³ (e.g. pathological gambling) have increasingly moved into the focus of the political interest. This is the reason why the terms 'drug and addiction policy' or 'addiction policy' find more frequent use gradually replacing the term 'drug policy'. As a result of the differences in the policy aims pursued and strategies deployed in the area of licit and illicit substances, the term 'drug and addiction policy' finds preferred usage in the German language.

Moreover, the range of vision is expanding from the original main focus on substance-related addiction to risky and harmful use and thus to a comprehensive understanding of health policy for substance-related disorders and risks. However, in the German language there is no appropriate term reflecting this expansion of the concept, so that the term of 'addiction policy' continues to be used. As a consequence, licit substances and common strategies for both licit and illicit substances have to be taken into account in the annual reports of the DBDD. In many cases however, it is not possible any more to set the two categories apart due to technical and political developments. Nevertheless, in line with the guidelines given for the topic of this report, exclusively illicit substances will be taken into consideration, where possible. Non-substance-related addiction is currently of no relevance for this report.

1.1.2 Objectives and focal points of "drug and addiction policy"

Created in 1998, the position of the Federal Government Commissioner on Narcotic Drugs reports to the Federal Ministry for Health. The Commissioner coordinates the drug and addiction policy of the Federal Government which is based on the following four areas:

² The term "addiction" no longer refers to a narrow target group, but comprises risky, harmful and addictive consumption.

³ There is still scientific controversy over the question whether pathological gambling should be regarded as a non-substance-related form of addiction or as a disorder of impulse control. So far, no final agreement could be reached on this. The non-uniform use of terms in this Reitox Report does not constitute a preference for either of the concepts. The policy introduces non-substance-related forms of addiction in the concept and measures of drug policy.

- Prevention of drug use
- Counselling and treatment of drug users
- Survival aid and harm reduction
- Repression and supply reduction

The intention hereby is to create a balance between measures undertaken to reduce both demand and supply. The Federal Government's addiction policy comprises licit psychotropic substances and associated risks taking into account European developments.

In line with the broad conception of the WHO, addiction is understood as a complex illness associated with psychological, somatic and social disorders requiring treatment. Existing measures undertaken to combat drug use and addiction are to be made available as early and comprehensively as possible. Prevention of addiction plays a primordial role in the addiction policy. It aims at preventing or at least significantly reducing risky consumption, harmful use and substance dependence. Existing measures and offers are to be further complemented and their quality secured. The national "Action Plan for fighting Drugs and Addiction" passed in 2003 (Die Drogenbeauftragte der Bundesregierung 2003), served as a framework for the addiction policy of the Federal Government until 2009. Details on this can be found in the REITOX Report 2004.

As a reaction to the new challenges posed to addiction and drug policy and current developments, the Federal Government Commissioner on Narcotic Drugs developed a "national strategy on drug and addiction policy" in 2010 that is currently (autumn 2011) coordinated with the departments of the Federal Government. This strategy is to replace the Action Plan for fighting Drugs and Addiction of the year 2003. It describes the challenges to be taken up and the basic principles to be followed by responsible drug and addiction policy and outlines concrete political measures and goals for the years to come. Hereby, current developments and activities undertaken by the government are taken into account in the same way as new use patterns and forms of addiction. The strategy comprises international initiatives and activities undertaken at the European and international level (Die Drogenbeauftragte der Bundesregierung 2011).

1.1.3 Political framework

Responsibilities of the Federal Government and the *Laender*

The Federal Government and the *Laender* share their responsibilities in drug and addiction policy. According to the Basic Constitutional Law, the Federal Government has legislative authority over the narcotic drugs law, the penal law, the law of penal execution and the social welfare law. On this basis, it has defined a legal framework for its drug policy and has formulated standards. However, the execution of these federal laws mainly falls under the responsibility of the *Laender*. In addition, the *Laender* also have their own legislative authority in areas which are of relevance for drug and addiction policy including school, health and education systems. The actual implementation of the drug and addiction policy – in particular also funding – mainly lies in the hands of the *Laender* and municipalities which

may very well set different focuses within the framework of given legal guidelines and common goals.

Currently, as part of the implementation of the drug policy, a few *Laender* are working on shifting competences especially with regard to counselling, care and general prevention activities to the municipalities in order to, among others, improve integration between youth welfare and addiction support systems. However, this will tend to render supra-regional exchange of information and surveying of the overall situation more difficult.

The role of the funding organs

Funding of treatment and rehabilitation is, for the most part, provided by the health or pension insurance schemes respectively. Alternatively, funding is taken over by social welfare providers. Costs caused by (secondary) disorders resulting from drug use and withdrawal (detoxification) are generally borne by the health insurance funds whereas outpatient and inpatient medical rehabilitation is paid for by the pension insurance funds. Social insurance providers act as independent self-governing bodies under public law. Therefore, political decisions often do not have a direct impact on the funding practice with regard to certain treatment offers.

The role of non-governmental organizations

In Germany, health care and social work in particular are governed by the principle of subsidiarity. The associations of SHI-accredited doctors (i.e. general practitioners) are tasked to guarantee outpatient medical care. Private charity organizations in particular, organize large parts of the measures of socio-therapeutic care for drug users for which they receive public funding – from national, *Laender*- and municipal budgets according to certain criteria. Only in few cases (e.g. counselling facilities run by public health offices or psychiatric clinics), the Federal Government itself provides special treatment offers and services for persons with addiction problems. Youth welfare relies on the joint work of governmental and non-governmental institutions (Social Security Codes, Sozialgesetzbuch, SGB VIII).

A general outline of the institutional framework and policies can be found in the structured questionnaire 32.

1.2 Legal framework

1.2.1 Laws, regulations, directives or guidelines in the field of drug issues

The Narcotics Act

The Narcotics Act (BtMG) contains all important regulations on how to deal with these substances taking into account the respective UN-conventions on addictive substances. Substances that are deemed as narcotic drugs in terms of the German Narcotics Act are listed in three schedules encompassing all substances mentioned in the international agreements on narcotic drugs:

- Schedule I: narcotics not eligible for trade and medical prescriptions (e.g. MDMA, heroin, psilocybin).
- Schedule II: narcotics eligible for trade but not for medical prescriptions, (e.g. meprobamate, methamphetamine).
- Schedule III: narcotics eligible for trade and medical prescriptions (e.g. benzodiazepine, opioids, substitution substances like methadone).

The prescription of narcotics (schedule III) as part of a medical therapy is subject to the special regulations on the prescription of narcotic drugs and requires for example the use of special prescription forms for narcotic drugs.

Social Security Codes

The social security codes define the framework for the financing of addiction therapy. The costs of drug addiction therapy (rehabilitation) are mainly borne by the pension insurance funds. Physical withdrawal (detoxification) and substitution therapy are paid for by the health insurance funds. Other funding organs are the local or supra-local social welfare providers and communities as supporting organs of youth welfare.

With the fusion of unemployment aid and social aid in 2005 ("Hartz IV"), the social security codes (in particular SGB II) have become even more important for people with drug problems. The central goal of the reform being to improve procurement of work, efforts are undertaken to work more intensely on the removal of obstacles hindering the placement on the job market. In this context, drug addiction represents a particularly problematic obstacle requiring specific attention. According to the social security codes (SGB II), the following institutions are in charge of granting aid: the employment agencies or working groups formed by the latter and the municipalities as well as the so-called opting municipalities.

Other laws

Other relevant laws defining the possible legal consequences of the consumption of psychological active substances, for example with regard to participation in road traffic, are the:

- Road Traffic Regulations (Straßenverkehrsordnung, StVO) which specify for example how to conduct traffic controls,
- Road Traffic Act (Straßenverkehrsgesetz, StVG) which sets blood alcohol limits and also describes driving motor vehicles under the influence of other intoxicating substances as a regulatory offence,
- Criminal Code (Strafgesetzbuch, StGB), which also goes into the consequences of the consumption of alcohol and other intoxicating substances in road traffic and
- Driving License Regulation (Fahrerlaubnisverordnung, FeV), which deals with the conditions for driving, doubts about the qualification for driving and the revocation of driving licenses for example because of an existing dependence on narcotic drugs.

1.2.2 Laws implementation

A host of information on legal practice and prosecution was provided in a Selected Issue of the Reitox Report 2008 and a publication of the EMCDDA. Both documents are available from the DBDD.

Discontinuance of prosecution

The German Narcotics Act § 31a provides for the possibility to discontinue prosecution for possession of drugs under certain circumstances, namely when the offender has grown, produced, imported, exported, bought or received and possessed in any other way narcotic substances in small amounts exclusively for personal use and when his guilt is deemed as minor and there is no public interest in prosecution. This provides the public prosecutor with an instrument to stop proceedings for consumption-related offences without court approval. All Federal *Laender* have regulated details of the application of § 31a BtMG through recommendations or guidelines. These guidelines considerably diverged from each other in the individual *Laender* a few years ago, but have meanwhile largely converged. Some divergences in the *Laender* regulations do however persist (cf. Schaefer & Paoli 2006).

Threshold values for “small amounts” of cannabis and other substances

Most of the *Laender* have introduced comparable threshold values for “small amounts” (upper/lower limit) for cannabis. The limits set by the individual *Laender* are guideline values from which public prosecutors and judges may diverge in individual cases. There is no legal claim to the discontinuance of prosecution in the case of possession of small quantities of drugs. However, discontinuance of prosecution does not automatically mean that the crime has no consequences. Public prosecutors have the right to stop proceedings under certain conditions (e.g. community service, fines or counselling in a social institution).

On 3 December 2008, the Federal High Court of Justice lowered the “non-small” amount for methamphetamine from 30 grams methamphetamine base to 5 grams in a principle-establishing ruling. In view of the scientific findings gathered on the toxicity of methamphetamine over the last ten years, the Senate considered it necessary to change the existing law and lower the threshold value. Contrary to a Land Court, the Federal High Court fixed the threshold value not to five gram methamphetamine hydrochloride but to methamphetamine base (for more details see also Patzak 2009).

Already in April 2007, the Federal High Court of Justice rendered a ruling defining the “non-small amount” of buprenorphine. With that, the Federal High Court of Justice added another decision to the series of landmark rulings on “non-small amounts” in which it dealt for the first time with a substance used in substitution therapy that has also made its appearance on the illicit market causing some concern (Winkler 2007). The “non-small amount” in the wording of the BtMG does not refer to – contrary to the term “small amount” – the weight of the seized substance but to the active ingredient contained in the substance.

Only few federal states have explicitly defined regulations for discontinuing prosecution in connection with other narcotic drugs. They provide for the possibility to discontinue

prosecution in the case of heroin (1 g), cocaine (depending on the federal state: 0.5 – 3 g), amphetamines (0.5 – 3 g) and ecstasy (between 3 and less than 20 tablets) (Patzak & Bohnen 2011).

In a circular order passed on the guidelines on the application of the § 31a alinea 1 BtMG, the Ministry of Justice (4630 – III.7 „IMA“) and the Ministry for Internal and Communal Affairs (42 – 62.15.01) of the Land North Rhine-Westphalia defined new regulations on 19 May 2011 (JMBl. NRW p. 106) on the small quantities of some substances intended for personal use in North Rhine-Westphalia. According to these new regulations, the department of public prosecution may discontinue prosecution in cases where found illicit substances were exclusively intended for personal usage, no harm was done to third parties and quantities of 10 g cannabis products (hashish, marijuana and flower tops without hashish oil), or respectively 0.5 g heroin, cocaine or amphetamines were not exceeded. As for other illicit narcotic drugs, a small quantity can no longer be assumed if it runs up to more than three consumption units. According to the circular order, the indications given for the small quantities sold at the lowest trade level, may only serve as guiding figures for ascertaining what is still to be regarded as a small amount. If there is information available on the purity of the found substance, the threshold value for the amount can be higher or lower. However, there is no room for applying this guideline even in the case of small quantities of illicit drugs if there are valid indications for drug dealing or supplying drugs. An indication may for example be the repeated detection of illicit narcotic drugs.

Act on diamorphine-assisted substitution therapy⁴

On 28 May 2009, the German Bundestag passed the “Act on diamorphine-assisted substitution therapy“ creating the legal preconditions for a transfer of the diamorphine-assisted therapy into regular care by changing the Narcotics Act, the Medical Products Act and the Regulation on the Prescription of Narcotic Drugs. The act stipulates among others that diamorphine (pharmaceutically produced heroin) becomes eligible to prescription – on very narrow criteria – as a narcotic drug used for heavily dependent opioid addicts. The act was then presented to the Bundesrat and finally endorsed in a plenary session on 10 June 2009. The Act on diamorphine-assisted substitution therapy entered into force on 21 June 2009.

The act makes it possible for the findings of a clinical study funded by the Federal Ministry for Health, which investigated the treatment of heavily dependent opioid addicts with diamorphine in comparison with a methadone-assisted treatment, to be turned into actual practice (cf. the REITOX Reports 2007 and 2008).

Government funding for the *Laender* and municipalities that participated in the demonstration project stopped end of February 2008. The Federal Government continues to fund the documentation and the monitoring of the diamorphine-assisted therapy in Germany till the end of 2011 in order to ensure quality assurance in terms of course of therapy, therapy standards and effects.

⁴ Federal Law Gazette (2009). Part I No. 41, Bonn: 20.07.2009.

BfArM: Indication expansion for methylphenidate containing drugs

On 14 April 2011, the Federal Institute for Drugs and Medical Devices (Bundesinstitut fuer Arzneimittel und Medizinprodukte, BfArM)) approved for the first time of an indication expansion for some methylphenidate containing drugs for adults. So far, the license was restricted to children and adolescents from 6 years of age due to insufficient study data. Thanks to the recently presented findings of clinical studies, the effectiveness and safety of an application in adults could be sufficiently proved (BfArM 2011).

25th Amending regulation on narcotic drugs (25th BtMAendV)⁵

Published on 17 May 2011 in the Federal Gazette, the main parts of the 25th amending regulation on narcotic drugs (Betaeubungsmittelaenderungsverordnung, BtMAendV) entered into force on 18 May 2011. It newly regulated the availability of narcotics containing pain killers in specialized ambulatory palliative facilities and in the care of hospices to be better able to respond to the needs of terminally ill patients. The hospices and facilities falling under this regulation are authorized in the future stockpile narcotic drugs for emergency situations. In addition, the new regulation expanded the possibility of making further use of narcotics that are not needed anymore but can be used further. Moreover, the position "cannabis" in the schedules I to III of the Narcotics Act was changed. This change makes it possible for the first time in Germany for cannabis containing proprietary medicinal products to be manufactured and prescribed by doctors after clinical testing and licensing by the BfArM. These drugs are for the moment eligible for the treatment of spastic pain in multiple sclerosis. Cannabis containing proprietary medicinal drugs can be offered here as another therapy option (BMG 2011).

Furthermore, the exception for flunitrazepam containing medicinal drugs with up to 1 mg flunitrazepam is cancelled as of 1 November 2011. From this point of time onwards, all preparations containing flunitrazepam are, without any exceptions, subject to the regulations on narcotic drugs (among others use of special prescription forms for narcotic drugs, dispensing documentation and safe-keeping).

Ruling of the Federal High Court of Justice (Bundesgerichtshof, BGH) on benzodiazepines and zolpidem

The Federal Supreme Court defined for the first time the non-small quantity for benzodiazepines and zolpidem (ruling dd. 2 November 2010, 1 StR 581/09). Benzodiazepines and zolpidem referred to by the ruling are so-called exempted preparations that do not fall under the regulations of the narcotics act up to a specific concentration of active ingredient. This exemption does however not apply to the second indent in schedule III, letter b, if the exempted preparations are intended for import or export (exemptions: codeine and dihydrocodeine). Exporting or importing such exempted preparations without authorization amounts to an offence in respect of § 29 alinea 1 p. 1 no. 1 BtMG. Unauthorized import of a non-small quantity in respect of § 30 alinea 1 no. 4 BtMG

⁵ Federal Gazette (2011). Part I No. 22, Bonn: 17.05.2011.

constitutes an offence carrying a minimum prison sentence of 2 years if the following levels of active ingredients are exceeded: diazepam 2,400 mg, alprazolam 240 mg, clonazepam 480 mg, lorazepam 480 mg, lormetazepam 360 mg, midazolam 1,800 mg, oxazepam 7,200 mg, temazepam 4,800 mg, tetrazepam 4,800 mg, triazolam 120 mg and zolpidem 4,800 mg (Patzak 2011).

Act on the new regulation of the medicinal drugs market

On 1 January 2011, the Act on the New Regulation of the medicinal drugs market (Gesetz zur Neuordnung des Arzneimittelmarktes, AMNOG) entered into force. The main goal of the act is to curb the soaring drugs expenses of the statutory health insurance funds. Changes were also made to §§ 12 and 19 BtMG and the exceptional position of cannabis in schedule I. For penal practice, only the latter change probably is of relevance. The legislator has excluded the industrial hemp varieties finola and tiborszallasi from the exemption so that transactions with these types of hemp always fall under the Narcotics Act. Transactions involving the industrial hemp varieties included in the common catalogue for agricultural plants do not constitute an offence in so far as the transactions only serve commercial or scientific purposes that exclude recreational use. This however does not apply to the cultivation of hemp that in turn falls under the indent following the position cannabis after the letter d (Patzak 2011).

Recommendation of the expert commission in line with § 1 alinea 2 of the Narcotics Act (BtMG)

In line with § 1 alinea 2 BtMG, the expert commission recommended on 6 December 2010 to place the substances JWH-015, JWH-081, JWH-122, 3-trifluormethylphenylpiperazin, para-fluorphenylpiperazine, methylbenzylpiperazine, butylone, 3,4-methylendioxypropylvalerone, ethylcathinone and naphyrone under the regulations of the BtMG. On 2 May 2011 followed a recommendation for the following substances to be placed under the BtMG (www.bfarm.de): the synthetic cannabinoids JWH-007, JWH-203, JWH-210, JWH-251, the adamantyl-derivate of JWH-018, AM 694 and RCS-4, the phenylethylamine/cathinone-derivates methylone, methedrone, flephedrone, 4-MEC, PMEA, 4-methylamphetamine, 4-FMA, the tropanalcaloid 4-fluortropacocaine. The recommendations take account of the fact that more and more synthetic substances contained in so-called "legal highs" make their appearance on the market as alleged herbal mixtures, bath salts or air fresheners (Newsletter Betaeubungsmittelrecht.info 2/2011; www.bfarm.de).

Expert opinion on the cross substance group placement of narcotic substances in the Narcotic Drugs Act

New psychotropic substances have been observed for some time to make a strong appearance at the national, European and international level. Manufactured for purely recreational purposes, these substances are generally made up of synthetic derivates that – due to slight changes made to the chemical structure – are not included by the Narcotics Act anymore, but have similar or even stronger effects than their precursor substances (designer drugs). With this, legal bans and controls under the Narcotics Act are bypassed and new

markets created or respectively maintained as a result of the legal grey zone that exists until the respective substance gets placed on the list of controlled substances. Manufacturers and vendors of designer drugs and products containing designer drugs generally react before or directly after a new regulation on narcotic drugs enters into force to the new legal situation as regards specific substances by substituting them through new chemically modified active ingredients. In order to counteract this practice, it would make sense to place not only one single specified substance but also its chemical modifications that may be used as substitutes with a summarizing structural chemical denomination under the Narcotics Act. An expert opinion⁶ assessed the feasibility of the introduction of a defined substance group to the Narcotics Act to prevent that regulations of the Narcotics Act are bypassed (cf. chapter 1.1.2).

1.3 National action plan, evaluation and coordination

1.3.1 National action plan

On 25 June 2003, the Federal Cabinet passed the “Action Plan for Fighting Drugs and Addiction” as a continual agenda to reduce addiction and drug problems in Germany. The coordination of the implementation of the Action Plan is shared between the Federal Government and the *Laender*. To this purpose, the Federal Government and *Laender* created the National Board on Drugs and Addiction in the year 2005 which was summoned by the Federal Government Commissioner on Narcotic Drugs in October 2005. The Board is to accompany the implementation of the Action Plan. It is tasked to advise on the set targets and measures outlined by the Action Plan, to support their implementation, to verify the outcome of the measures and to give recommendations for their implementation and further development.

The National Board on Drugs and Addiction is composed of representatives of socially relevant groups and institutions that are involved in the reduction of addiction-related problems and in the provision of help for addicts. Focal areas of work are defined by the Board itself. In a session held on 6 March 2006, the Board decided on its working programme for the 16th legislative period and established the following focal areas: “The primordial goal of the Action Plan for Fighting Drugs and Addiction” is to reduce the consumption of licit and illicit psychoactive substances and to curb non-substance related addictions as well as the health, psychosocial and economic risks and problems that are linked to the use and use behaviour. The focal areas set by the National Board on Drugs and Addiction until 2008, were evaluated through surveys conducted by the Federal Centre for Health Education (For the findings of this evaluation cf. the Reitox Reports 2009 and 2010).

The National Board on Drugs and Addiction of the 17th legislative period had its constituent session on 10 November 2010, cf. on this paragraph 1.3.2 (Implementation and evaluation of the national action plan).

⁶ Further information available under <http://drogenbeauftragte.de/drogen-und-sucht/illegal-drogen/heroin-und-andere-drogen/legal-highs/jahrestagung-der-drogenbeauftragten.html>.

1.3.2 Implementation and evaluation of the National Action Plan for Fighting Drugs and Addiction

New constitution of the National Board on Drugs and Addiction

The National Board on Drugs and Addiction of the 17 legislative period set to work in its constituent meeting on 10 November 2010. The Board serves as an advisory body for the Federal Government Commissioner on Narcotic Drugs. Like in the past, the Board is made up of experts from science, politics, administration, associations and institutions of the health care system. In its first session, the National Board on Drugs and Addiction debated at length on its tasks, goals and subjects areas that need to be dealt with. Moreover, the Board appointed the working groups "Prevention of Addiction" and "Interfaces in the care of addicts". The members and the rules of procedure of the National Board on Drugs and Addiction can be looked up at the website www.drogenbeauftragte.de.

National strategy for a modern drug and addiction policy

Today's drug and addiction policy is faced with new challenges and needs to keep abreast of the developments of the last years. The Federal Government Commissioner on Narcotic Drugs has set herself the goal of combining the basic principles and targets of this policy in a "national strategy of drug and addiction policy". This strategy is to replace the Action Plan for Fighting Drugs and Addiction that ran from 2003 to 2009. To this purpose, a modern and contemporary strategy for a drug and addiction policy was developed in 2010 that is currently coordinated with the departments of the Federal Government. It describes the challenges to be taken up and the basic principles to be followed by responsible drug and addiction policy and outlines concrete political measures and goals for the years to come. Hereby, current developments and activities undertaken by the government are taken into account as well as new use patterns and forms of addiction. The strategy comprises international initiatives and activities undertaken at the European and international level. This strategy is to react to the challenges posed to our society in the future by demographic change, societal transformations but also new forms of addiction. The Federal Government Commissioner on Narcotic Drugs notes on this in her annual report (2011):

- *"Changes to social life and interpersonal relations as well as raised demands to life in our modern society make people feel out of their depth and try to cope by resorting to addictive substances. It is up to our addiction help system to respond to this situation.*
- *As a result of demographic development people get older and older and addictive diseases increase in old age especially as regards alcohol and medical drugs. It will be imperative in the future to create and expand special help offers for older people.*
- *New non-substance-related forms of addiction like media or online addiction make their appearance. It is necessary to make suitable help offers to people suffering from these new forms of addiction.*

- *There have been developments over the last years with new use patterns that need to be responded to. People from the most different parts of society and age groups excessively abuse licit but also illicit addictive substances to an increasing extent.*
- *Politics is moreover called upon to react to the new psychoactive substances that repeatedly emerge as so-called “legal highs“.*

German addiction research network

Since 2001, one focal area of Germany's drug and addiction policy has been addiction research that was continued until November 2008. In four research networks, funded by the Federal Ministry for Education and Research, scientists from different fields have cooperated with facilities of primary care and addiction support within the framework of application-oriented research projects in their region.

Even though government funding for the research networks stopped in 2007, it is to be expected that the formed networks will continue to carry out common research activities and will also be able to identify new funding possibilities to realize the numerous initiatives some of which are derived from Federal Government projects. A series of results presented in this report and pertaining publications stem from the projects carried out within the framework of the research networks or their follow-up initiatives.

Demonstration programmes and research projects funded by the Federal Government

The order of the subsequently presented projects is oriented by the construction of the Reitox Report. Measures are reported under the titles of the chapters that deal more closely with the respective projects (or that were presented in previous Reitox Reports).

Drug policy: Legislation, strategies and economic analysis

- EU-Project DRUID
The German Federal Highway Research Institute (Bundesanstalt fuer Straßenwesen⁷) was the consortium leader of the project of the European Commission that comprised 37 partners working together on "Alcohol, Drugs, Medicines and Driving"⁸. The results of this interdisciplinary research project are expected to provide important information on how often psychoactive substances appear in road traffic as well as on their risk potential. Moreover, experimental studies on these psychoactive substances are expected to serve as a basis for recommendations to be made on currently non-existing danger thresholds that are to be defined in analogy to the per mill thresholds for alcohol (for more information cf. also the last Reitox Reports). The concluding conference was held end of September 2011 in Cologne.
- Expert opinion on the cross-substance group placement of narcotic drugs in the Narcotics Act
An expert opinion assessed the feasibility of the introduction of a defined substance

⁷ BAST, www.bast.de

⁸ www.druid-project.eu

group to the Narcotics Act to prevent that regulations of the Narcotics Act are bypassed. See also chapter 1.2.2.

Drug use in the population and specific subgroups

- Online survey "Use, users and motives of use of 'legal highs'"

The online survey in 2011 is to reach an as big as possible sample of persons who have experience with so-called "legal highs". These are legally traded products that are mostly wrongly labelled with intent (e.g. "herbal mixtures" or "bath salts"). Many of these products are composed of synthetic substances that do not fall under the Narcotics Act and that have a similar effect like certain illicit drugs (especially cannabis and party drugs). Moreover, many of the ingredients are sold abroad in their pure form in the Internet as research chemicals. In the last few years the number of substances offered in this form has strongly increased. Since large parts of the buyers use the Internet to purchase "legal highs" and to inform themselves about potential risks of use or the legality of certain substances, the online survey lends itself to a survey method. The results of the survey are to give insight into the use patterns and opinions as well as structure and use motives of people having experience with "legal highs". By beginning of August 2011, approximately 660 completed data sets were available within the framework of the survey.
- EU project "Spice and synthetic cannabinoids"

Under the lead management of the Institute for Legal Medicine of the University Clinic Freiburg and under participation of the Federal Criminal Police Office, the EU project researches new synthetic cannabinoids and their effects. It moreover develops contemporary detection methods and approaches for the prevention work in the area of "legal highs". "Spice and synthetic cannabinoids" is a co-operation project between Germany and various organisations from Poland, Finland, Austria and Switzerland.

Prevention

- eltern.aktiv

Started in 2009, the two-year demonstration project is to better reach parents of young drug users and to improve the quality of work with them. At the same time, optimized pro-active work with the parents is to provide better access to young drug users as part of an early intervention measure. Within the framework of the project, a parents survey was carried out to find about the demand for support and a "parents' suitcase" was packed for prevention professionals with graded concepts to gain access to parents and parental work (further information at www.dhs.de, projects).

Affiliated to the Federal Project is the LWL(Landschaftsverband Westphalen Lippe – Area Association Westphalia Lippe)-project "Pro-active parental work with parents of substance using children and teenagers performed by youth protection and youth welfare professionals" as an additional project. The project is to give support to youth welfare staff – in particular the ones who are preoccupied with the protection of youth – in their pro-active work with parents. The material and strategies developed within the framework of the federal project are available to all youth welfare offices and can be tested in

practice and adapted if necessary (also in cooperation with the local addiction counselling services). The goal of the LWL-project is in particular to test whether it is possible for youth care authorities to reach parents of drug using teenagers and motivate them to make use of further help offers⁹. For more information on both projects see also chapter 3.3.

- Parents help parents

Funded by the Federal Ministry for Health and run by the Federal Association of the parent's groups of sons and daughters at risk of addiction and with substance abuse disorders¹⁰, the project was preoccupied with developing a "guideline for the future work of the parent's groups". Core elements of the project were in-depth interviews and workshops with experts on possible new approaches of how to better reach parents with sons and daughters at the risk of addiction and with substance abuse disorders as well as a survey conducted among the approximately 180 parent's groups in Germany in order to evaluate the current demand and requests of parents with children at risk of addiction or with substance abuse disorders. The results were presented at the final conference held on 10 September 2011.

- FreD goes net

Placed under the title "FreD goes net"¹¹, the German demonstration project "Early intervention in drug users who have come to the notice of police for the first time" was implemented in 17 countries of the European union and scientifically evaluated by the Cologne Society for Research and Counselling in Health and Social Affairs (Gesellschaft fuer Forschung und Beratung im Gesundheits- und Sozialbereich, FOGS), cf. also previous REITOX Reports. The project was run by the LWL-coordination centre "Addiction". "FreD goes net" was jointly funded by the European Commission, the participating member states as well as by the German Federal Ministry of Health. After a three-year project period, "FreD goes net" was completed in November 2010 as scheduled. The project was successfully implemented in eleven of the twelve pilot countries in the settings police or respectively judiciary, school, youth welfare, work, family and/or hospitals. The target group of the project were teenagers and young adults aged between 14 and 21 years who came to the notice of police in connection with the use of illicit drugs and/or alcohol. Effects achieved by the short intervention measure were among others positive changes in the attitude towards use, use behaviour and problem solving skills. As a result of the promising results, the FreD-approach will be transferred to several European countries. A certified training to become a FreD-trainer makes an important contribution to quality assurance and to the further transfer of the concept. Further information on the project can also be found in chapter 3.5.3.

- Access to the addiction aid system by people with a migration background

With a view to develop, test and evaluate culture-sensitive addiction aid, the project

⁹ http://list.lwl.org/LWL/Jugend/LWL/Jugend/lwl_ks/Projekte_KS1/RFJH/Projekte_KS1/Eltern_aktiv_Start/

¹⁰ www.bvek.org

¹¹ www.fred-goes-net.org und www.lwl-fred.de

“transVer-sucht” was launched in early summer 2009. Funded by the BMG, the project will run for three years. Alongside six regional projects that are to serve as examples for testing and evaluating target group specific access and development of measures, the initiative also comprises an accompanying scientific project that is carried out by FOGS (Gesellschaft fuer Forschung und Beratung im Gesundheits- und Sozialbereich - Society for Research and Counselling in Health and Social Affairs in Cologne) in cooperation with FTK – Fortbildung transkulturell (Society for transcultural further education) in Freudenstadt. Furthermore, a scientific advisory committee was set up to support the demonstration project. The projects (carried out in Berlin, Cloppenburg, Cologne, Leipzig, Nuremberg and Warstein) realize a broad range of measures for various target groups in very different regional settings (www.transVer-sucht.de). First results indicate a better accessibility of people with a migration background at the project locations and the importance of multi-ethnic teams and of the further development within the service providers and institutions as well as within the teams. Further information on this project can be found in chapter 3.3.1.

- Trampolin - Modular prevention concept for children from families with addiction problems
The goal of the project Trampolin¹² is to develop and evaluate a modular group programme for children of families afflicted by addiction problems. After the development of a manual for the prevention offer that is characterized by its resource orientation, low-thresholdness and addiction specificity, the concept will be evaluated in terms of effectiveness within the framework of a randomized controlled multi-centre study. The project is carried out in cooperation between the German Centre for Addiction Research in Childhood and Adolescence at the University Clinic Hamburg Eppendorf (Deutsche Zentrum fuer Suchtfragen des Kindes- und Jugendalters, DZSKJ) German Institute for Addiction and Prevention Research (Deutsches Institut fuer Sucht- und Praeventionsforschung, DISuP) and the Catholic College NRW (Katholischen Hochschule NRW). The project started in autumn 2008 and runs for a period of 3.5 years. Following a successful pilot study, the project Trampolin has been carried out since March 2010 in many counselling facilities with different settings like addiction counselling, family, youth or addiction help centres all over Germany and has been scientifically evaluated.

After the currently ongoing prevention programme Trampolin has been completed and data collected, the results will be evaluated and published. At the end of the project a broad transfer into practice will be ensured in order to guarantee the sustainability of the modular prevention programme (cf. also REITOX Report 2010, chapter 3.3.2 and chapter 12).

¹² www.projekt-trampolin.de

Drug-related treatment

- **INCANT**

The counselling centre “Therapieladen“ took part for Germany in the international research project INCANT¹³ that was completed in the year 2010. The therapy evaluated within the framework of the study was addressed to young cannabis users in the age group between 13 and 18 years. The findings of the study that have been made available so far suggest a superiority of the shorter but much more intense work within the framework of the multidimensional family therapy over the normal therapy offer. Especially the integration and support of the parents and other family members have proved to be particularly important for the success of the therapy. N=120 teenagers/families could be included in the study by the “Therapieladen“ until the completion of the study in the year 2010. The report on the findings of the German study can be downloaded from the homepage of the Federal Government Commissioner on Narcotic Drugs¹⁴. First results of the European study have recently also been published (Phan et al. 2011). The study was already presented in detail in REITOX Reports of last years.

- **Development of the group training “CAN Stop“**

Tasked by the Federal Ministry for Health, the German Centre for Addiction Problems among children and adolescents (Deutsches Zentrum fuer Suchtfragen des Kindes- und Jugendalters, DZSKJ) analyses and evaluates a manualized treatment programme called “CAN Stop“ from February 2008 until April 2011 on the psychological education and relapse prevention for young people (14-21 years) with problematic cannabis use“. “CAN Stop“ is evaluated within the framework of a multicenter study with a pre-post design that includes catamnestic data. The evaluation is carried out in different settings (outpatient youth help, inpatient and outpatient medical care, youth prisons). So far, data are available on 141 test persons with an average age of 18.4 years. 76% of the male (n=118) and all female test persons (n=23) are graded as dependent on cannabis according to the SDS¹⁵. The final report is expected to be presented by the end of 2011. The project CAN Stop was already presented in the REITOX Report 2010.

- **Long-term effects of substitution therapy: PREMOS**

Based on the results of the COBRA-Study (Cost Benefit and Risk Appraisal of Substitution Treatments), the Federal Ministry for Health commissioned a research project in 2007, in order to gain insight into the long-term effects of substitution treatment. Within the framework of a nationwide representative, clinical epidemiological study running under the acronym PREMOS¹⁶ (Predictors, Moderators and Outcomes of Substitution Treatment), the clinical, psycho-pathological, social and substance-related

¹³ www.incant.eu

¹⁴ www.drogenbeauftragte.de/fileadmin/dateien-dba/Service/Downloads/INCANT_Behandlungsstudie_Ergebnissbericht_100111_Drogenbeauftragte.pdf

¹⁵ www.canstop.med.uni-rostock.de/

¹⁶ www.premos-studie.de

course and outcome of the therapy of more than 2,600 patients from 223 facilities were longitudinally analysed and described over a period of time of up to seven years. The final report was presented in June 2011 (www.drogenbeauftragte.de). In addition, a special issue of the journal "Suchtmedizin in Forschung und Praxis" was published in autumn and presented numerous results of the study which are also available on this homepage. The PREMOS study was already presented in last years' REITOX reports; first results will be reported in chapter 5.

- Quality assurance in diamorphine-assisted therapy – documentation standards and monitoring of heroin-based therapy in Germany

Since the end of the federal demonstration project carried out on heroin-based therapy in the middle of the year 2007, the documentation of treatment standards and therapeutic effects has been guaranteed by the introduction of a quality assurance project funded by the Federal Ministry for Health¹⁷. For the year 2008, documentation sheets on the therapy course of a total of 231 patients treated with diamorphine are available. Out of these patients, 40 have been newly included (since the middle of 2007) into therapy (17.3%). The results of the therapy documentation of the year 2008 show that also the new entries match the profile of severely addicted heroin users. In comparison with the participants in the federal demonstration project there are only few and, if at all, slight divergences in the patient profiles to be found at the beginning of the therapy. The new patients are, on average, three years older, live in somewhat more stable housing conditions and a larger portion of them has got work. Their health condition is bad – similar to the one of the patients who took part in the demonstration project. The therapy courses show on the one hand a long-term stabilisation or slight improvement of the patients who have been treated with diamorphine since the demonstration project. On the other hand, there is a positive development in the health condition and consumption behaviour to be recognized in the newly admitted patients, even though they are in most of the cases not as pronounced yet as among the "old patients".

Response to health correlates and consequences

- Pilot project on hepatitis prevention in Berlin

The Berlin drug aid association Fixpunkt¹⁸ has been running a pilot project on hepatitis C prevention since October 2008. Funding for the demonstration project comes from the Federal Ministry for Health and for the scientific evaluation carried out by the Centre for Interdisciplinary Research (Zentrum fuer Interdisziplinäre Suchtforschung, ZIS) in Hamburg from the Land Berlin. The goal of the project is to reach especially young drug users who do not yet apply drugs intravenously and to inform them about risks of infection and ideally to prevent injecting drug use (cf. also chapter 7 of this Report).

- "Prevention of health damage in injecting drug users in Germany: syringe exchange programme – a status report"

Funded by the Federal Ministry of Health in 2010 and carried out by the IFT in Munich,

¹⁷ www.zis-hamburg.de

¹⁸ www.fixpunkt.org

the study had the goal to take stock of available programmes, measures and approaches adopted to prevent health damage (safer use) in injecting drug users in Germany. Data was collected at federal and Land level in selected cities. The report on this project was presented in spring 2011 and can be downloaded from www.drogenbeauftragte.de. Further information and results are presented in chapter 7.

Other projects funded by the Federal Ministry for Health in the context of drugs

- SKOLL

The goal of the demonstration project SKOLL¹⁹ (self control training), that runs for three years, is to promote responsible behaviour in teenagers and adults who engage in risky use of either alcohol, cannabis or other addictive substances. A ten-week long training is to enable participants to at least stabilize their use, possibly to reduce it and ideally to stop it completely. The first two years of the project showed that the low-threshold, non-target oriented approach is well suited to reach people with risky use and to bring about a change in their use behaviour. A special feature of SKOLL is the cross-substance approach. People of all age groups with the most different use patterns can actively participate in a group. With this, the approach is also suited especially for counselling facilities in rural regions. The scientific evaluation of the project (UKE Hamburg-Eppendorf) will contribute to having an evidence-based approach in the end that can be implemented in the counselling facilities countrywide.

- Research study KOLIBRI

The goal of the study "Use of performance enhancing drugs for everyday and recreational purposes"²⁰ (KOLIBRI) is to collect representative data for the whole of Germany especially on the doping behaviour in recreational and mass sports. The findings of the study are moreover to serve as an important basis for the activities undertaken within the framework of the national doping prevention plan for the area recreational and mass sports. Furthermore, the representative survey does not only allow to compare between the doping behaviour of people who do sports and those who don't but also to find out about the use of performance enhancing substances beyond sport-related motivations. The main focus of the study is to investigate whether the use of performance enhancing substances – broken down in the areas food supplements, tranquillizers/sleeping pills, slimming and muscle building pills and performance enhancers can be related to the active engagement in different types of sport in the population. The findings of the study are available since early summer 2011. The presented Kolibri data show that while the regular use of over the counter performance enhancers is not uncommon, the use of prescription performance enhancing drugs without medical indication in the overall population above the age of 18 years tends to be very low in the 12-month category.

¹⁹ www.skoll.de

²⁰ www.rki.de/DE/Content/GBE/Erhebungen/WeitereEpiStudien/Kolibri/Kolibri__inhalt.html

Projects and research projects funded by the European Commission

German experts participate in a series of international projects and research projects in the area of drugs that are (co-) funded by the European Commission within the framework of various funding programmes. It is not always guaranteed that the information on the German participation in these projects is known to the expert public. Therefore, this year's REITOX Report contains for the first time an overview of current projects that are related to illicit drugs in which German experts are involved as partners or as coordinators. The overview is based on a brochure published by the European Commission listing all projects in the area of drugs from the following three funding programmes of the European Union:

- Drug Prevention and Information Programme (Directorate-General Justice) - DPIP
- Public Health Programme (Directorate-General for Health and Consumers) - PHP
- 7th Research framework programme (Directorate-General for Research and Innovation) – FP7.

The brochure contains also short descriptions of all listed and other (older and completed) projects and can be downloaded from the website of the EMCDDA²¹. The following Table 1.1 is limited to projects and studies that were carried out or initiated during the reporting period (2010/2011).

²¹ www.emcdda.europa.eu/themes/research

Table 1.1 Overview of EU funding projects and studies with German participation

	Project period	German partner
Projekts with German project coordinator (in brackets: funding programm*)		
REBOUND Resilience-based drug education (www.my-rebound.eu) (DPIP)	01/2010-12/2012	Henrik Jungaberle, Institut fuer Medizinische Psychologie, Universitaet Heidelberg
Social Norms Intervention for the prevention of Polydrug use (SNIPE) (DPIP)	03/2011-02/2013	Claudia Pischke, Hajo Zeeb, Universitaet Bremen (UNIHB), Institut fuer Praeventionsforschung und Sozialmedizin
WISEteens (DPIP)	04/2011-03/2013	Rainer Thomasius, Universitaetsklinikum Hamburg-Eppendorf (UKE); Deutsches Zentrum fuer Suchtfragen des Kindes- und Jugendalters (DZSKJ)
'Spice' and synthetic cannabinoids (DPIP)	01/2011-12/2012	The
		Further German member of consortium: Bernd Werse, Johann Wolfgang Goethe-Universitat Frankfurt, Centre for Drug Research (CDR)
		Further associated German member of consortium: Bundeskriminalamt (BKA)
Health promotion for young prisoners (PHP)	04/2010-03/2013	Caren Weilandt, Wissenschaftliches Institut der Arzte Deutschlands (WIAD)
AMASS Surveillance in wide maritime areas through active and passive means (FP7)	03/2008-08/2011	Thomas Anderson, Carl Zeiss Optronics GmbH
		Further German member of the consortium: Fraunhofer-Gesellschaft zur Foerderung der angewandten Forschung e.V
		Further German member of the consortium: Iq Wireless GmbH

* Abbreviations of funding projects: DPIP=Drug Prevention and Information Programme (DG Justice); PHP=Public Health Programme (DG Health & Consumers, EAHC); FP7=Seventh Framework Programme (DG Research and Innovation)

Table 1.1 (continued) Overview of EU funding projects and studies with German participation

	Project period	German partner
Projects with German projector coordinator (in brackets: Country code of the project coordinator and funding programm*)		
Throughcare services for prisoners with problematic drug use (www.throughcare.eu/) (UK; DPIP)	12/2008-12/2011	Caren Weilandt, Wissenschaftliches Institut der Arzte Deutschlands (WIAD) (www.wiad.de)
European Harm Reduction Network (EuroHRN) (www.eurohrn.eu/) (UK; DPIP)	01/2010-12/2011	Akzept e.V. (www.akzept.org)
ORION - Overdose Risk Information Project (UK; DPIP)	01/2011-01/2013	Norbert Scherbaum, Landschaftsverband Rheinland (LVR) Kliniken und Institut der Universitaet Duisburg – Essen
CONPHIRMER - Counterfeit Pharmaceuticals Interception using Radiofrequency Methods in Real-time (UK; FP7)	07/2011-06/2014	Deutsch-Franzoesisches Forschungsinstitut Saint-Louis (ISL), Saint-Louis (www.isl.eu)
Projects with German participation as associated partner (in brackets: country code of the project coordinator and funding programme*)		
Development of rehabilitation and reintegration programme for children using drugs (LI; PHP)	12/2008-03/2011	Gerd-Bodo von Carlsburg, Paedagogische Hochschule Heidelberg, Institut fuer Erziehungswissenschaft
Democracy, Cities & Drugs II (www.democitydrug.org) (F; PHP)	05/2008-04/2011	Christian Heise, BWLV (Renchen), European Treatment Centres for Drug Addiction (EURO-TC)
Club Health – healthy and safer nightlife of youth (www.club-health.eu) (SI; PHP)	04/2009-04/2012	Zentrum fuer empirische paedagogische Forschung, Universitaet Koblenz/Landau
		Katholische Hochschule NRW, Deutsches Institut fuer Sucht- und Praeventionsforschung
		Institut fuer Suchtforschung der Fachhochschule Frankfurt am Main
Recreational Drugs' European Network (ReDNet) (UK; PHP)	04/2010-03/2012	Norbert Scherbaum, Landschaftsverband Rheinland (LVR) Kliniken und Institut der Universitaet Duisburg – Essen
Boys and Girls – An interactive web-based series to promote healthy lifestyles among European adolescents (NL; PHP)	09/2010-08/2012	Katholische Hochschule NRW, Deutsches Institut fuer Sucht- und Praeventionsforschung

* Abbreviations of funding projects: DPIP=Drug Prevention and Information Programme (DG Justice); PHP=Public Health Programme (DG Health & Consumers, EAHC); FP7=Seventh Framework Programme (DG Research and Innovation)

Activities undertaken by the *Laender*

As a result of the federal structure of the Federal Republic of Germany and the principle of subsidiarity as well as the differences in the degree of problems and starting conditions, there exist considerable regional differences in how substance-related disorders are dealt with. As a consequence, drug and addiction programmes are subject to different guidelines and rules in the individual *Laender*. However, the *Laender* have agreed on a profile for regional outpatient addiction support facilities. There are no uniform formal requirements or criteria for quality assurance with regard to measures aiming at the reduction of drug demand. Approaches going into this direction – e.g. the development of guidelines and programmes for quality assurance – are solely adopted at a technical level by professional and scientific associations as well as by the funding organs. Compliance with and application of these guidelines are, however, not mandatory (see chapter 5.5). Therefore, a multitude of different approaches and methods or instruments are currently used in the individual *Laender* and municipalities. Furthermore, large differences with regard to the availability of resources are to be found between the *Laender*.

The *Laender* have a very well developed network at their disposal to deal with people suffering from addiction problems. It is based on the cornerstones of prevention, treatment and aftercare. The countrywide offers made range from prevention, outpatient counselling, qualified detoxification treatments, adaptation facilities, complementary measures (low-threshold facilities, day-care facilities, job programmes and employment projects, assisted living, youth housing, socio-therapeutic transitional residential facilities, hostels for the homeless), other specific offers (nursing homes and treatment ordered by a judge) to self-help initiatives. The work of the large majority of the care facilities is governed by an integrative approach (licit and illicit substances, pathological gambling, addictive problems linked to computer or Internet use, eating disorders, etc.), which is, if necessary, complemented by specific measures for certain target groups. As for the preventive activities undertaken for at-risk groups, both local approaches and countrywide available projects like early intervention in drug users who have come to the notice of the police for the first time (FreD) or the implementation of the intervention programme “Realize it“ in the *Laender* have proved successful.

The *Laender* too, have set a focus on children and teenagers as well as on licit addictive substances. Central to their work are a stronger target orientation of help offers, the comparison of demand and offer in addiction care and the optimization of the aid system through improved cooperation, cost control and work sharing. Some of the activities deployed by the *Laender* are also presented under the respective topics of the chapters.

There are numerous projects carried out in the Federal *Laender* addressing a series of target groups with different settings and focuses. They range from specific services offered like for example to migrants or socially disadvantaged families over school projects or initiatives undertaken by sport clubs to differentiated interventions, for example in drug users who have come to the notice of the police for the first time.

Note: In the period of enquiry 2010/2011, the drug and addiction commissioners of the federal states reported numerous activities and projects that focused on the topic “Children of addicted parents”. Since one of the Selected Issues of this Report is dedicated to this subject area, these measures are not presented again in the following overview.

Nearly all drug and addiction commissioners of the federal states have – generally in close consultation with the respective ministries of justice - put in a great deal of effort to collate specific information on the Selected Issue “Drug-related health policies and services in prison”. With the provision of this information they contributed to create a comprehensive basis for in-depth reporting and to draw the attention to numerous measures and projects undertaken in this area.

Baden Wuerttemberg

From Baden Wuerttemberg information is available on a series of projects and measures that revolve around the topic area “Children from families with addiction problems” and that are presented in this year’s Selected Issue. Furthermore, a regulatory order was passed by the Ministry of Justice on 15 July 2011 on substitution therapy in prison that will be dealt with in detail in the Selected Issue “Drug-related health policies and services in prison” (chapter 11).

In Baden Wuerttemberg, cooperation and cross linking at the communal level is mainly ensured by the communal addiction aid networks that have been established in all boroughs and counties. These networks have evolved into a countrywide noticed system in which all people and facilities involved in the provision of care for addicted people are engaged in a binding cooperation at district level making more effective and efficient use of available resources. Integrated into these communal addiction aid networks are the partners of the youth welfare system in order to involve the families of addicted people and, ideally, to integrate them in the overall therapy plan.

Bavaria

Carried out for many years in Bavaria, the project “mindzone” (drug prevention for young party goers) held an expert conference in 2011 on the topic of “Adventure party life” on the occasion of its 10-year existence²². “Mindzone” has moreover complemented its information material by a flyer on the topic of “Research Chemicals”.

The spectrum of services offered to help seeking users of illicit drugs in Bavaria comprises also numerous work projects²³ that are provided by nearly all addiction help organisations. The municipal drug counselling centre of the city of Munich started a new project in 2011 in order to offer long-term drug users a chance to find work on the “secondary labour market”.

²² Documentation on the conference is available at www.mindzone.info.

²³ E.g. Condrops e.V.: Offers of part time jobs at contact centres or qualification measures for the reintegration into the labour market; mudra Nuernberg: Approx. 85 jobs and apprenticeships; Laufer Muehle: Offers for people from the region or Weißer Rabe: Approximately 500 jobs in 15 companies for people with handicaps.

Berlin

The early intervention project carried out by Fixpunkt e.V. on the prevention of hepatitis C was already presented in the last REITOX Report (chapter 7.3) and is also on the list of projects funded by the Federal Ministry for Health.

The provision of syringes and tubes has been an established practice in Berlin for more than 20 years. However, no evaluation has been carried out on the provision of drug use utensils and disposal offers during that period of time. The Berlin centre Fixpunkt e. V. collected information on the current situation by means of questionnaires and expert interviews in the period between June to December 2009 and developed recommendations for the further development of the service. The evaluation report on the provision of syringes in Berlin was made available to the general expert public in early summer 2011 (cf. also chapter 7).

The Berlin TEST IT-project builds on the experience made with HCV-tests carried out within the framework of the Berlin pilot project FiP-C and with HIV-quick tests within the framework of the Dortmund demonstration project "TEST IT". The project is carried out between 01.01. – 31.12.11 by Fixpunkt e. V. by order of the German Help Association for Aids (Deutsche Aidshilfe e. V.) and is funded by the MacAids Fund. The low-threshold and anonymous test offer is to make it easier for people with risky use of illicit drugs to access HIV/hepatitis C tests. The counselling offer that is focused on infection risks in the context of drug use is to support drug users in their possibilities to become active with regard to health care and prevention. Early recognition of hepatitis- and HIV-infections is to facilitate the access to medical treatment. Hepatitis C-infections are often curable. As for HIV-infections, the most important aim is to prevent progression of the infection. Detailed information on the project is available at www.testit-berlin.de.

Hamburg

Hamburg provided information on the topic area "Children from families with addiction problems" that is reported in this year's Selected Issue.

Hesse

Hesse provided information on projects and measures that revolve around the topic area "Children from families with addiction problems" that is highlighted in this year's Selected Issue.

Mecklenburg-Western Pomerania

In the period between 01.10.2008-31.10.2009, the Land Centre for Addiction Issues carried out the project FAIRE (Agency for labour market integration and reintegration of addicted people). A short description of the project that was funded by the Federal Ministry for Health is included in the attachment. In 2010, a similar measure was undertaken by the Land Centre for Addiction Issues.

The addiction aid centre of the Caritas Mecklenburg e.V. runs a "Contact shop for drug users" that offers a syringe exchange programme. The facility is a successful example of sustainable prevention.

The Land Centre for Addiction Issues has been coordinating the project “Addiction in old age – sensitization and qualification of trained personnel working in care facilities for the elderly and addicted people since 1 October 2010. The project is funded by the Federal Ministry for Health and runs for 2 years.

From Mecklenburg-Western Pomerania information has been made available on the networks established for children from families with addiction problems who receive special attention in this year’s Selected Issue.

Rhineland-Palatinate

In order to promote the vocational (re-) integration of addicted people in substitution therapy, two demonstration projects have been set up to arrange and coordinate the necessary help and intensive support services on a case-by-case approach. In the district Mayen-Koblenz the project “Assisted integration of drug users in substitution therapy into the labour market“ (AIDA) and in the district Bad Kreuznach the project “Intensive support for drug users in substitution therapy to promote integration into the labour market and assisted living“ were set up. Each project can accommodate 20 participants. The local job centres, psychological counselling services of the addiction counselling facilities and the substituting doctors closely cooperate in these two projects. The institutions involved regularly exchange information to ensure a close linkage between the help systems and a close monitoring of the patients. In both projects, a central role is assumed by the two educational staff who attend to the clients and who serve as contact points for all institutions involved. The skilled staff offer ambulatory outreach work on a case-by-case approach in order to facilitate access to the various help systems for drug users. Part of their tasks is to support clients in finding a job or an apprenticeship, to coach them, give practical assistance in their daily lives, provide follow-up support and maintain motivation for change. Financial funding comes from the European Social Fund, the job centres and the Ministry for Social Affairs, Employment, Health and Demography.

Saxony

The Saxon addiction counselling and therapy facilities were contacted by more than 28,500 persons in 2010. About 60% of the clients make use of the counselling services primarily because of alcohol problems. At the same time it is to be observed that counselling services are increasingly requested for problems with illicit drugs (Saechsische Landesstelle gegen die Suchtgefahren e.V 2011; cf. also chapter 5).

The city Leipzig participates in the project "IKUSH – Intercultural addiction help in Leipzig from voluntary work to profession" that is carried out within the framework of the federal demonstration project "Access to the help system for people with migration background".

Respectively one addiction counselling and therapy facility in Chemnitz, Dresden and Leipzig makes itself available as a location for the project "Trampolin" that is also being carried out on behalf of the Federal Ministry for Health.

Saxony-Anhalt

In August 2010, the German National Pension Insurance (Deutsche Rentenversicherung, DRV) Central Germany and the regional directorates Saxony-Anhalt-Thuringia of the Federal Employment Agency have passed a cooperation agreement on the "Provision of services for addicted people" complete with a description of the procedure. The goal of the cooperation is to open up a new way of access to addiction rehabilitation so that people in need of therapy can start addiction therapy as early as possible and with as little as possible institutional "friction loss" (DRV Mitteldeutschland et al. 2010).

Thuringia

From Thuringia a series of projects and measures (like round table talks, expert conferences) revolving around the topic area „Children from families with addiction problems“ are reported and included in this year's Selected Issue.

Activities undertaken by the Federal Centre for Health Education (Bundeszentrale fuer gesundheitliche Aufklaerung, BZgA)

The prevention activities undertaken by the BZgA aim at motivating potential and actual users of harmful substances to critically reflect their consumption behaviour and to establish less risky forms of use. Apart from illicit drugs, special attention is given to licit and socially accepted drugs like nicotine and alcohol. In the years 2010/2011 the topic "Pathological Internet use and computer gambling" was added to the topic area prevention. Apart from forming critical norms and values with regard to problematic Internet use in the population, the BZgA provides information and aids specifically geared to young people between 12 and 18 years of age and their parents (universal and selective prevention). The brochure "Online sein mit Maß und Spaß" gives tips for every day life as well as basic information on computer games and social networks in the Internet.

In the following, two projects carried out in the years 2010/2011 are presented to offer a glimpse of the prevention activities undertaken by the BZgA:

- Integration of "Making children strong" into the campaign "Team 2011"
In the context of the FIFA Women's Championship 2011 in Germany, the BZgA accompanied the countrywide club campaign "Team 2011" in cooperation with the German Football Association (July 2009 to June 2011). The BZgA campaign "Making children strong" was already run with several offers on the topic of prevention of addiction in sports clubs and schools during the football championship in 2006. Within the framework of the campaign, 2,000 multipliers took part in trainings on the prevention of addiction in sports clubs. About 1,600 further addresses organized their own campaign day in the setting school/football club under the motto "making children strong" and distributed information material of the campaign.
- Internet platform www.drugcom.de with a focus on illicit drugs
With this low-threshold, selective preventive project, the BZgA aims at the target group of teenagers and young adults with an affinity for drugs. The goal of the Internet-based,

anonymous information and counselling offers is to motivate young people to critically reflect their drug use and possibly change their use behaviour. The modular offer comprises a comprehensive, regularly updated information area, interactive knowledge and substance tests, personal counselling offers via email and chat as well as structured reduction programmes for alcohol (“change your drinking“) and cannabis (“quit the shit“). Posted since 2004 at www.drugcom.de, the evaluated cannabis reduction and cessation programme “quit the shit“ could offer support to more than 3,000 cannabis users in their efforts to reduce cannabis use or stop completely (cf. 3.5.3).

The website is regularly tested in terms of acceptance among the target group by means of continual quality management. In the year 2010, 24,000 page impressions and more than 2,000 visits were recorded on average per day. This illustrates that the Internet website www.drugcom.de continues to be often visited and the offer well accepted as in the previous years.

Conferences and working groups

As in previous years, a host of conferences and working sessions were held also in the reporting year. From the large number of administrative, organisational, specialist and scientific events, only a very small and arbitrary selection will be presented serving as examples for the host of events on offer.

- 3rd German Addiction Congress in Tuebingen
In September 2010, the 3rd German Addiction Congress was jointly held by the German Society for Addiction Research and Addiction Therapy (Deutschen Gesellschaft fuer Suchtforschung und Suchttherapie e.V.) and the German Society for Addiction Psychology (Deutschen Gesellschaft fuer Suchtpsychologie e.V.) in Tuebingen. Alongside the host of scientific topics that were on the agenda of the congress - reaching from problematic substance and media use by teenagers, excessive and addictive use of the Internet and computer gaming, biological parameters of the development of addiction to new (psycho-) therapeutic methods used in the case of the development of addiction – a nursing congress and a separate pupils and teachers congress were integrated into the programme.
- 19th Congress of the German Society for Addiction Medicine (Deutschen Gesellschaft fuer Suchtmedizin)
Placed under the motto “Doping in everyday life – addiction and performance“, the 19th Congress of the German Society for Addiction Medicine was held in Berlin from 5-7 November 2010. Central topics of the congress were neuroenhancement, doping in everyday life as well as the provision and appreciation of performance. A total of 435 participants and lecturers took part in the congress – this shows the great interest that exists in the topic area.
- Workshop run by the DBDD on “Drugs in Prison“
Funded by the Federal Ministry of Health and supported by the Federal Commissioner on Narcotic Drugs, a workshop was held by the DBDD in Berlin on 19 November on the

topic “Drugs and prison“. The goal of the workshop was to promote an exchange of information between experts from theory and practice and stimulate a discussion. Lectures were held by representatives of the ministries of justice from North Rhine-Westphalia, Hesse and Berlin as well as of the statutory pension insurance fund, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the joint welfare association Baden-Wuerttemberg. International experts were sent by the Spanish ministry of the interior and the federal health agency of Switzerland. It became clear at the workshop that there continues to be friction between local institutions and national framework structures that has an impact on all partners involved in the system and on the prisoners. The report and documentation on the conference are available at www.dbdd.de.

34th federal congress held by the fdr - (Fachverband Drogen und Rauschmittel e.V., Federation of addiction help organisations)

The 34th federal congress took place from 30 May to 1 June 2011 in Berlin under the motto “Fit for the future. Addiction help staff between tradition and innovation“. The Professional Association Drugs and Narcotic Substances has been holding the federal drug congress since 1980 as a specialists’ conference in the context of addiction help with a focus on illicit drugs. The congress is to create a platform for people from the practical world in order to give them the opportunity to exchange information and experience, present projects and improve practical procedures in general. The congress topics serve to initiate important discussion processes. Documentation on the conference is available at www.fdr-online.info.

- Scientific symposium of the German Centre for Addiction Issues (Deutsche Hauptstelle fuer Suchtfragen, DHS)

The 19th scientific symposium held by the DHS in June 2011 in Tutzing was dedicated to the topic “Brain doping – lifestyle or risk of addiction?“. Pressure to perform and to succeed – in professional and private life – promotes risky ways of life. Healthy adolescents and adults try to cope with increased demands by enhancing the performance of their brains but also their emotional and social skills. The DHS recommends looking for alternatives and calls health policy to engage in result-oriented condition prevention. On the occasion of the scientific symposium, the DHS presented its position paper “brain doping“ in which it recommends not only to look at specific substances but also to take into account specific use situations and areas of life like for example substitution therapy, participation in road traffic and safety hazards at the workplace. The symposium is addressed to decision makers, multipliers and scientists from fundamental research and action research.

- 12th Interdisciplinary Congress for Addiction Medicine

In July 2011, the 12th interdisciplinary congress for addiction medicine took place in Munich. The congress offers specialists from addiction medicine and addiction therapy the possibility to exchange the latest scientific knowledge and acquire basic knowledge in addiction medicine.

- The topic of the annual meeting held by the Federal Government Commissioner on Narcotic Drugs on 11 October in Berlin was "Dope from the chemistry lab. Speed, Spice & Co". The specialists' conference dealt with the new challenges posed by synthetic drugs and took a look into the prevalence and use as well as possible prevention approaches. At the same time, the conference broached relevant aspects as regards the response to and control of new synthetic drugs.
- 51st DHS Specialists' conference from 14 - 16 November 2011 in Hamburg
This year's topic of the DHS specialists' conference was "International addiction help and addiction policy – what do we have from Europe and what does Europe have from us?" The goal of the conference is to show communalities in European addiction help as well as regional diversity. The conference offers the opportunity to make different approaches and good practice examples in prevention, self-help, therapeutic methods and funding basis known and to take them into consideration in the future shaping of addiction aid. In an effort to find an answer to specific questions, different addiction therapy approaches, migration aspects and different opinions on addiction are discussed. The topic area of the three-day conference at which approximately 300 participants are expected addresses all addiction aid associations affiliated with the DHS and especially representatives from politics. The 51st DHS specialists' conference represents a platform for researchers and addiction experts to exchange scientific and practical knowledge.
- Specialists' conference "10 years FreD"
The main goal of the conference "10 years FreD" which will be held in Muenster on 22 November 2011 is to provide information on the further development, quality assurance and the transfer of the FreD concept in Germany. To provide information and exchange information on current topics revolving around the target group expansion of FreD and similar approaches are further goals of the federal conference. The event addresses certified FreD trainers, specialists from addiction and drug aid, youth help and adjacent areas (schools, working groups between municipalities and employment agencies, apprenticing companies, police, judiciary etc.) and cooperation partners with a view to spread the intervention approach.
- Specialists' conference "Substitution and psychotherapy in the inpatient and outpatient setting"
The purpose of the conference organized by akzept e.V. on 2 December 2011 in Berlin is to discuss the possibilities of improving the connection between substitution therapy and inpatient rehabilitation and facilitating the access to psychotherapeutic therapy for patients undergoing substitution treatment in the in- and outpatient setting. Participants to the conference are to develop approaches to overcome existing sectorization in order to achieve a better integration of medical rehabilitation, psychotherapy and substitution therapy. In this connection, possible organisational, financial and legal problems are to be discussed and approaches for solutions to be developed. The conference, at which approximately 100 participants are expected, addresses researchers and specialists from the area substitution in the whole of Germany.

International cooperation

Germany actively cooperates with international institutions in the area of drugs and addiction. Its most important partners are the European Commission, the Horizontal Drugs Group (HDG), the European Monitoring Centre for Drugs and Addiction and the Pompidou-Group at the Council of Europe. Germany also plays an active role in the activities undertaken by the United Nations such as the current assessment of the implementation status of the UNGASS-resolutions. Germany is also an active partner in the Commission on Narcotic Drugs of the United Nations (CND). The Federal Commissioner on Narcotic Drugs assumes an important coordinating function when representing Germany in the European and other international bodies dealing with drug policy (Die Drogenbeauftragte der Bundesregierung 2009). She shares her function with the special agencies of various ministries (Ministry of the Interior, Ministry for Health, Ministry of Foreign Affairs) or experts from other areas when representing Germany at the international stage. German representatives also actively participate in the Civil Society Forum on Drugs of the European Commission.

In the reporting period, Germany engaged in various bilateral cooperation projects with regard to drugs and addiction with Turkey (twinning projects, IPA III Project of the EMCDDA), Central Asia (Central Asian Drug Action Programme) and participated in various international projects (e.g. DRUID, or “FreD goes Net”) in which German experts cooperated with colleagues from countries within and outside of the EU.

1.3.3 Other drug policy developments

There are no new developments to report.

1.3.4 Coordination arrangements

Coordination between the Federal Government and the *Laender* takes place in the conferences of government departments and their working groups. The so-called interministerial working groups guarantee the exchange and coordination of cross-departmental measures between the various federal agencies. The national Board on Drugs and Addiction (Drogen- und Suchtrat, DSR) as well as its steering group also play an important role in this field since they facilitate both the vertical and horizontal exchange between the different institutions and the federal and Land ministries. As part of the steering group, the working group ‘German Statistical Report on Treatment Centres for Substance Use Disorders’ has been installed in order to coordinate the collection of statistical data in this area. The working group ‘Interface problems in the care of addicts’ of the DSR also deals with coordination tasks. It mainly strives to improve the transfer of addicted people from treatment to work, to facilitate the transfer at the interface between prison and reintegration, as well as to improve early-intervention in counselling and treatment of people suffering from addiction and the cooperation with youth aid and the help system for the homeless. In addition, cooperation between Federal and *Laender* governments also takes place within the framework of various projects.

On a national level, the Federal Centre for Health Education (Bundeszentrale fuer

gesundheitliche Aufklaerung, BZgA) is in charge of the planning and execution of prevention programs and the monitoring of preventive activities and their quality assurance. It chairs the working group "Addiction prevention" which also reports to the Board on Drugs and Addiction. The Federal Institute for Drugs and Medical Devices (Bundesinstitut fuer Arzneimittel und Medizinprodukte, BfArM) is responsible for the licensing of pharmaceuticals. Affiliated with the BfArM is the Federal Opium Agency which, among others, grants the licences to trade in narcotic drugs and precursors and supervises the trade in narcotic drugs and precursors among licence holders. It also keeps the national substitution register.

1.4 Economic analysis

1.4.1 Overview

A detailed overview of the data sources available in Germany giving an insight into public expenditures as well as the presentation of the problems linked to the collection and analysis of these data were the subject of a Selected Issue of the Reitox Report 2007 which is available in German and English language at the website of the DBDD. In spring 2008, the EMCDDA moreover published a summary of the information provided by the member states on the subject matter which is also available from the DBDD.

To understand the structure of funding, one needs to have a grasp of the Federal structure of Germany and the principle of subsidiarity, which has led to a complex system of responsibilities at the Federal, *Laender* and local levels along with social insurance schemes with respect to the funding and execution of tasks. Especially information on financial resources which the *Laender* and local governments allocate to drug or addiction problems is not aggregated or compiled at the national level at present as a result of limited comparability.

Another problem posed by the compilation of public expenditures for drug-related issues is the fact that the German care system does not differentiate any more between individual substances or licit and illicit substances respectively rendering the task of ascertaining the share of illicit drugs in the costs expended almost impossible. It is furthermore particularly difficult to identify *non-labelled* costs specifically relating to addiction in the cross-sectional areas of police and judiciary, detention and social welfare system which would however account for a considerable portion in a comprehensive estimation of the overall costs.

It is apparent, then, that solely the identification of costs incurred (prior to the calculation of specific shares for licit or illicit substances) is associated with considerable effort.

1.4.2 Public expenditures and budgets

Funded by the Federal Ministry for Health, the DBDD carried out a study in 2008 in cooperation with the chair of medical management of the university to venture for the first time an overall estimate of the direct (labelled and non-labelled) government expenditure and funds provided by the statutory social insurance schemes in the area of illicit drugs in the year 2006 (Mostardt et al. 2009).

Various approaches were combined for data collection: At the level of the central, regional and local authorities, the budget documents available to the public were analyzed and ministries and subordinate authorities as well as other key persons were interviewed. Complementing data from published studies and statistics were used to develop alternative calculation or estimation methods. The data on the expenses effected by the social insurance institutions were collected by means of paper-based interviews.

Adding the identified and calculated expenditures, one gets a range between 5.2 and 6.1 billion EUR spent in 2006 for the area of illicit drugs which breaks down as follows: the portion of the German National Statutory Pension Insurance in the funding for medical rehabilitation, participation in working life and benefits granted for the reduction in earning capacity amounted to about 172 million EUR. The extrapolation of the expenditures of the medical health insurance institutions for medication, hospital treatment, rehabilitation etc. came to 1.4 billion EUR. At the institutional level, an amount of 3.6 to 4.5 billion EUR was provided for the prevention and reduction of the consequences of drug-related problems in the form of prevention, intervention and repression measures.

The expenditures are broken down in more detail in standard table STPE.

Applying the internationally used classification of the functions of government (COFOG)⁴ (European Commission 2007) for the assignment of expenditures, one finds that a large part of the estimated expenditures (>65%) is assigned to the function “public security and order”. Funds provided for the functions “health” and “social security” are often difficult to separate from each other and account for a considerably lower portion in the overall spending. However, here the largest gaps in data collection are to be found.

Due to missing data and methodological restrictions, the overall result needs to be regarded as a conservative estimation. Especially for the *Laender*, the expenditures calculated are based on very rough estimation methods. There are no representative data available from the municipalities. Even though the funds presented under this chapter do by no means lay claim to completeness, the result does represent the most comprehensive and best approximation currently available in Germany.

In view of the great expense associated with the data collection, the question arises however whether and how a regular update of the estimation of the expenditures can be done in the future.

There are no new systematic estimations available for the reporting year 2010.

1.4.3 Social costs

So far, there have been no studies carried out on the social costs of the use of illicit substances in Germany.

2 Drug use in the population and specific targeted groups

2.1 Introduction

Aspects of drug use

Experience with drugs means, in many cases, a one-off or only infrequent use of drugs. After the drug was 'tried', its use is, in most cases, completely discontinued in the course of time. Drug use related to the lifetime is therefore only a rough indicator of the extent of drug use at a given point of time. The figures also include people reporting experience with drugs sometimes dating back 20 or 30 years.

Therefore, drug use in the 12 months (12-month-prevalence) prior to the survey is a better indicator of current user numbers. More significant is the information provided by surveys on drug use 30 days prior to the survey. The clear difference that is shown in the total population between lifetime-prevalence, 12-month-prevalence and 30-day-prevalence identifies experimental or short-term use as the most common pattern of consumption.

National data sources and international studies

In Germany, epidemiological sources for drug use data are mainly available through regular national representative surveys and prevalence studies which are complemented by regional quantitative and qualitative studies. Furthermore, international studies in which individual *Laender* and regions are taking part, will also be mentioned in this chapter. Due to their international comparability, these surveys are also grouped under "national data" although studies like ESPAD (see below) or HBSC (see below) have so far not been carried out by all *Laender*. The short descriptions also contain information on the participating countries.

- The Drug Affinity Study (DAS) carried out by the Federal Centre for Health Education (BZgA) investigates the use, the motives for use and the situational conditions with regard to tobacco, alcohol and illegal addictive substances among teenagers and young adults (age group 12-25 years) on a long-term basis. The study has been conducted since 1973 every 3 to 4 years. Initially designed as a personal interview, it has been carried out as a telephone interview (CATI) with a sample of 3,000 interviewees. The last survey dates back to the year 2008. Its results were presented in the Reitox Report 2009 (BZgA 2010).
- In addition to the DAS, the Federal Centre for Health Education published the findings of a representative survey conducted on cannabis use among 3,602 interviewees in the age group from 12 to 19 years (BZgA 2007) in 2007. A summary of the results was already presented in the REITOX Report 2007.

In 2011, the Federal Centre for Health Education presented the findings of a representative survey recently conducted on the cannabis use of adolescents and young adults in Germany (BZgA 2011c). The representative survey was carried out countrywide in the age group of the 12- to 25-year olds. It uses a multi-level random sample based on an ADM telephone sample system (computer generated telephone numbers, random selection of 12- to 25-year olds in a household) of N=7,000 cases with a response rate of 52.6% (interview period: June -August 2010). The results are reported in chapter 2.3.2.

- The Epidemiological Survey on Substance Abuse (ESA) (former Federal Study on the abuse of psychoactive substances among adults in Germany) is a paper-based national study on the use of psychotropic substances, their effects and assessment as well as on other basic data. Since 1980 the study has been conducted every 3 to 4 years on the basis of a representative sample of the resident population in the age group from 18 to 64 years. Funded by the BMG, the survey has been conducted by the IFT since 1990. The sample taken in each survey has comprised about 8,000 persons since 1995. Some of the *Laender* have provided additional funding for a regional expansion of the sample to create a statistical basis for regional evaluations. The design of the study, methods used (Kraus & Pabst 2010) and results (Pabst et al. 2010, Kraus et al. 2010) of ESA 2009 were presented in the REITOX Report 2010.
- The “European School Survey Project on Alcohol and other Drugs” (ESPAD) was carried out already in 1995 in 26, 1999 in 31 and 2003 in 35 European countries. In 2007, some *Laender* participated for the second time in the survey after 2003. The participants in 2007 were Bavaria, Berlin, Brandenburg, Hesse, Saarland, Mecklenburg-Western Pomerania and Thuringia. Initiated by the Pompidou-Group at the Council of Europe and coordinated by CAN²⁴ (Stockholm) in Stockholm, the survey uses European-wide uniform standards for data collection. The survey is carried out among 15- to 16-year olds in school grades 9 and 10. In 2007, the adjusted sample size comprised 12,448 pupils from 586 classes at 567 schools (Kraus et al. 2008). The ESPAD data are, in parts, also based on individual *Laender* surveys.
- As part of the WHO-funded Study on the Health Behaviour of School-Aged Children (HBSC), which is meanwhile carried out every four years in 41 countries, five *Laender* (North Rhine-Westphalia, Berlin, Hamburg, Saxony, Hesse) participated in the survey on the health behaviour of pupils between 9 and 17 years of age in 2005/2006. For the survey conducted in 2006, data was also collected on the use of illicit drugs. Results have been available since summer 2007 (Nickel et al. 2008; Settertobulte & Richter 2007). The Reitox Report 2008 presented also data from an evaluation of an HBSC study carried out by the Land North Rhine- Westphalia (Richter et al. 2008).

²⁴ Swedish Council for Information on Alcohol and Other Drugs.

- Early in 2007, the first results of the Health Interview and Examination Survey for Children and Adolescents (Kinder- und Jugendgesundheitssurvey, KiGGS) were presented (Lampert & Thamm 2007). The findings are based on countrywide representative data on the health state of children and adolescents in the age of 0-17 years. A total of 17,641 children and adolescents participated in the study. For the analyses of the tobacco, alcohol and drug use, the data from the interviews conducted among the 11 to 17 year old boys and girls and their parents were used. The most important results of the evaluation have already been presented in the Reitox Reports 2007 and 2008. Schleswig-Holstein made its own contribution to the national health survey by publishing a report on the health state of children and adolescents in Schleswig-Holstein (RKI 2007a; Schuetze et al. 2007) which was also referred to in the REITOX Report 2008.

Data from the *Laender* and the regional monitoring systems

Apart from these surveys, most of which are conducted on a regular basis, various studies commissioned by some individual *Laender* are carried out irregularly at regional and local level focusing among others on the extent and effects of the use of a specific substance, use patterns or characteristics of a specific group of users. These studies are based in part on individual evaluations carried out within the framework of larger national studies which have already been mentioned under the rubric of the national data sources (e.g. regional evaluations of KiGGs, HBSC and ESPAD).

- In May 2009, the findings of the MODRUS IV study (*Moderne Drogen- und Suchtpraevention – Modern Drug and Addiction Prevention*) were presented in Saxony-Anhalt. In the forth sociological - empirical MODRUS study, students and teachers from grade six to twelve were asked about their experience with and attitude towards licit addictive substances, drugs and their use of the computer and the Internet (N=2.432). The results were already presented in the Reitox Report 2009.
- After the last data collection in 2007/2008, a survey called “Hamburg School bus“ was carried out for the fourth time in 2009 within the framework of the Local Monitoring System LMS) among students aged 14 to 18 years at schools providing general or vocational education. The results of the survey 2009 are based on a random sample drawn among the 14- to 18-year-old adolescents and young adults in Hamburg (N=1.132) (Baumgaertner 2010). The sample was adapted to the statistical report on schools in terms of gender, age and type of school and weighted in terms of age and gender according to the official population survey. The findings of the survey were already presented in the REITOX Report 2010.

- Another source that has been providing information on drug trends at local level for many years is the Monitoring System Drug Trends (MoSyD) from Frankfurt/Main. MoSyD is made up of several components: a representative school survey, a trend scout panel²⁵, a scene-based survey and an expert survey²⁶.

In the reporting period 2010, students aged between 15 and 18 years N=1,064 (weighted and corrected sample) were surveyed at schools providing general and vocational training within the framework of a yearly school survey (Werse et al. 2011). Furthermore, data is also available from the recently carried out expert survey, the trendscout panel and the scene survey conducted within the framework of the MoSyD. The results are reported in chapters 2.3.2 and 2.4.

The results of the survey carried out among the open drug scene in Frankfurt am Main within the framework of MoSyD were published in 2010 already for the fifth time in a separate report (Mueller et al. 2011). As in the previous years, the random sample taken comprised N=150 drug users. About half of them were recruited directly in the open drug scene in the area around the central station and the other half in the low-threshold facilities of the Frankfurt drug help system. The survey instrument used was a standardized questionnaire that was closely oriented by the questionnaires used by the scene surveys conducted in previous years to allow systematic comparisons. In 2010, the so-called HIV-code was surveyed at the end of the questionnaire for the first time in order to record for future surveys who has already been interviewed in previous years and whether there are possible changes in the use behaviour are to be observed. The users were also asked for the first time how often they were checked by police and how often they were removed from a premise or how often they received a banning order. The results of the scene study are reported in chapter 2.4.

Use of available data sources

This report presents the respectively relevant results of the most recent studies focusing on the national epidemiological studies on substance and drug abuse (Epidemiological Survey on Substance Abuse, ESA and Drug Affinity Study, DAS). Insofar as no new data were published in the period under review, this report confines itself to presenting only a few basic data.

When interpreting the results of population surveys, it needs however to be taken into account that the figures may be non-negligibly underestimated given the fact that in particular

²⁵ The trend scout panel used by MoSyD is a partly standardized survey instrument of qualitative, ethnographic nature. The primary goal of the instrument is to track new trends and changes with respect to use of illicit drugs in Frankfurt/Main. To this purpose, recreational scenes are selected especially from youth cultures. The selection of the different settings is focused on the scenes for which a relatively high use prevalence of illicit drugs can be assumed. The trend scout survey is designed as a panel survey that measured the same sample of respondents in regular intervals (twice a year since 2006). The survey is based on a half-open guideline-based interview.

²⁶ In the expert survey people who are professionally involved with the area of drugs (prosecution, drug help, youth aid, prevention, school) are regularly interviewed in a group interview.“

persons with a high use of illegal drugs are more difficult to reach by such studies and often have a tendency to underreport the frequency and quantity of their use. Therefore, especially in the case of heroin addicts, estimation methods tapping other data sources (e.g. police files, cf. chapter 4.2). In addition to quantitative data, also qualitative studies have been taken into account.

2.2 Drug use in the general population

2.2.1 Overview of the use of various drugs

Table 2.1 presents a minimal estimate of the prevalence of the use of illicit drugs in Germany. It is based on the last two epidemiological surveys conducted on substance abuse²⁷ (ESA 2006, 2009) and the most recent DAS (2008).

Table 2.1 Prevalence of illicit drugs in Germany

	Source	Age	Prevalence	Total ¹⁾
Lifetime	ESA 2009	18-64	26.7%	13,812,000
	ESA 2006	18-64	23.7%	12,270,000
	DAS 2008	12-17	10.0%	508,000
12 Months	ESA 2009	18-64	5.1%	2,638,000
	ESA 2006	18-64	5.0%	2,589,000
	DAS 2008	12-17	7.4%	376,000
30 Days	ESA 2009	18-64	2.6%	1,345,000
	ESA 2006	18-64	2.5%	1,294,000
	DAS 2008	12-17	2.8%	142,000

1) Figures are rounded. Population figures in the age categories:

18-65 years: 51,773,467 (year 2006); 51,729,010 (year 2007, more recent figures are not available) (Source: Statistisches Bundesamt 2009b); figures from the Federal Statistical Office for the age groups 18-65 in comparison with 18-64 in ESA, therefore slight deviations in the above-mentioned absolute figures;

12-17 years: 5,075,140 (year 2008) (Source: Gesundheitsberichterstattung des Bundes, GBE 2010)

BZgA 2010; Kraus et al. 2007, Pabst et al. 2010.

The lifetime prevalence is not suitable as an indicator for current changes since it does not give any valuable clues to the current use behaviour of the interviewees. In literature, the 12-month prevalence is generally used as a reference value since, on the one hand, it is referred to a reasonably limited time window of past use and, on the other, it provides interpretable prevalence values (whereas the 30-day prevalence of the use of illicit drugs with the exception of cannabis often only gives extremely low figures) (details on the population surveys are also contained in the online standard table 1).

While the lifetime prevalences of the use of illicit drugs among adults in the age group 18-64

²⁷ In addition a detailed Laender analysis for Hamburg is available for download under <http://www.hamburg.de/contentblob/3078458/data/ift-bericht.pdf>.

years (ESA) slightly increased between 2006 and 2009 (2006: 23.7%; 2009: 26.7%), the figures for the use of illicit drugs in the 12-month category remained practically unchanged between the two data collection years 2006 and 2009 (2006: 5.0%; 2009: 5.1%). The situation is similar for the use within the last 30 days prior to the survey (2006: 2.5%; 2009: 2.6%) (Pabst et al. 2010a).

Since the prevalence of the use of illicit drugs (total) significantly depends on the use experience with cannabis (and is almost identical with it), the findings of the ESA 2009 indicate a stabilisation of the decline of the current use of cannabis in the general population, which had already been observed by the ESA 2007. Within the framework of the ESA 2009, only 7.4% of the interviewees (2006: 5.8%) report experience with other illicit drugs in the lifetime category. Even lower are the values for the 12-month (1.3%) and 30-day prevalence (0.6%), which have remained practically unchanged in comparison with the survey carried out in 2006 (1.2% and 0.7% respectively) (cf. also Table 2.2).

2.2.2 Comparison of the use of individual drugs

National data

The most recent data on the prevalences of the use of individual drugs among adults stem from the ESA 2009 and were reported in the REITOX Report 2010. Data on the use of illicit substances among teenagers and young adults was provided in 2008 by the DAS and presented in the REITOX Report 2009.

In order to give an overview of the use of the general population, the most important and most recent data on the lifetime, 12-month and 30-day prevalence for the use of individual substances for the age groups 12-17 and 18-64 years were compiled in Table 2.2.

There have been hardly any changes in the adult population between the two ESA surveys conducted in 2006 and 2009 (with the exception of slight differences in the lifetime prevalences). Current use (12-month prevalence) of amphetamines and cocaine was found to slightly increase, at an extremely low level though. Given the stimulating effects of the two substances, both changes do however point into the same direction.

In the reporting year 2009, the herbal mixture "spice" was included for the first time in the catalogue of questions²⁸. A complete overview of the lifetime, 12-month and 30-day prevalences broken down by gender and age group from the ESA 2009 is provided by table 2.3 of the REITOX Report 2010. Table 2.4 of the REITOX Report 2010 presents an overview of the trends in the lifetime and 12-month prevalences of the use of illicit drugs among young adults in the age group 18 to 39 years that are based on the seven surveys conducted between 1990 and 2009.

²⁸ In this context, it should be noted that comparable herbal mixtures (that are proved to contain synthetic cannabinoids) disappeared already at the beginning of the year 2009 from the market as a result of changed legislation. Since this time however, numerous me-too products have been following continually especially via online trading.

Table 2.2 Prevalence of the use of illicit drugs broken down by substances

Source Substance	DAS 2008 (%; 12-17 Years)			ESA 2006 (%; 18-64 Years)			ESA 2009 (%; 18-64 Years)		
	LT	12 M	30 D	LT	12 M	30 D	LT	12 M	30 D
Cannabis	9.6	6.6	3.7	23.0	4.7	2.2	25.6	4.8	2.4
Amphetamines	0.7	0.6	0.2	2.5	0.5	0.3	3.7	0.7	0.3
Ecstasy	1.1	0.8	0.3	2.0	0.4	0.2	2.4	0.4	0.2
LSD	0.4	0.3	0.0	1.7	0.1	0.0	2.4	0.1	0.1
Heroin	0.1	0.1	0.0	0.4	0.1	0.1	0.5	0.1	0.0
Cocaine	0.9	0.8	0.3	2.5	0.6	0.2	3.3	0.8	0.3
Crack	0.5	0.3	0.1	0.3	0.1	0.0	0.2	0.1	0.0
Mushrooms	1.2	0.9	0.2	2.4	0.4	0.1	2.8	0.1	0.1
Volatile substances	0.4	0.4	0.2	--	--	--	--	--	--
Any illicit drug	10.0	7.4	2.8	23.7	5.0	2.5	26.7	5.1	2.6
Illicit drugs besides Cannabis	2.7	2.0	0.6	5.8	1.2	0.7	7.4	1.3	0.6

LT: Lifetime, 12 M: 12 Months, 30 D: 30 Days

BZgA 2010; Kraus et al. 2007, Pabst et al. 2010

Use of illicit drugs is a phenomenon occurring primarily in younger age groups. The portion of the 12-month-users among the below-30-year olds lies on average around 14%, among older users however, it is only about 2%. For many substances (except cannabis), the current (i.e. 12-month) consumption prevalences are already low among younger age groups, among the above-30-year olds they lie for all older age groups consistently below 1%. Apart from cannabis, only amphetamines and cocaine play a major role among the 20-29-year olds, although consumption experience with ecstasy, LSD and hallucinogenic mushrooms in the age groups above 30 years is quite common in the lifetime category. Looking at the relation between lifetime prevalences and current consumption, it is to be assumed that use of these substances is only of a transitional nature in the majority of users.

Trend data provided by the DAS for the lifetime prevalences for the use of cannabis by adolescents and young adults between 12 and 25 years of age were presented in the REITOX Report 2009.

2.3 Drug use in the school and youth population

With a prevalence of about 5-6%, psychological disorders linked to the use of illicit drugs in children and adolescents continue to be among the epidemiologically most important psychiatric disorders occurring during childhood and adolescence (Sack et al. 2008). Current studies moreover suggest that cannabis use has a much more harmful effect on the brain in adolescents than in adults (Sonnenmoser 2008; Thomasius & Petersen 2008). The vast

majority of adolescents stop using drugs when entering adulthood. Early interventions can help to prevent the onset of substance-related disorders and the beginning of an addiction career (Stolle et al. 2007). Alongside the majority of young people who do not develop any persisting disorders, there is a non-negligible group, though, who displays highly problematic use patterns already at an early age and, in many cases, also develops psychological co-morbidities at a later stage such as disturbed social behaviour, affective disorders and anxiety disorders (e.g. Thomasius & Stolle 2008b). For this group of persons it is particularly important to be provided with specific treatment offers as described for example by Kuestner and colleagues (2008), (see also Thomasius & Stolle 2008a). Universal and selective prevention of nicotine consumption apparently assumes a key role in preventing the later onset of substance-related disorders in adolescents since nicotine dependence is highly associated with other disorders as a result of the use of illicit substances (Perkonigg et al. 2008). In view of the particular importance assumed by the use of also licit psychotropic substances (especially alcohol and tobacco) by teenagers and young adults, findings on the use of licit substances will be cursorily presented in the following.

So far, research on trend prognoses for substance use disorders especially for childhood and adolescence is scarce. A few individual surveys however identified abetting and protective factors for the development of substance disorders (cf. REITOX Report 2010, quoted from: Thomasius 2009, Sack & Thomasius 2009a).

2.3.1 Use of licit psychotropic substances

Alcohol

The findings of the representative survey conducted by the Federal Centre for Health Education in the year 2010 with a focus on alcohol use (BZgA 2011b) confirm that experience with the consumption of alcohol among 12-25-year olds is very common. About three quarters (72.3%) of the 12- to 17-year olds already have had experience with alcohol once in their lifetime. Among the 18- to 25-year olds, the quasi totality of all interviewees report consumption at least once in their lifetime (96.6%). The 12-month prevalences for both age groups are slightly lower (63.3% and 92.2% respectively). Gender-specific differences were not found with regard to prevalences. As for regular consumption (defined as at least once a week) though, gender- and age-specific differences are substantial. Generally speaking, more male teenagers and young adults regularly drink alcohol. Regular consumption has been on the decline since 1979 among adolescents and young adults (from 44.7% to 26.1%).

An indicator for measuring risky consumption behaviour among young people is the so-called binge drinking, defined as consuming five or more drinks at a time. At present, one in six teenagers aged between 12 and 17 years states to have engaged in binge drinking at least once in the last 30 days, about five percent of this group report to do this four times or more in the last 30 years. With this, there is a sizeable figure of young people showing risky alcohol use behaviour that increases the probability of the later onset of alcohol-related

problems and disorders.

Findings on alcohol consumption among young people from the Health Interview and Examination Survey for Children and Adolescents (Kinder- und Jugendgesundheitssurvey, KiGGS) (Lampert & Thamm 2007) and the HBSC study (Settertobulte & Richter 2007) were already presented in the REITOX Reports 2007, 2008 and 2009.

Tobacco

Data on the use of tobacco among adolescents and young adults are also available from the alcohol survey conducted by the Federal Centre for Health Education in 2010 (BZgA 2011f). The lifetime prevalence of smoking among the 12- to 25-year olds was at 55.8% in 2010. About one in six teenagers and young adults smokes daily, 11.4% even more than 10 cigarettes a day. The average age at onset of smoking is 14.0 years and has slightly increased since 1986. The quota of smokers among the 12- to 17-year old teenagers continually declined between 1979 and 1993, rose again until 1997 and stagnated at a high level until 2001. Since 2001, the portion has considerably shrunk again and currently is at 14.2% (male teenagers) and 11.5% respectively (female teenagers).

Findings on the tobacco consumption of adolescents from the last HBSC study (cf. also Nickel et al. 2008), KiGGS and MODRUS IV have already been presented in the REITOX Reports 2007 and 2009.

2.3.2 Use of illicit drugs

The results of the European School Survey Project on Addiction and other Drugs (ESPAD) were already presented in the last REITOX Reports (Kraus et al. 2008). The review data from the DAS on the use of illicit drugs by adolescents and young adults was already presented in the REITOX Report 2009 (chapters 2.2.1 and 2.2.2).

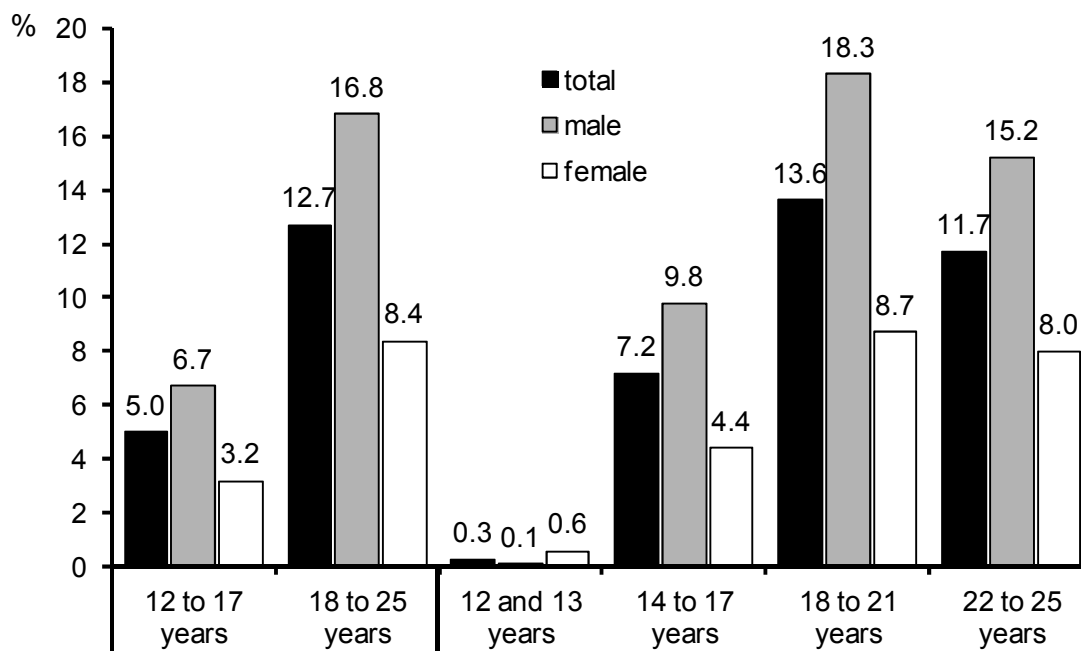
Trend data on the use of illicit substances by adolescents (12- to 17-year olds) and young adults (18- to 25-year olds) have been provided by the DAS since 1979 (BZgA 2010). From 1979 to 1993, the development of the lifetime prevalences of illicit drugs among adolescents between 12 and 17 years of age vary only slightly on the whole running almost parallel for females and males until 1989. Afterwards, the portion of those who have already had experience with any illicit drug, is subject to diverging developments in the female and male adolescents: among the female adolescents, the portion of those with consumption experience with illicit drugs jumped from 4.5% (1993) to 15.2% (1997)²⁹. From 2001 (11.7%) onwards, the lifetime prevalence declined again and was at 8.0% in the year 2008. The lifetime prevalence among the male adolescents continually increased from 8.7 percent in 1993 to 19.0 percent in the year 2004 and fell back to 12.0 percent in 2008 (for a graphic presentation of this development, see REITOX Report 2010, figure 2.1).

²⁹ This increase was mainly attributable to the increase in the use of ecstasy as a "new party drug" in the context of the then forming techno party scenes and the increase in use of cannabis.

Use experience with illicit drugs among the 18- to 25-year olds is significantly higher across all categories measured than among the 12- to 17-year olds. In this age group, gender differences are also more pronounced across the board. The portion of male young adults who have already had experience with drugs is between five and 14.7 percent points higher than the one of the female young adults over the whole reporting period. Since the beginning of the 1980s, the lifetime prevalence of the 18- to 25-year olds declined for both genders: the portion in the female young adults sank from 24.5% (1982) to 16.3% (1993) and in the male young adults from 32.5% (1982) to 26.8% (1989). From then onwards, the gender specific lifetime prevalences significantly increased till the year 2004. After that, the values hardly changed and were at 47.3% (male young adults) and 35.8% (female young adults) in 2008 (for a graphic presentation of this development, see REITOX Report 2010, figure 2.2).

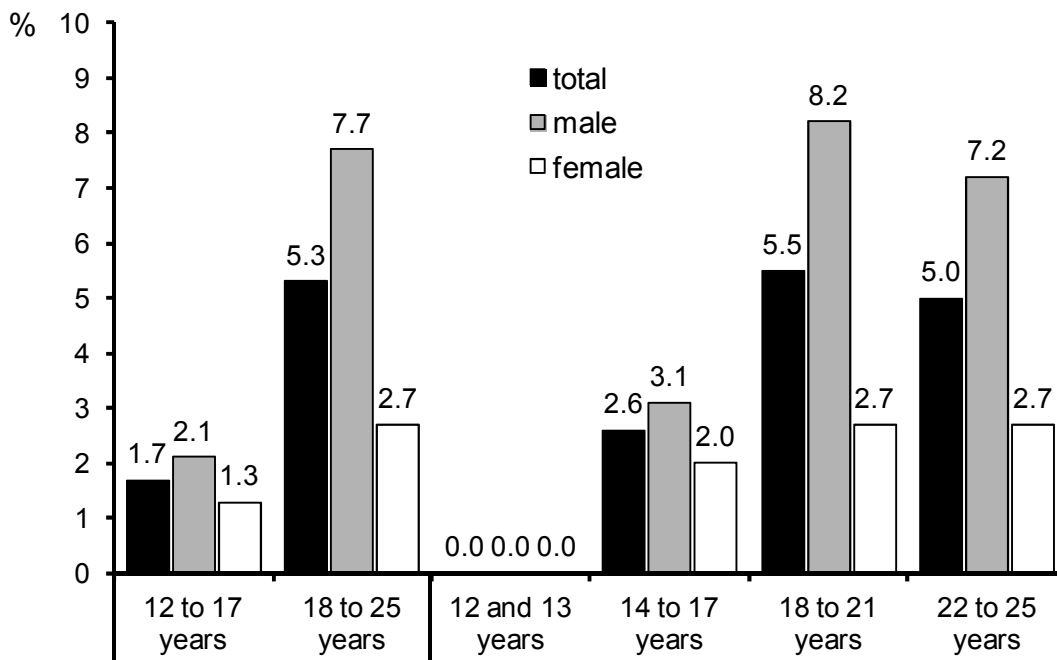
In 2011, the Federal Centre for Health Education presented the findings of a recent representative survey on cannabis use among teenagers and young adults in Germany (BZgA 2011c). According to this survey, 7.4% of the adolescents aged between 12 and 17 years and 35% of the young adults aged between 18 and 25 years have used cannabis at least once in their lives (lifetime prevalence).

The portion of those who used cannabis in the last 12 months before the interview was at 5.0% among the 12- to 17-year olds and respectively at 12.7% among the 18- to 25-year olds (12-month prevalence; Figure 2.1). In the last 30 days before the interview, 1.7% of the adolescents and 5.3% of the young adults used cannabis (30-day prevalence; Figure 2.2).



BZgA 2011c.

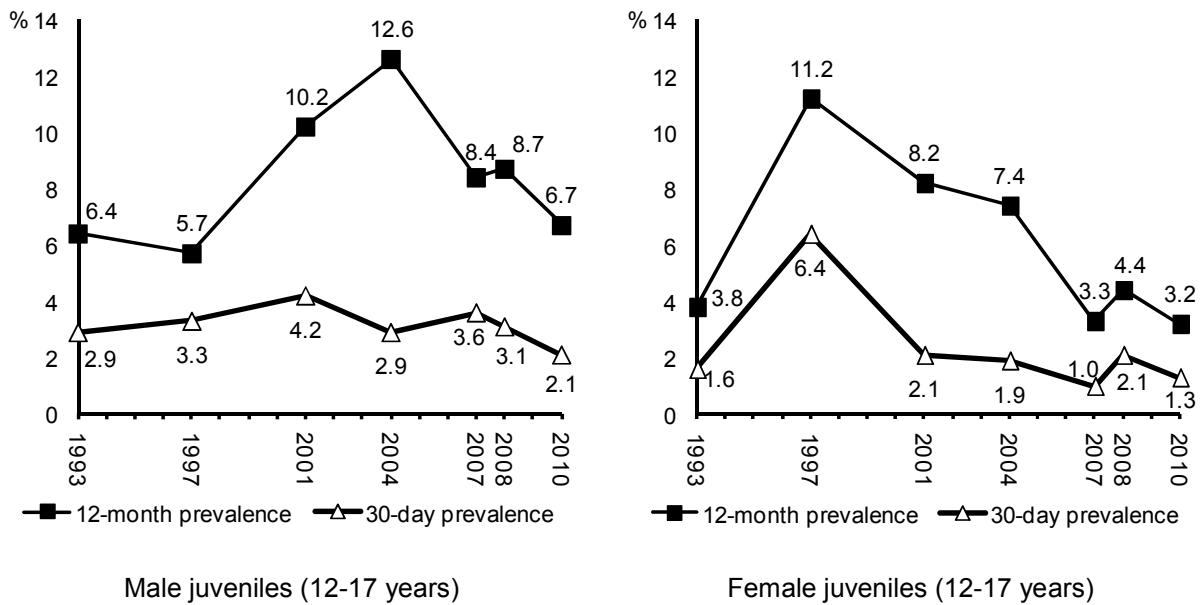
Figure 2.1 12 month-prevalence of cannabis use among adolescents and young adults in 2011



BZgA 2011c.

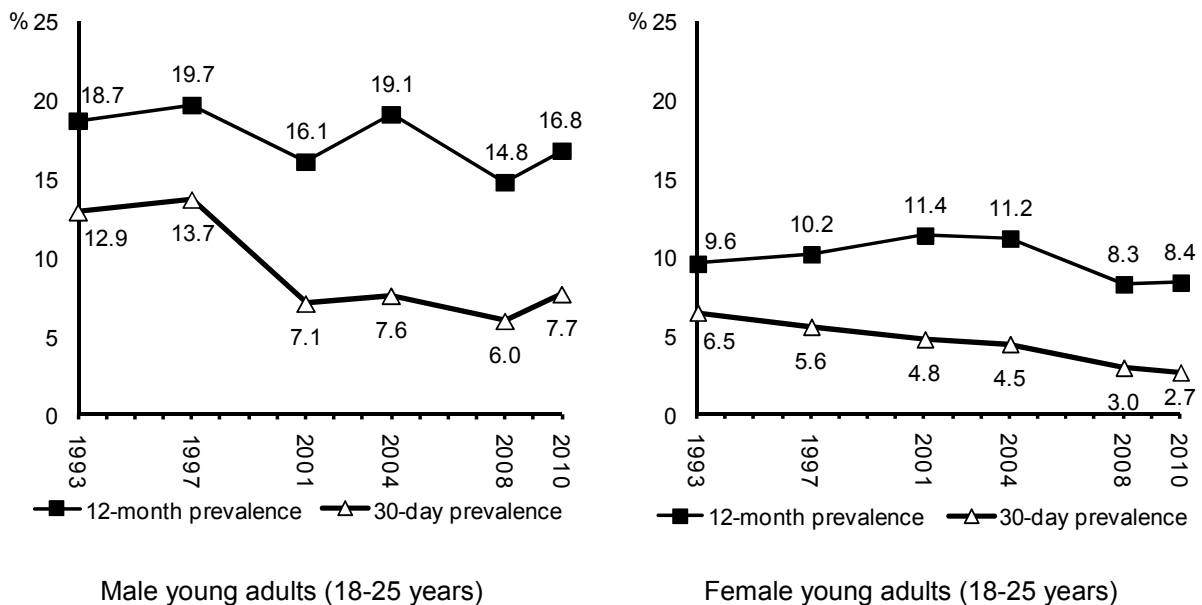
Figure 2.2 30- day prevalence of cannabis use among adolescents and young adults in 2011

After having significantly increased in 1990s, the lifetime prevalence of cannabis use is currently declining again in all age and gender groups. The 12-month prevalence and the 30-day prevalence found by the recent survey are lower on a statistically significant scale than in previous years (Figure 2.3, Figure 2.4).



BZgA 2011c.

Figure 2.3 Trends of the 12-month and 30-day prevalence of cannabis use among adolescents in 2011



BZgA 2011c.

Figure 2.4 Trends of the 12-month and 30-day prevalence of cannabis use among young adults 2011

Experience with the use of cannabis among teenagers and young adults is very common in Germany. It is more prevalent among male adolescents than among female ones. However, many users use cannabis only once, occasionally or episodically since the portion of those who used cannabis in the last 12 months or last 30 days, is significantly lower than the portion of persons with use experience in the lifetime category.

Nevertheless, there is a considerable portion of adolescents and young adults who regularly (i.e. more than ten times) used cannabis in the last 12 months. A total of 0.6% of the adolescents and 3.2% of the young adults used cannabis more than ten times in the last 12 months. The portion of regular cannabis using young adults in the age of 18-25 years amounts to little less than a quarter of a million people.

According to the Federal Centre for Health Education, the data on the use of an illicit substance rather tends to under- than to overestimate the real extent of the problem as a result of the socially desired response behaviour.

Data from the *Laender* and the regional monitoring systems

Frankfurt (MoSyD)

As in the previous year, 9% of the 15-19-year old Frankfurt students reported in 2010 that they had experience with at least one illicit drug³⁰ except cannabis (Figure 2.5). The 12-month prevalence in 2010 is comparable to the one of the year 2009, the 30-day prevalence ranges in 2010 between the values of the years 2009 and 2008.

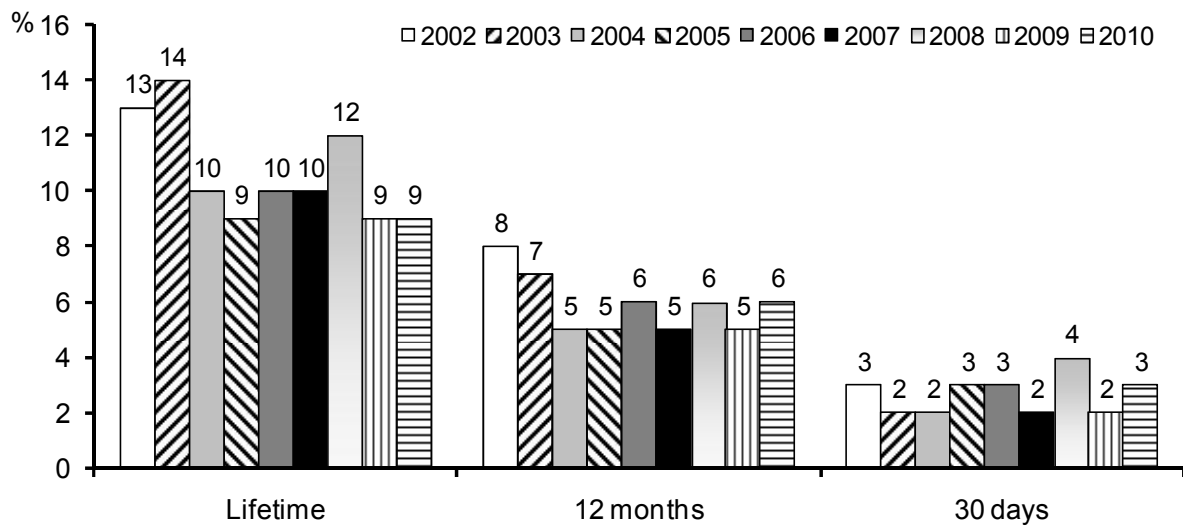
As in the previous year, 3% of the students reported in 2010 that they had used ecstasy at least once in their lives; the 12-month prevalence is stable as well (2%).

After having declined in the previous year, the lifetime prevalence of speed increased significantly and reached with 6% the highest value since 2002 whereas the increase of the 12-month prevalence was less pronounced with 3%, ranging between the values of the years 2008 and 2009.

The portion of the 15- to 18-year old Frankfurt students who have experience with cocaine use, amounts to 4% (2009: 3%), 3% of the students used cocaine at least once within the last year before the interview.

The lifetime prevalence of methamphetamine, which is among the most rejected drugs among the 15-18-year-olds, was still only at 1%.

³⁰ Summary of the substances: Psychoactive mushrooms, ecstasy, speed, cocaine, LSD, crack, heroin, crystal and GHB.



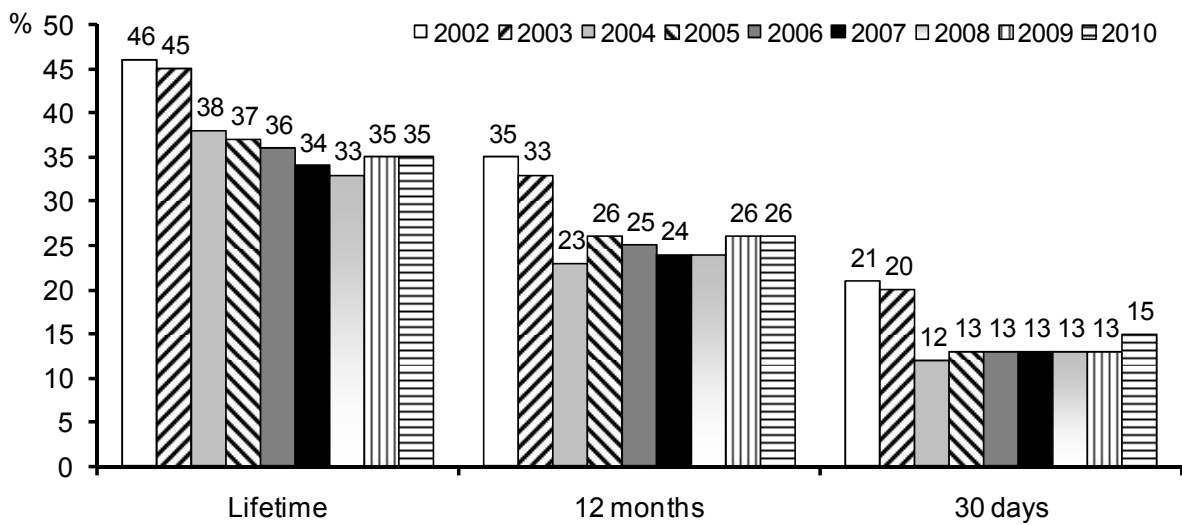
Werse et al. 2011.

Figure 2.5 Lifetime-, 12 month- and 30-day-prevalence of the use of illicit drugs³¹ (except cannabis) among Frankfurt students aged between 15 and 18 years - 2002-2010 (MoSyD)

Since 2007, use experience with psychoactive mushrooms (2010: 4%) and LSD (2010: 3%) has practically remained unchanged and still only a small minority (2010: 1%) of the 15- to 18-year olds has experience with heroin (Werse et al. 2011).

As regards use of cannabis, the findings of the school survey conducted within the framework of the Frankfurt MoSyD did not show any changes in the lifetime and 12-month prevalence (Werse et al. 2011). The 30-day prevalence has slightly increased for the first time since 2005 and currently lies at 15% (Figure 2.6).

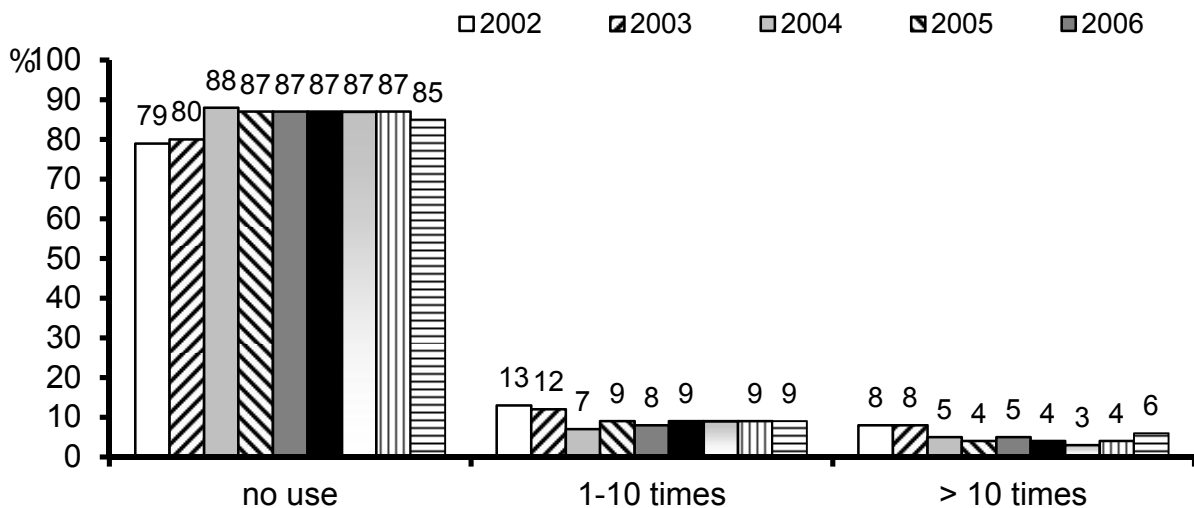
³¹ Summary of the substances: Psychoactive mushrooms, ecstasy, speed, cocaine, LSD, crack, heroin, crystal and GHB.



Werse et al. 2011.

Figure 2.6 Lifetime-, 12 month- und 30-day-prevalence of cannabis use among Frankfurt students aged between 15 and 18 years - 2002-2010 (MoSyD)

Despite the unchanged low prevalences, there is a group of cannabis users with intense use patterns (> 10 times within a month) also among Frankfurt students. After having declined in the years 2007 and 2008 their portion has been increasing since 2009 and currently (2010) is at 6% (Figure 2.7).



Werse et al. 2011.

Figure 2.7 Cannabis use frequency in the last month among Frankfurt students aged between 15 and 18 years - 2002-2010 (MoSyD)

In 2008, data on the use of herbal mixtures which had moved into the centre of attention under the name “spice“ (cf. also the REITOX Reports 2009 and 2010), were collected for the

first time within the framework of the Frankfurt school survey MoSyD. According to the findings of the survey, about 6% of the 15-18-year-olds reported in 2008 that they had used “spice” at least once in their lives, 3% also in the last 30 days (Werse et al. 2009). In the year 2009, the lifetime prevalence was at 6% whereas the 30-day prevalence dropped to 1%. In 2010, the lifetime prevalence increased again (9%), the 30-day prevalence was at 2% and ranged between the comparative values of 2009 and 2008 (Werse et al. 2011).

In 2010, data was collected for the first time within the framework of the school survey conducted on the so-called legal highs (misleadingly sold e.g. as bath salts, fertilizer pills or as pure substance under the general term “research chemicals”. With a lifetime prevalence of 3% and a 30-day prevalence of 1%, these substances seem however to play a minor role (see on this also chapter 2.4). In reply to the following open question (“*What kind of product or substance was it?*”), only eight persons (1%) named a product or gave a name from this product group (e.g. “bath salt” or “Volt 220”). The other interviewees with corresponding use experience (n=21) did either not specify the product or mentioned other substances (e.g. “grass” or the name of a so-called herbal mixture). Therefore the prevalence rates are to be attached with qualifications.

As for the results found by a survey conducted as well in Frankfurt on “spice” and other herbal mixtures and its final report finished in 2010 (Werse & Mueller 2010), cf. chapter 2.4.

Summary and trends

Tables 2.3 and 2.4 summarize the findings of the most recent studies carried out on the prevalence of the use of illicit drugs and cannabis among adolescents and young adults.

Table 2.3 Prevalences of the use of illicit drugs except cannabis among school populations and adolescents in various German studies

Source ¹⁾	Year	Age group	Region	Prevalence (%)		
				30 Days	12 Months	Lifetime
BZgA	2008	12-15	National	0.4	1.0	1.1
BZgA	2008	16-17	National	1.0	3.6	5.3
BZgA	2008	18-19	National	1.1	3.4	5.9
BZgA	2004	12-15	National	0.1 ²⁾	1.1	1.9
BZgA	2004	16-17	National	0.2 ²⁾	2.6	3.8
BZgA	2004	18-19	National	0.2 ²⁾	3.5	8.4
ESPAD	2007	15-16	7 <i>Laender</i>			10.1
ESPAD	2003	15-16	6 <i>Laender</i>	3.8	8.3	12.3
MoSyD	2010	15-18	Frankfurt	3	6	9
MoSyD	2009	15-18	Frankfurt	2	5	9
MoSyD	2008	15-18	Frankfurt	4	6	12
MoSyD	2007	15-18	Frankfurt	2	5	10
Schulbus	2009	14-18	Hamburg	2 ²⁾		6
Schulbus	2007	14-18	Hamburg	2		7
Schulbus	2005	14-18	Hamburg	5		12

1) BZgA: ecstasy, amphetamines, LSD, cocaine, crack, heroin, psychoactive mushrooms, volatile inhalants. The presented data from the year 2004 are the result of a re-analysis carried out by the BZgA. Therefore, figures can diverge from those of previous years.

ESPAD: amphetamines, LSD, ecstasy, cocaine, crack and heroin. ESPAD interviews students from grades 9 and 10, the focus is therefore on the 15-16-year age range, but also a few students aged 14 and 17 years were included.

MoSyD: psychoactive mushrooms, ecstasy, speed, cocaine, LSD, crack, heroin, crystal and GHB/GBL.

Schulbus: ecstasy, mushrooms, LSD, speed/amphetamine, cocaine, crack and heroin.

2) Corresponds to "present use" (BZgA 2004) or respectively "current use" (Schulbus).

Table 2.4 Prevalences of the use of cannabis among school populations, adolescents and young adults in various studies

Source	Year	Age group	Region	Use in period (%)		
				30 Days ¹⁾	12 Months	Lifetime
HBSC ²⁾	2006	15	5 Laender	7.1/4.3		18.1/13.8
HBSC	2002	M=15,7	4 Laender		18.0	24.0
KiGGS ²⁾	2003-2006	11-17	National		9.2/6.2	
BZgA	2010	18-25	National	5.3 (3.2) ³⁾	12.7	35.0
BZgA	2010	12-17	National	1.7 (0.6) ³⁾	5.0	7.4
BZgA	2008	12-19	National	3.7 (2.0) ³⁾	9.1	16.7
BZgA	2007	12-19	National	3.4 (2.3) ³⁾	8.0	15.1
BZgA	2004	12-19	National	3.4 (2.3) ³⁾	12.1	21.3
ESPAD ⁴⁾	2007	15-16	7 Laender	8.1	17.2	25.2
ESPAD	2003	15-16	6 Laender		24.0	31.0
MoSyD	2010	15-18	Frankfurt	15	26	35
MoSyD	2009	15-18	Frankfurt	13	26	35
MoSyD	2008	15-18	Frankfurt	13	24	33
MoSyD	2007	15-18	Frankfurt	13	24	34
Schulbus	2009	14-18	Hamburg	11		27
Schulbus	2007	14-18	Hamburg	10		28
Schulbus	2005	14-18	Hamburg	17		39
Schulbus	2004	14-18	Hamburg	17		40

1) BZgA 2004 (30 days = "present"), Schulbus ("current use" = 30 days).

2) HBSC (2006) and KiGGS: First figure: boys, second figure: girls.

3) In brackets: Regular use (> 10 times in the last year).

4) ESPAD interviews students from grades 9 and 10, the focus is therefore on the 15-16-year age range, but also a few students aged 14 and 17 years were included.

When comparing the data it needs to be taken into account that:

- The age groups surveyed by the individual studies are not identical.
- The ESPAD and HBSC were only conducted in some of the 16 federal states.
- Some of the divergences in the prevalence estimates may also be attributable to different methods used (telephone vs. face-to-face interviews) or different wording in the questionnaires.

Details on population surveys are contained in the online standard table 2, on youth population surveys in standard table 30.

After the considerable increase of the use prevalences of cannabis from about the middle of the 90s onwards, the more recently presented study findings give the impression of a

noticeable easing with regard to the use and spread of cannabis, especially among youth populations and young adults.

Prolonged changes in the use of other substances have not been reported recently. However, there are still significant regional differences to be observed in the use behaviour and characteristics of the markets (e.g. prices and/or purity levels of various substances).

Moreover, individual substances or groups of substances (e.g. GHB/GBL, methamphetamines, biogenic drugs, tilidine) have repeatedly moved into the centre of attention in recent months, often in connection with intense media reporting. It is a problem that regular monitoring systems are not available for all of these substances. Moreover, some of the appearances of these substances are transitional phenomena that cannot be necessarily taken as indicators of prolonged changes in the use patterns.

In connection with the use of illicit substances by teenagers and young adults it is important to note that the use of illicit and licit substances (especially alcohol, tobacco but also medical drugs) is often closely linked so that important developments may possibly be neglected when looking at the use of illicit substances in an isolated manner.

It remains to be seen in how far the appearance of synthetic cannabinoids, which was first reported in connection with the consumption of herb mixtures such as "spice", will lead to a change in the market. With the ban of these substances, which were identified in December 2008, the large majority of the mixtures that were free to sell on the market until then, are not available any more in Germany. This development is however counteracted by the growing relevance of online-trading.

In view of the increasing spread of synthetic drugs, the Federal Government Commissioner on Narcotic Drugs issued a warning in November 2010 against the potential health damages caused by the use of new and unknown substances (aerzteblatt.de 2010b). Among these, the substance mephedrone – that also made its appearance in other European countries – was in the centre of attention. Sensational media coverage on new synthetic drugs and the consequences of use has considerably increased since 2010. It remains unclear however what the actual use prevalence of this substance is in the population.

In the Frankfurt Techno and other party scenes, the attention for so-called legal high products was found to have only slightly increased in 2010 (Werse et al. 2011). According to experts from Frankfurt, the distribution channels and use patterns for illicit synthetic drugs are apparently so well established in the techno scene that there is hardly any need for legal alternatives. Nevertheless, the so-called legal highs belonged to the most discussed substance group in the year 2010. For these kind of products it was reported that the offer was continually expanded while there remained uncertainty over their legal status. As regards the prevalence of the substance, the results of the expert panel survey conducted within the framework of the MoSyD only allow statements on the existence of a demand - with diverging views on its extent. In general, it can be observed that the speed at which new or so far unknown substances make their appearance on the markets, has recently increased.

2.4 Drug use among targeted groups/settings at national and local level

Repatriates and migrants

Substance abuse among migrants is in third place on the list of psychological disorders. Even more frequent are psychosomatic and depressive syndromes. Post traumatic stress disorders and psychoses have a lower incidence than drug dependence (Collatz 2001). Adolescent ethnic German immigrants from Russia constitute a specific social risk group in Germany exhibiting disintegrated biographies at a disproportionately high scale including substance abuse and deviance. Access to migrants who only make use of care offers upon referral continues to constitute a special problem. Mediators speaking the mother tongue of the immigrants could contribute to overcoming barriers both in preventive and curative care and facilitate the access to the health care system (Walter et al. 2007).

Studies analyzing the explanatory models for addiction-related illnesses of repatriates from the former Soviet Union, migrants from Turkey or native Germans confirm that cultural differences assumed by the explanatory models with regard to substance abuse may lead to communication problems with the personnel of addiction support facilities (Heimann et al. 2007; Penka et al. 2008). The lower usage of health care offers by patients with a migration background in comparison with native Germans also results from a different conceptual understanding of “addiction“ and care structures which are to be called on if necessary. It is not possible to convey medical or every day conceptions beyond merely linguistic notions without taking into account the respective cultural context and related connotations of language. Recent studies on the therapy of people with substance abuse disorders and migration background can also be found in chapter 5.

(Techno-) party scenes and other youth cultures

According to the findings of the surveys conducted within the framework of the expert panels and trend scout panels of the MoSyD 2010 (Werse et al. 2011), cannabis and speed are the most commonly used illicit drugs in this setting. A higher interest of the scene members was recorded for the active crystalline ecstasy-ingredient MDMA. The development observed in 2009 of having MDMA replaced in ecstasy pills by other synthetic chemicals, especially m-CPP, continued in 2010, which is obviously the reason for a strong decrease in demand for ecstasy tablets.

The portion of amphetamine-cases in the overall figure of preliminary investigations conducted in connection with illicit drugs in Frankfurt somewhat increased. GHB/GBL does not seem to play a role anymore in Frankfurt’s party scene.

Speed/amphetamines increased their lead as the most frequently used “hard drug“ in the different scenes in the year 2010. Surveys continue to report about a high availability at comparatively low prices.

Ketamine significantly increased in importance in the year 2010. This substance penetrated into all segments of the techno party in 2010 setting after having had only sporadic

appearances in the previous years. This substance is used at so-called chill-out or after-hour events.

Survey conducted in the open drug scene in Frankfurt/Main (MoSyD)

In 2011, Mueller and colleagues (2011) presented already the fifth report on the open drug scene in Frankfurt/Main within the framework on MoSyD. Since 2008 the average age of the interviewees increased by more than two years to 38.2 years. The portion of precariously housed interviewees continued to decline in 2010: currently 6% of the interviewees are homeless, 32% live in emergency shelters. 54% of the respondents have children. One in five did not have a school leaving degree – this is the highest level ever recorded. 60% of the interviewees did not have a completed vocational training – this is also the highest level ever recorded. More than 80% are without job, the average duration of unemployment increased from 4.9 to 5.9 years between 2008 and 2010. More than a quarter of the interviewees receive social benefits and only 15% have gainful employment.

Heroin and Crack are the by far most commonly used drugs in the open drug scene. The increase in importance of heroin observed over the previous years, did not continue in the reporting period. Current use of crack, by way of contrast, slightly increased again after having lost a bit of its importance in the previous years. The significantly increased importance of illicit benzodiazepines for the use patterns of the scene members found by previous surveys, remained almost unchanged in the year 2010: as in the previous year, little less than half used such substances in the last 24 hours. The portion of people applying these substances (also) intravenously did however not continue to increase. The slight increase in the prevalence of powder cocaine observed in the previous years, was reversed again: the 30-day prevalence dropped from 49% to 30%, the 24-hour prevalence from 11% to 7%. Non-prescribed substitution substances have been used by half of the interviewees, but they appear to play a minor role in everyday use: 9% used illegally traded methadone in the last 30 days, 6% buprenorphine. Only two interviewees reported that they had taken such substances in the last 24 hours.

The majority of the interviewees surveyed in the open drug scene continue to display polydrug use patterns. Alongside heroin and crack as well as benzodiazepines and substitution substances, alcohol and cannabis form an integral part of the use activities. As regards use intensity, there are indications of an overall decline in 2010: For example, the portion of frequent users among the current benzodiazepine users, which was found to increase in the previous surveys, was on a slight decline again. Similar was the situation found for the other measured substances. The portion of persons with excessive use patterns (more than eight times per day) also increased in the reporting year.

The surveyed users hang out for 12.8 years on average in the scene. Women a bit longer than men. Injecting drug use continues to mainly take place in the Frankfurt drug consumption facilities whereas crack is mostly used on the street. About 20% of all interviewees had received a move on direction or a banning order in the 30 days before the survey. Almost four of five interviewees have already served a prison sentence. With a

statistical average of 4.6 prison sentences served, these people spent a bit more than four years behind prison walls.

Nearly all of the interviewees currently have got health insurance. After a certain improvement in the previous years, the current health condition is practically unchanged. With two thirds of the interviewees being affected, the hepatitis C infection rate has been at an unchanged high level since 2002, 6% reported in 2010 that they were HIV positive. The HIV infection rates within this group has decreased since 2002 by almost half.

Currently, one in seven users uses an injection needle at least occasionally several times, little less than 30% share utensils for injecting drug use with others and one in four occasionally shares drugs with others in one injection needle. A bit more than half of the interviewees stated that they did not engage in such risky use behaviours.

More than half of the surveyed people (57%) currently are in substitution therapy. With this, the trend that has been observed to increase since 2003, strongly continues. Practically all interviewees made use of at least one offer made by the Frankfurt drug help system in the last three months (contact shop, food, drug consumption room, counselling and needle exchange). More than 90% used offers of the drug help system at least once a week.

Herbal mixtures: consumption and motives of consumption

In summer 2010, the final report on the project “Spice, Smoke, Sence and Co. – herbal mixtures containing cannabinoids: use and motives of use set against a changing legal situation“ (Werse & Mueller 2010). The study is preoccupied with the consumption of spice and other so-called herbal mixtures that were intensely discussed in the media especially in the year 2008.

The survey investigates especially the characteristics of the users and their main motives of consumption as well as the general prevalence of the substances³². According to the findings of the study, a total of 7% of the 15- to 18-year old students had experience with the consumption of herbal mixtures in 2009. While this figure hardly changed in respect of 2008, the current use (30-day prevalence) declined from 3% to 1% and repeated consumption is an exception. Students with spice use experience are for the most part cannabis users with a generally high affinity with licit and illicit drugs.

Adults with repeated use of these herbal mixtures have for the most part extensive experience with cannabis and often have at least tried various other substances. In general these users are socially integrated people, but parts of them also come from the group of intense drug users with problematic use patterns. Reasons for consumption are – alongside the effects – mainly legal aspects. Among these, concrete experience with drug tests or fears of undergoing such a test play a central role (in particular random police checks or impending loss of the driving license, drug screenings in connection with therapy and substitution). The

³² To this purpose, a representative school survey in Frankfurt/Main was evaluated and guideline-based interviews with N=25 experienced users of these substances were conducted.

relatively easy availability of these products is also mentioned as an important motive of consumption. Without such specific motives however, herbal mixtures don't appear to be an alternative for the majority of the experienced cannabis users. Many persons who repeatedly use herbal mixtures, are only poorly informed about the different herbal mixtures. According to the authors, occasional users in particular often do not even know the names of the respectively consumed substances. Head shops were the most frequently mentioned supply source mentioned alongside Internet dealers.

2.5 Further research results and findings with a focus on diagnostics

Review on MRI-studies on the effects of cannabis

Hermann (2011) recently presented a review with the findings of a systematic literature research he performed on MRI-studies investigating the effects of cannabis on the brain. The findings are based on 37 original works, out of which 97% were published between 2004 and 2010. In the reviewed studies, he found contradictory results in almost all areas of work as soon as more than one study was published on the area. As possible reasons for the divergences the authors cite low case figures, genetic differences, diverging concentrations of THC³³ and CBD³³ in the consumed cannabis products, by-use of alcohol and other drugs, portion of tobacco users in the control group or diverging portions of test persons with predisposing factors like for example high impulsivity. Therefore, the validity of these studies is restricted. However, cannabinoids apparently do change the neuronal plasticity, i.e. the processing of stimuli partly takes place in other neuronal assemblies. This is an indication of the brain adapting to a frequent or constant effect of externally supplied cannabinoids. According to the current state of knowledge, chronic cannabis use does not invoke global structural changes of the brain. Sub-regions of the brain involved in memory forming (hippocampus) and emotions (amygdala) do however show slight decreases in volume. Cannabis use is also associated with small changes of the frontal connectivity and neurometabolic changes in the basal ganglia and DLPFC (dorsolateral prefrontal cortex). Functional MRI-studies indicate adverse effects caused by THC like inhibition of learning. CBD, by way of contrast, has positive characteristics and exerts for example an anxiolytic effect by inhibiting the amygdala. Cannabis use also leads to a changed activation of cerebral regions in the processing of various cognitive tasks, which is an indication of a changed neuronal plasticity.

Screening questionnaire for addiction diagnoses

Sack and colleagues (2011) conducted a study to measure the sensitivity and specificity of the RAFFT³⁴ screening questionnaire in terms of addiction diagnoses and in particular

³³ Tetrahydrocannabinol (THC) and cannabidiol (CBD) are important active ingredients contained in cannabis.

³⁴ RAFFT is an acronym that stands for Relax, Alone, Friends, Family, Trouble

cannabis-related diagnoses³⁵. For the RAFFT-Drugs questionnaire used for 14- to 18-year olds, the authors report a sensitivity of 100% and a specificity of 54% for drug-related diagnoses and a sensitivity of 100% and a specificity of 51% specifically for cannabis-related diagnoses. According to the authors, the RAFFT-Drugs is the instrument of choice for the screening of risky cannabis or respectively illicit drug use in the age group of the 14- to 18-year olds. The authors recommend to validate the revised RAFFT tool by means of an unselected sample.

Validity of the DSM-IV-criteria for the abuse of and dependence on cannabis among adolescents

In a recently published survey, Piontek and colleagues (2011) investigated the validity of the diagnostic criteria of the DSM-IV for the abuse of and dependence on cannabis in a sample drawn among 17- to 19-year olds. Methods used and results found by the study are presented in more detail in chapter 4.4.1.

³⁵ The sample measured within the framework the study was made up of N=109 patients of a psychiatric drug and alcohol ambulatory in the age of 13-33 years.

3 Prevention

3.1 Introduction

3.1.1 Organisational framework

The primary goal of prevention is to promote the health of the individual, maintain abstinence, prevent and reduce abuse and addiction. The prevention of addiction is - alongside addiction therapy and repressive measures – an integral part of the comprehensive addiction and drug policy of the Federal Republic of Germany. Apart from severe psychological and physical harm done to the individual, substance abuse and addiction also cause enormous damage to the national economy. Prevention of addiction therefore assumes a central position in Germany. Prevention is one of the four main areas of German addiction and drug policy is based on (cf. chapter 1.1.2).

The prevention of addiction has been strengthened by the development of a comprehensive prevention strategy in the *Action Plan for fighting Drugs and Addiction* that matches set targets with concrete measures in the area of addiction prevention (Die Drogenbeauftragte der Bundesregierung 2003).

Responsible for the implementation of the *Action Plan for fighting Drugs and Addiction* and the pertaining prevention activities are the respective ministerial agencies, in particular the Federal Centre for Health Education (BZgA), the *Laender*, communal administration and the self-governmental bodies of the social insurance funds. Obligated to the principle of subsidiarity, this multitude of players makes sure that the preventive measures are broadly spread across all federal levels of the Federal Republic of Germany.

3.1.2 Current developments and trends

Current substance-related developments and trends have been described in detail in chapter 2. This chapter will therefore only refer to a few particularly relevant aspects.

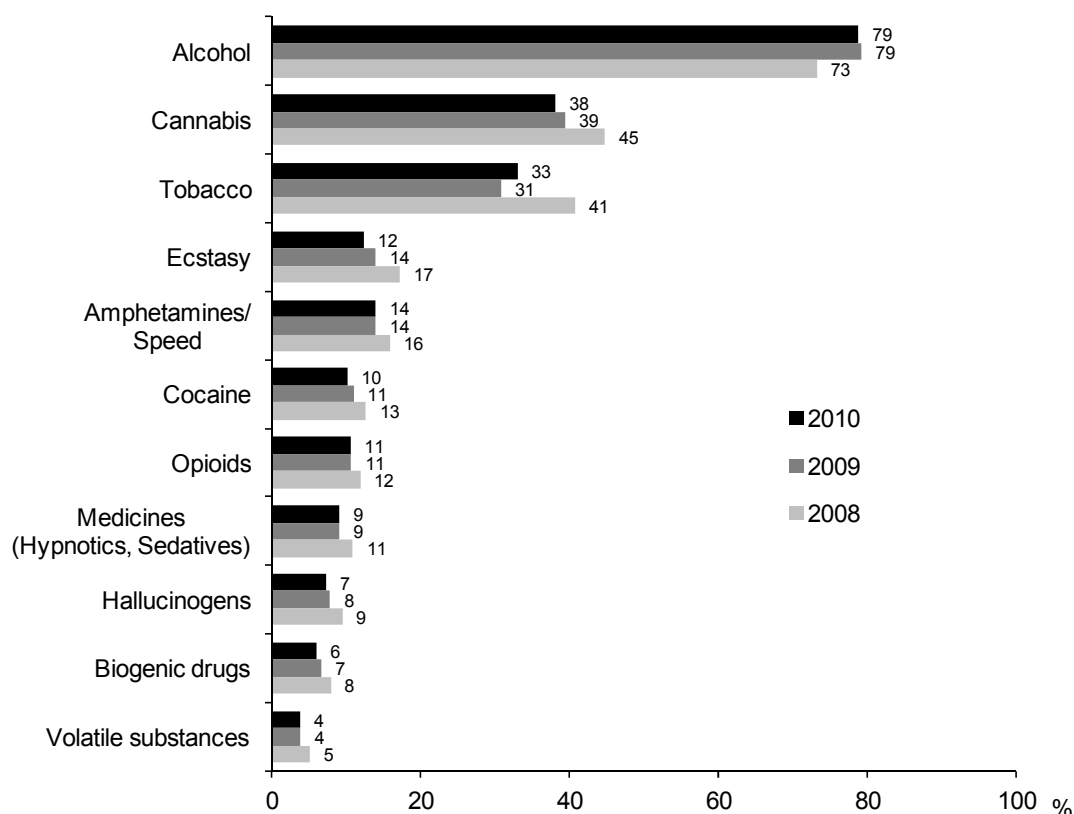
Cannabis use among adolescents and young adults in Germany continues to decline, but is still widely spread. In a study conducted by the Federal Centre for Health Education in the year 2010, 7% of the 12- to 17-year old adolescents and 35% of the 18- to 25-year old young adults reported cannabis use at least once in their lives (lifetime prevalence). With this, the life-time prevalence of cannabis together with the 12-month prevalence, the 30-day prevalence and the prevalence of regular cannabis use (BZgA 2011c)³⁶ dropped at a statistically significant scale compared to the study conducted by the Federal Centre for Health Education in 2004. Irrespective of the declining trends in the cannabis use among adolescents and young adults it remains imperative to address the illicit substance cannabis

³⁶ 15% of the adolescents and 43% of the young adults mentioned in 2004 that they had used cannabis once in life (lifetime prevalence).

by suitable prevention measures in order to reduce the still too high prevalences of cannabis use, especially of regular use, in Germany.

Last year's report already referred to the (moderator) role played by alcohol in connection with the use of illicit psychotropic substances (BZgA 2010). Simultaneous use of alcohol and another illicit drug is a widely spread risk behaviour especially among adolescents (EMCDDA 2009a; Laging 2005). Moreover, children and adolescents are particularly endangered by alcohol use. The sooner they start drinking, the higher is the risk they run to be affected by health damages and/or develop dependence later on in life (BZgA 2011b).

With a view to promote low-risk use of alcohol in all age groups of the population and to reduce cannabis use, prevention specialists undertake a host of substance-related prevention measures. The data recorded by the documentation system Dot.sys therefore shows a concentration of measures specifically related to the substances alcohol, cannabis and also tobacco (Figure 3.1).



Number of the prevention activities recorded in Dot.sys: N(2010)=16,373 , N(2009)=16,059, N(2008)=14,381

Dot.sys 2010, own presentation.

Figure 3.1 Development of the substances addressed between 2008 and 2010

79% of the prevention measures documented in Dot.sys address the substance alcohol; this figure corresponds exactly to the percentage recorded for the year. The percentage breakdown of the substance-related measures largely corresponds to the breakdown of the previous year (Figure 3.1).

3.1.3 Effectiveness and efficiency in addiction prevention

Prevention activities are carried out by various players in Germany. This makes it possible to take a broad approach and to transfer promising and successful measures into actual practice.

Central starting points for increasing effectiveness and efficiency in addiction prevention are evaluation, networking and transfer of good-practice examples. In order to guarantee a structured and systemic sustainable exchange and transfer, structures and co-operations at various levels with almost all relevant players have been successfully developed over the last years. Among these are for example also the development of quality standards and the further development of existing quality assurance measures in addiction prevention. In this connection, the BZgA-Laender-cooperation group "addiction prevention" (a cooperation between the *Laender* representatives and the BZgA) is equally trend-setting as the events and experts' meetings organized by the German Monitoring Centre for Drugs and Drug Addiction (Deutschen Beobachtungsstelle fuer Drogen und Drogensucht, DBDD), the BZgA, the German Centre for Addiction Issues (Deutsche Hauptstelle fuer Suchtfragen, DHS) as well as by many other players, and last but not least the monitoring system *Dot.sys* (documentation system used for addiction prevention), a joint project of the BZgA and the *Laender*.

2. Expert conference "Quality in addiction prevention"³⁷

The two-day expert conference "Quality in addiction prevention" jointly organized by the Federal Centre for Health Education (Bundeszentrale fuer gesundheitliche Aufklaerung, BZgA) and the Saxon State Ministry in Dresden in May 2011 followed up on the topics discussed at the first event held in 2009. At this conference, individual core topics of quality development were dealt with more intensely within the framework of workshops like for example networking, effects of prevention measures, communication and methods used in addiction prevention.

By focussing on workshops, the conference participants were able to gain application knowledge and to kick off a transfer of conference results into their own fields of activities. The second expert conference is a further step towards practice-oriented quality assurance and quality development in the prevention of addiction.

Dot.sys

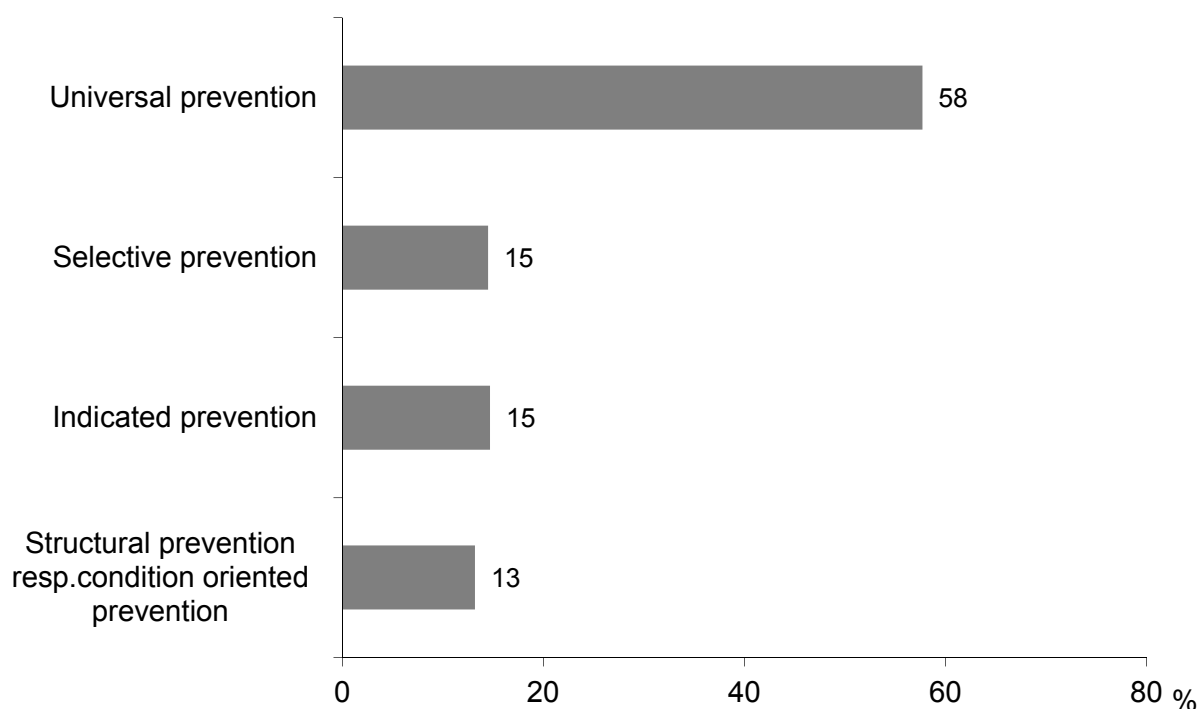
The project *Dot.sys* that is jointly carried out by the BZgA and the *Laender*, provides comprehensive information on the prevention activities implemented in Germany within one calendar year. With this, *Dot.sys* makes an important contribution to reporting on prevention and improving also the quality and transparency in prevention practice. The participating counselling centres, authorities, associations, specialized ambulatories and coordination

³⁷ www.gesunde.sachsen.de/13611.html#article13624 idarticle13624

agencies at Land level permanently document their activities in the electronic data collection system. Documentation takes place on a voluntary basis, therefore no claim can be laid on completeness of the documented prevention measures.

In the reporting year 2010, 340 facilities countrywide documented more than 34,000 projects, programmes and prevention measures undertaken in the area of addiction in Dot.sys (2009: 338 facilities, 2008: 320 facilities).

The documentation system Dot.sys is continually developing further. After 2009, the categories were more specified and extended as regards contents with the effect that it was possible for the first time in the reporting year 2010 to collect data on the type of prevention³⁸. 58% of the measures can be assigned to universal prevention, respectively 15% of the measures to selected or indicated prevention and 13% to structural or condition prevention (Figure 3.2).



Dot.sys 2010, N=25,555, own presentation

Figure 3.2 Prevention type

Further selected results show that:

- 48% of the undertaken measures were addressed to final addresses. Almost as many measures (45%) were addressed to the target group of the multipliers and about 7% of

³⁸ To answer the variable "Kind of prevention: Which kind of prevention is the documented method?" the categories "universal prevention", "selective prevention", "indicated prevention" or "structural prevention respectively proportional prevention" could be selected.

the entries can be assigned to the area information and communication. Since 2008, there has been a shift observed from measures addressed to multipliers, which have slightly declined, to measures addressed to final addressees, which have increased.

- In 2010, 16,373 substance-specific measures were undertaken (48% of the measures documented). As in the previous years, these measures focused on the substances alcohol (79%), cannabis (38%) and tobacco (33%). The areas of concentration in prevention at the federal and regional level continue to be alcohol, cannabis and tobacco prevention.
- 42% of the measures were non-substance-specific and aimed mainly at promoting life skills and teaching alternative forms of experience. Aspects of personality formation and specific life situations of the target groups are central areas of these measures. 9% of the measures address non-substance related addictions.
- The setting “school“ still is the primary field of action in addiction prevention with 42% of the documented measures. In the setting “workplace“, by way of contrast, only 8% of the measures were implemented. 50% of the measures undertaken at work are substance-specific, 41% fall in the category “non-substance-specific“. 9% address non-substance-related forms of addiction. 54% of the measures aim at multipliers and 44% at final addressees.
- 31% of the measures were or are evaluated; the evaluations are generally done internally by the respective institution.

3.2 Universal prevention

Universal prevention forms the mainstay of the prevention activities undertaken in Germany. Universal prevention comprises programmes, projects and activities that address the general population or parts of it that run a low or average risk of developing addiction or dependence. Prevention or help measures are ideally provided in the everyday world of the targeted groups, this also applies to universal prevention measures. Typical activity areas for universal prevention measures are schools, workplace settings, communal facilities or sports clubs, to mention just a few (Spring & Philips 2007).

Universal prevention comprises behavioural and condition prevention measures (BZgA 2007) and are split up into substance-specific, non-substance-related and cross-substance projects. Cross-substance prevention activities are mainly referred to as activities serving to teach life skills or to promote forming critical opinions.

8% of the prevention measures documented by Dot.sys in 2010, take place countrywide in the setting “workplace“. The measures carried out in this sphere of life reach beyond this setting into other social areas and thus represent an effective method of conveying prevention messages to the working population.

Prevention of addiction forms part of company health management. Prevention measures undertaken by companies in the area of addiction prevention comprise among others

information and early intervention in case of conspicuous behaviour. Especially early intervention assumes particular importance in addiction prevention activities undertaken at work (Wienemann 2010).

The federal demonstration project “Prev@WORK“ is a holistic programme offered in the area of universal prevention that embeds the prevention of addiction into vocational training. Developed by the agency for addiction prevention of the Land Berlin and successfully tested since 2008, this innovative approach of health promotion in the setting “workplace“ has been funded by the Federal Ministry for Health since 1st March 2011 as a demonstration project and implemented in seven *Laender*. The project is based on the most recent scientific findings. The theoretical basis is formed by the concept of early intervention, theme-centred interaction (TCI) and the trans-theoretical model (TTM) (Bensieck & Schmidt 2011).

The early intervention activities undertaken within the framework of the project Prev@WORK are addressed to all young people who are in the phase of vocational orientation, preparation or training and involve all multipliers in these institutions“ (Bensieck & Schmidt 2011). Furthermore, gender-specific intervention modules and special modules make it possible to address also people with special needs (selective prevention).

Alongside non-substance related addictions, the Prev@WORK seminars held for apprentices deal especially with the substances alcohol, cannabis and tobacco. A central goal of the evaluated project is among others to inform about the effects and risks of drug use. This creates the preconditions for developing and strengthening the risk skills of the apprentices in order to promote responsible substance use behaviour. Young people participating in Prev@WORK are given the opportunity to reflect on their situation, recognize action alternatives and to become aware of provided help offers (indicated prevention).

Concepts and methods used by the content-related modules of the Prev@WORK seminars for apprentices are presented and practiced within the framework of the seminar held for multipliers (“Trainer“ - colleague, teacher etc.). “Decision makers and trainers in the companies are advised on the framework conditions in respect of prevention and health promotion and trained in the early recognition of substance abuse, possibilities of intervention and referral to the help system“ (Bensieck & Schmidt 2011).

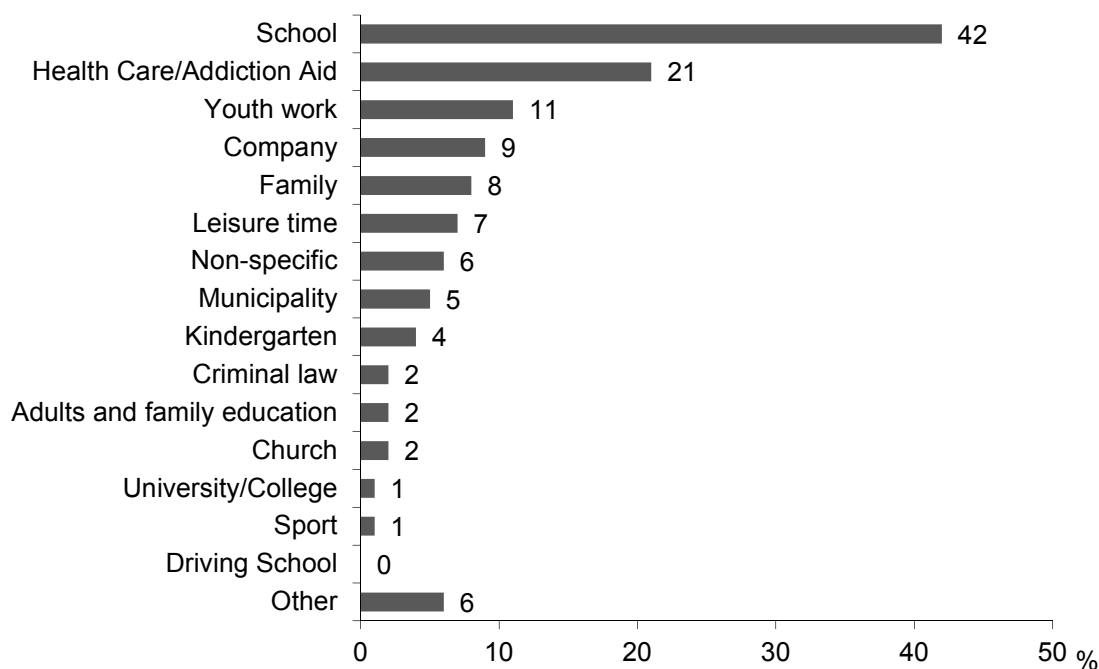
Prev@WORK reaches apprentices – mostly adolescents and young adults – in their every day work life before they develop problematic use behaviour³⁹.

3.2.1 School

Schools are an ideal setting for carrying out universal prevention measures. They provide the broadest access to the main target group of universal prevention and make it possible for preventive measures to be integrated into the school curriculum. Schools are equally suited for substance-related, non-substance-related and cross-substance-related activities.

³⁹ Further information is available at <http://www.berlin-suchtpraevention.de/Fruehintervention-c1-l1-c1-l1-ar76.html>

The programmes run in the school setting have been successfully implemented all over Germany for many years. *Be smart – Don't Start, Smoke free School and Class 2000* are mentioned here as examples. The aforementioned programmes are generally made up of different modules ranging from promoting social skills and conveying information to motivating to lead a healthy lifestyle.



Dot.Sys 2010, = 32,486, own presentation

Figure 3.3 Settings of prevention measures in 2010

With 42% of the prevention activities undertaken and documented in Dot.sys, the primary field of action in the area of addiction prevention was the school setting (Figure 3.3) in 2010 as in the previous years. The main target group are students (children and adolescents) who were addressed by 64% of the measures carried out in the setting school. Teachers in their function as multipliers were addressed by 34% of the measures undertaken in schools⁴⁰.

One in two measures carried out in the setting school was substance-related, the main focus being on alcohol, tobacco and cannabis. 42% of the documented measures fell into the category of the non-substance-specific measures. Merely 8% of the prevention measures undertaken in the school setting addressed non-substance related addictions in 2010 (especially eating disorders, Internet / other media). Formation of values, promotion of skills and transfer of information as well as formation of critical opinions are at the foreground of prevention work performed at school.

⁴⁰ 1% of the measures undertaken in the setting school are assigned to information and communication; rounded to nearest integer.

74% of the measures undertaken in the setting school can be assigned to the category of universal prevention. Schools represent a typical field of work for the implementation of universal prevention measures since they are regarded as an “excellent setting to reach children and adolescents” (Buehler & Kroeger 2006).

“drop+hop” is presented as another example of prevention activities undertaken in schools in grade 6⁴¹. Introduced in 1997 in Delmenhorst, Lower Saxony, “drop+hop” has become an integral part of municipal basic care in the area of prevention in the town of Delmenhorst in 2010 ensuring the continuance of sustainable prevention work performed at schools⁴². The universal prevention course is oriented by the life skills approach and addresses an age group between childhood and youth in interdisciplinary teaching units. The transfer of knowledge is performed by male and female “teamers” - a group formed by teachers, parents and external specialists. “drop+hop” conceives prevention of addiction as community work that needs to be embedded in numerous areas of life. This understanding is reflected by the composition of the team that turns the concept into practice. In this way, another important function is fulfilled alongside the work performed with the main target group children and adolescents: basic knowledge is created in the surroundings of the children.

“drop+hop” is made up of four modules. The goal of the first module “Parents’ evening” is to sensitize parents for the topic drugs and addiction and provide them with information. Module 2 is a kick-off seminar held outside of the school setting in which the students of one class acquire factual information on the topic. The underlying hypothesis is that more knowledge on drugs and addiction leads to a (negatively corrected) change of attitude towards substance use. Module 3 (drugs suitcase) and module 4 (teaching units) are carried out in the school. They serve to provide more in-depth information on licit and illicit drugs and link factual information with the life-world of the students. The goal is to strengthen the personality of the children and adolescents and to sensitize them for the individual danger of an addictive disease. The effectiveness of “drop+hop” was proven in 2007: The students who participated in the course have considerably more knowledge about the risks of substance use.

The cannabis prevention campaign “Cannabis denn Suende sein?” run by the town Wesel, North Rhine-Westphalia (NRW), is specifically addressed to students of lower and middle secondary schools. The campaign combines proven media, materials and measures of acknowledged campaigns like “Stark statt breit” (Strong instead of stoned) – cannabis prevention programme NRW, the countrywide cannabis counselling programme “Realize it” or “MOVE” – Land Coordination Centre Prevention of Addiction NRW and uses a gender-specific approach to put them into practice. Universal prevention is provided within the

⁴¹ Grade 6 is generally attended by children aged between 11 and 14 years.

⁴² Further information is available at <http://kommunale-suchtpraevention.de/wettbewerb-2008-2009/beitraege/1340/1131>.

framework of parents' evenings (information of the parents and the public) or for example a cannabis quiz in the pedestrian zone⁴³.

“Maedchen Sucht Junge“ is an interactive learning project in the area of gender-specific prevention of addiction for children and adolescents from 13 years of age onwards. The boards used in Baden-Wuerttemberg on the topics of smoking, alcohol, media (PC & Co) and body were revised in 2009/2010 and are available countrywide since 2010 for interactive teaching in grades 7 to 9. A manual for teachers provides additional ideas and material for an interactive implementation in class. The didactic instrument “Maedchen Sucht Junge“ promotes critical self-reflection of the adolescents and leads to an exchange between the teenagers on the own (cross- substance) use behaviour⁴⁴. Data on the number of reached final addressees is expected for end of 2011.

Approximately one in ten interventions follow the approach of peer education. Peer education approaches are based on the assumption that fellows of the same age (peers) are better suited than for example teachers or counselling experts to create favourable preconditions for initiating learning processes. This is, among others, attributable to greater social closeness between peers, the use of common language codes and thus to greater authenticity. (Backes & Schoenbach 2002). Teenagers who are willing to assume the roles of peers, are trained to provide support as experts in problem situations and to promote problem solving skills among their fellow students. Peers thus serve as prevention helpers at ground level, i.e. also at places where licit and/or illicit drugs are consumed.

The HaLT-project “Clique leaders – Training of teenagers to become protectors in respect of excessive alcohol use“ of the district Osterode in the Harz for example is based on the peer approach: young opinion leaders are trained as multipliers in a weekend seminar and are used as leaders in their peer group on the topic alcohol and alcohol use in the setting school or sports club (DifU 2011).

3.2.2 Family

As the most important and constant socialisation instance for children and adolescents, the family assumes an important role in the field of work of prevention. Until the start of puberty, the family exerts the largest influence, positive or negative, on the norms and values adopted by children and thus also on forming different modes of behaviour. Parents and siblings, but also close relatives and acquaintances often serve as role models whose lifestyle is - consciously or unconsciously - imitated and adapted to. Given this, the family also has a great influence on the health education and thus on the health condition of the child.

8 % of the measures documented in Dot.sys in 2010 were undertaken in the setting family. The measures are mainly geared to final addressees (68%). These are parents and family members (59%), adolescents with use experience (23%) and/or children and adolescents

⁴³ <http://kommunale-suchtpraevention.de/node/164/1423/1410>

⁴⁴ www.suchtprophylaxe-bw.de

(21%). 40% of the measures are non-substance specific. The portion of substance-specific activities slightly increased in respect of 2009 to 45%. As in the previous year, the substance-specific measures undertaken in the setting family focused on the substances alcohol (62%) and cannabis (55%). With 15%, the portion of non-substance-related measures documented in Dot.sys for the setting family is, as in the previous years, relatively high in comparison to the other fields of action. In this context, prevention in the family setting is mainly focused on the Internet/other media and eating disorders.

Many parents can only be reached with great difficulty or cannot be reached at all via the classic instruments of parental work, like for example parents' evenings or invitations for a talk during office hours. However, in an effort to reach this target group by prevention measures, the project "Family ties" (Familienbande)⁴⁵ funded by the EU was developed in the district Traunstein, Bavaria. "Family ties" is made up of several modules or individual projects respectively (project period: June 2008 – May 2011). Some of the individual projects share the same goals like:

- "Strengthening the solidarity within the family
- Increase the parenting skills of parents and other adults involved in the upbringing and help them to develop responsibility and decision making skills
- Creating risk awareness with regard to substance abuse
- Strengthening the prevention network in the district Traunstein" (DifU 2011: 85).
- Running for three years, the cross-border project "Family Ties" carried out by the Addiction Prevention Centres of the Caritas Ambulatories Traunstein and Berchtesgadener Land (Germany) and "Akzente Salzburg" (Austria) sets the focus on strengthening the family and existing social networks and addresses parents and guardians with children and teenagers aged between 10 and 16 years.
- The module "Parents' Table" (Elterntisch) is an outreach offer made within the framework of parent education" and allows addiction prevention to gain access to the setting family. "Parents' table" makes it possible for 6 – 10 parents or guardians respectively to get together and discuss central prevention topics like alcohol consumption, smoking, cannabis use and Internet gaming. The talks are guided by a moderator who also invokes the role model function of parents. The moderator accompanies the talks after having received a two-day training course by prevention specialists.
- Since 2008, 70 "Parents' tables" have been organized. The outreach approach makes it possible to reach a multitude of families with migration background (so far 46) as well as socially disadvantaged families. The module finds great acceptance and receives good ratings in terms of satisfaction with the offer. An external evaluation is planned for 2011.

⁴⁵ www.familienbande.cc

- “Family ties“ is an award-winning contribution to the 5th competition “Best practice strategies of communal addiction prevention “ held in the year 2011 (cf. chapter 3.2.3).

3.2.3 Community

To be holistic and sustainable, addiction prevention needs to involve not only family and school but also the social environment of children and teenagers. It is imperative for communities, cities, regions and districts to participate in the development and implementation of prevention measures. In this context, communities are not only to serve as a setting for the implementation of these measures but they are to assume a more active role. Generally speaking, the role of a community as an active player in addiction prevention strongly depends on its size or more specifically on the number of inhabitants. Small municipalities often do not have the staff and financial resources to implement preventive measures at the local government level.

Community-based addiction prevention activities are often carried out in inter-community and supra-local cooperation projects with various local partners being involved like for example addiction prevention facilities, churches, self-help organizations, local clubs and institutions, parties and associations, etc. Apart from kindergartens and schools, especially organized and non-organized recreational settings as well as the public health sector serve as fields of works for community-based prevention.

The national competition “Best practice strategies of communal addiction prevention“ was organized for the fifth time in 2010/2011 by the Federal Centre for Health Education and was placed under the topic “Addiction prevention for children and adolescents in specific life circumstances”⁴⁶. The goal of the national competition is to make best practice prevention approaches and projects undertaken at local government level known and invite other local governments to follow the example. 63 towns, municipalities and districts in Germany participated in the competition.

Community drug addiction prevention in Germany is marked by a multitude of regionally developed projects that take account of regional peculiarities. With its changing areas of concentration, the community-based drug addiction prevention competition allows to get an idea of prevention work performed at community level and to make best practice strategies of communal drug addiction prevention known to other local governments in the whole of Germany and invite them to follow the best practice strategies.

3.2.4 Recreational and sports settings

Apart from the aforementioned fields of work (school, family and community), recreational and sports settings are important areas of activity for universal prevention measures. More than 70% of all children and teenagers are, at least for a short time, members of a sports club. Sports clubs exist throughout the country and thus guarantee high accessibility to

⁴⁶ Information and documentation are available at www.kommunale-suchtpraevention.de

children of different social strata including the socially disadvantaged ones with a low risk of stigmatization of this target group.

Sports clubs have been playing an important role for a long time as a setting for the intervention measures undertaken by the Federal Centre for Health Education in the area of addiction prevention (cf. REITOX Reports 2010, 2009). The Federal Centre for Health Education has been participating with the “Smoke-free Beach Club“ in the Festival of Sports representing an event module of the non-smoking campaign⁴⁷. The Beach Club toured six cities in 2010 to participate in a total of 17 events (BZgA 2011a).

3.3 Selective prevention

Selective prevention is addressed to groups of people who have a significantly higher risk of developing addictions than the average population. This risk can be immanent or a group of people can carry a higher risk of developing addiction through their whole lives (Spring & Philips 2007). Both biological, psychosocial, social and environmental influences are to be taken into account as risk factors. Selective prevention measures are for example developed for:

- early school leavers
- socially disadvantaged people
- homeless youth
- people with a migration background
- children and teenagers from families with addiction problems
- teenagers with use experience
- clubbers

The target groups of selective prevention measures are often addressed in recreational settings. Interventions for socially disadvantaged youth or children and teenagers from families with addiction problems are often carried out in school and pre-school settings. Generally speaking, this approach has got the advantage of using existing resources at an early stage. However, the risk of stigmatizing target groups by selective prevention activities cannot be denied. Therefore, advantages and disadvantages need to be carefully weighed.

Parents play a key role in accessing young drug users (parents as key persons). However, many parents and families with drug using adolescents have inhibitions to make use of

⁴⁷ <http://www.rauch-frei.info/>. The smoke-free Beach Club was embedded in 2010 into the Festival of Sports and the national sports day in cooperation with the German Olympic Sports Confederation (Deutscher Olympischer Sportbund, DOSB) and the German Youth Power Sports Association (Deutsche Jugendkraft, DJK). The idea of the initiative is to combine the provision of information on non-smoking with join-in activities in a relaxed beach atmosphere. The events annually staged by the DOSB together with various cities in Germany, reach approximately 400,000 visitors, mostly from the target of the adolescents and young adults.

professional help offers. Started in 2009, the two-year federal demonstration project “Parents.active – Pro-active parental work in ambulatory addiction help (Eltern.aktiv - Pro-aktive Elternarbeit in der Suchthilfe⁴⁸)” is on the one hand to remove these barriers and to facilitate the access to the parents of drug using adolescents in particular by offering a systematic initial meeting. On the other, optimized pro-active parental work helps to better address adolescent drug users by early intervention measures. To this purpose, offers in the sense of pro-active parental work are developed, for example a manual for addiction help facilities with recommendations on how to reach parents. The flyer “Drug use in adolescence – tips for parents“ answers first questions parents may have on addiction, drugs and possibilities of action. “Parents.active“ is complemented by the product “Parents suitcase“, that comprises the contents “Information evening for parents“, “Home party“ and the group concept “Help, my child goes through puberty“. An optimized access to parents and a qualitative improvement of the work with parents increase the degree to which adolescent users can be reached (Rummel und Kuehne 2010).

The federal demonstration project is complemented by the project “Pro-active parental work with parents of drug using children and adolescents performed by the youth protection/youth help professionals“ of the area association Westfalen-Lippe (Landschaftsverband Westfalen-Lippe, LWL). The material and instruments developed within the framework of the federal project are used and tested by the complementary project. „Eltern.aktiv“ is a project jointly organised by the DHS⁴⁹ and LWL-KS⁵⁰ and funded by the Federal Ministry for Health (project period: November 2009 – October 2011). An accompanying evaluation is carried out by the university Hildesheim.

Pro-active parental work still is an exception in the area of selective prevention. Here, Germany still has development needs as shown by the project „AVerCa“ jointly carried out by the German Centre for Addiction Issues and the Area Association Westfalen-Lippe. There are still too few offers made for parents in the area of selective prevention. “Parents.active “ is a first step on the path of expansion of pro-active parental work so that parents and relatives of drug using children and adolescents can find help themselves at an early stage and drug using adolescents can be reached earlier and more efficiently than in the past. By optimizing the access to the parents, drug using children and adolescents can also be better reached⁵¹.

⁴⁸ http://list.lwl.org/LWL/Jugend/LWL/Jugend/lwl_ks/Projekte_KS1/RFJH/Projekte_KS1/Eltern_aktiv_Start/

⁴⁹ Deutsche Hauptstelle fuer Suchtfragen (German Centre for Addiction Issues).

⁵⁰ Landschaftsverband Westfalen-Lippe Koordinationsstelle Sucht (Area Association Westfalen-Lippe Coordination Centre Addiction).

⁵¹ Further information can be found at www.lwl-ks.de und www.dhs.de.

3.3.1 At-risk groups

Socially disadvantaged groups

People living in socially difficult circumstances are very often placed at particular health risks. Statistically, the risk of falling seriously ill or dying earlier is double as high for people from a lower social class than for those from higher social strata. Social disadvantages thus create inequality in health conditions (BMG 2008). People living in socially difficult circumstances are very often placed at particular health risks. Statistically, the risk of falling seriously ill or dying earlier is double as high for people from a lower social class than for those from higher social strata. Social disadvantages thus create inequality in health conditions (BMG 2008). Poverty, unemployment and a low social status are further risk factors favouring the onset or aggravation of addiction-related problems. It is therefore particularly important to promote and strengthen this group of people in the development as early as possible. However, children and teenagers with promotional needs often do not have the personal, social and/or cognitive skills to sufficiently translate prevention contents so that the “usual” prevention measures are hardly useable for the work with these children and teenagers.

Addiction prevention for people with a migration background

Addiction prevention for people with a migration background comprises a multitude of measures ranging from establishing contact with a public addiction facility over activating and supporting self-help initiatives to strengthening the personality and reducing the risk of developing addictions. These activities are generally embedded in comprehensive measures to promote the social and societal integration of immigrants, which are for example funded by the Federal Ministry for Families, Senior Citizens, Women and Youth (Bundesministerium fuer Familie, Senioren, Frauen und Jugend, BMFSFJ) or by the Federal Agency for Migration and Refugees (Bundesamt fuer Migration und Fluechtlinge, BAMF).

In comparison with the German population, the education and income level of the population with migration background is lower. However, the differences in education levels among the group of people with migration background are so big that it can be assumed for this reason alone that this population group is heterogeneous. The people subsumed under the term “population with migration background“ differ in migration-specific and socio-economic factors (BZgA 2011e) – this variety needs to be reflected in addiction prevention. “Only by taking a more differentiated view at the interaction of various factors like country of origin, social status, immigration generation and gender, it is possible to counteract specific risks and promote health potentials in a targeted way“ (BZgA 2011e: 257).

Moreover, migrants are faced with several barriers when they are trying to access the help system. Communication problems, information deficits or the fear of residence permit sanctions prevent among others migrants to seek help from addiction help facilities (Suezen 2010, Salman 2010). For these reasons, the continually growing population portion with migration background is regarded as target group that is difficult to access (Krauth et al. 2011). In order to reduce information deficits and/or access barriers it is imperative to choose

a culture-specific approach to address the respective subgroup of the people with migration background (culture specific access).

Looking at the landscape of addiction prevention in Germany, one notices that target group specific information over care offers is still scarce. This is why only one percent of the measures documented in Dot.sys name migrants as addressees. This is however contrasted by a population portion with migration background in a narrower sense in Germany of 19% (in the year 2009)⁵². The portion of drug users with migration background is above all in agglomerations like Berlin, Frankfurt, Hannover or Cologne correspondingly at around 20% (Suezen 2010).

In the last few years, a multitude of individual projects have been launched for migrants in the area of addiction prevention (Salman 2010). Since its inception in the year 2009, the portal www.suchthilfe-koeln.de/ has developed into one of the most important information sources for help, counselling and therapy possibilities offered to the inhabitants of the city of Cologne. The Internet offer is to address especially young people who could not be reached so far. After the Turkish version of the portal went online in autumn 2010, a version in Russian language has been made available since 2011 (BZgA 2011d). An intercultural opening of existent (and new) offers continues to appear imperative also in the future in order to reach migrants with addiction prevention projects in keeping with their portion in the population. With “transVer“ and “Origin-Arrival-Destination“ two approaches addressing this field of problems are presented in the following.

In the reporting year 2010, 220 projects for migrants at risk of addiction were funded by the Federal Ministry for Families, Senior Citizens, Women and Youth and the Federal Agency for Migration and Refugees. The prevention projects aim at stabilizing the personality of the immigrants and at promoting social integration. 16 projects are related to a special aspect of addiction and drug prevention (Die Drogenbeauftragte der Bundesregierung 2011). Access of migrants to help structures is generally to be improved. Therefore it is necessary to remove access barriers and provide target-specific help offers. To this purpose, the Federal Ministry for Health launched already in 2009 the initiative „transVer – transkulturelle Versorgung von Suchtkranken“ (transcultural care of addicts) with the view to develop culture sensitive addiction help. Six regional demonstration projects running in Berlin, Cloppenburg, Koeln, Leipzig, Nuremberg und Warstein test until 2012 a target group specific approach and implementation of the measure⁵³.

Apart from the access possibilities provided by the “new media“ (see above), the concept of the key persons offers another possibility to gain access to a specific group of migrants. “Which key persons have access and are trusted by the target group and can therefore be multipliers in the most different settings [...]?” (BZgA 2011e: 259f.). Key persons show their

⁵² www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Navigation/Statistiken/Bevoelkerung/MigrationIntegration/MigrationIntegration.psm1

⁵³ www.transver-sucht.de

fellow citizens with migration background ways of accessing the help and support offers made by the addiction help system.

28% of the population in Hamburg have a migration background⁵⁴. This cultural variety is matched by the project “Origin-Arrival-Destination“ (Herkunft-Ankunft-Zukunft) launched in 2006 and continually further developed by the addiction prevention system in Hamburg. The concept comprises 40 training hours during which the members of the respective migrant group – the key persons or multipliers – receive tailored training. These key persons, who work on a voluntary basis, pass on their knowledge acquired during the training on the causes of the onset of addiction and on the addiction help system in Hamburg into their own social environment. After the completion of the training, the multipliers are capable of organizing and running information events in their mother tongue on the addiction help system and other substance-specific topical areas.⁵⁵ Each information event organized by the key person is evaluated by means of an anonymous questionnaire in the mother tongue of the participants. The systematic evaluation of these questionnaires by the Office for Addiction Prevention and the abridged report written by the key persons give a clear idea of the quantity and quality of the information events. In the years 2010 and 2011 (until July 2011) more than 230 final addressees could be reached by the information events offered by the intercultural key persons.

The training of the key persons improves the integration process of migrants by combating addiction problems and by bypassing language hurdles when making contact, not least thanks to the broad spectrum of languages offered: material is provided in Turkish, Russian, English, Twi, French, Farsi, Albanian, Kurdish and Polish.

3.3.2 At-risk families

Children and adolescents from families with addiction problems

At present, about 2.65 million children and teenagers living in Germany have a parent affected by an alcohol-related disorder (abuse or dependence) and another 40,000 children and adolescents live with a drug-dependent parent. An estimated 6 million adults grew up as children in families with addiction problems⁵⁶. Substantive scientific findings show that children from families in which at least one parent is affected by alcohol or drug dependence, run a higher risk of developing addictive diseases themselves than children from families without addiction problems. Therefore, children and adolescents from addiction-stricken families form one of largest known target groups of selective prevention measures. Reasons for the higher risk of developing addiction are among others are domestic violence, separation and divorce of the parents, physical and emotional abuse or also sexual abuse that occur more frequently in addiction-stricken families than on average (Thomasius et al. 2008).

⁵⁴ www.statistik-nord.de

⁵⁵ www.sucht-hamburg.de/projekte/her-an-zukunft

⁵⁶ www.fruehehilfen.de

Addiction of one parent (licit and illicit drugs) is taken as a central risk factor in the family. Substance abuse and substance dependence indicate a high need of support for the children affected (Die Drogenbeauftragte der Bundesregierung 2011). How important it is to strengthen children from families with addiction problems is shown by Klein (2010) in his review on resilience research and prevention. The findings of resilience research can be used specifically for prevention by strengthening children from addiction-stricken families. (BZgA 2011e). Last year's Report already presented the federal demonstration project Trampolin⁵⁷ (c.f. chapter 1.3.2) that aims at preventing negative developments of children from families with addiction problems and promoting the formation of resilience and protection factors by using methods of resilience promotion.

“Fruehe Hilfen” (Early aids) begins early or at least in time. In order to prevent a negative impact of stress factors on the development of the child, (expecting) parents are to receive support at an early stage – ideally already during pregnancy.

The Federal Ministry for Families, Senior Citizens, Women and Youth (Bundesministerium fuer Familien, Senioren, Frauen und Jugend, BMFSFJ) launched the action programme “Fruehe Hilfen fuer Eltern und Kinder und soziale Fruehwarnsysteme” (Early aids for parents and children and social early warning systems) already in 2006⁵⁸.

In March 2007, the National Centre for Early Aid (Nationale Zentrum Fruehe Hilfen, NZFH) set to work to implement the programme. Its organisational structure provides for a multi-professional cooperation between the systems. Funding and supporting organs are the Federal Centre for Health Education (Bundeszentrale fuer Gesundheitliche Aufklaerung, BZgA) and the German Youth Institute (Deutsches Jugendinstitut, DJI). The headquarters of the NZFH are located in Cologne at the BZgA. The work performed by the NZFH was originally only funded until the end of the project period until the end of the year 2010. The NZFH continues its work in a second funding period until end of 2014.

The NZFH provides support for the practical work to recognize family risk factors earlier and more effectively and to make adequate help offers. Selected demonstration projects are funded, scientifically accompanied and evaluated. Currently, the NZFH scientifically evaluates the different requirements to be fulfilled by Early Help within the framework of demonstration projects in cooperation with the *Laender* and the communities (BZgA 2011e).

An example of “Early help” is the help project “Menschenskind” (DifU 2011) – an award winning contribution to the communal drug prevention competition in 2011. Under the lead

⁵⁷ www.projekt-trampolin.de

⁵⁸ “Early help” is to be established as an effective, prevention support offer for parents and their children (0 to 3 years). By effectively linking help services provided primarily by the health system and the children and youth help system, the project is to support parents and to protect children earlier and better from suffering harm. By providing a variety of services (gynaecology, midwifery, office-based paediatry), the health system offers many ways of access to at-risk families/high-risk families especially in the time around birth. Children and youth help, for its part, provides a variety of offers to help parents with tailored measures to cope with their specific life situation. But also other institutions (like for example pregnancy and parenting counselling centres, drug help facilities, women support organizations, childcare offers, judiciary and police) form part of the “Early help” network.

management of the health department of the district Marburg-Biedenkopf, Hesse, and in cooperation with the Child Protection Association, the Early Promotion Centre, the youth protection authorities and the baby and toddler ambulatory the project aims since 2006 at reaching families in particularly difficult life situations. The different health care and youth help institutions work hand in hand in order to improve the life circumstances for small children from families in difficult life situations and with drug problems. Access to the target group is provided by the low-threshold outreach approach: midwife and social worker attend to the family with children from 0 to 3 years. The family receives support among others with questions on infant care, financial and organisational consulting and visits to the doctor or authorities. The project stops when the family situation is stabilized. Currently, 32 families participate in the project (status October 2010)⁵⁹.

Launched in 1994 by the city of Karlsruhe, Baden-Wuerttemberg, the project “KiD – help for drug dependent parents and their children“ comprises the individual projects “Care for pregnant women“, “Parents training“ and “Social education group work/kids group“. The target group is formed by pregnant women dependent on illicit drugs and (formerly) drug addicted parents and their children.

“KiD“ is also an award winner of the competition “Drug addiction prevention for children and adolescents in special circumstances of life“ 2010/2011 (awarded the health insurance funds’ special prize; cf. 3.2.3). During its 17-year long project period, the project could reach 670 parents dependent on illicit drugs with 750 children and accompany 174 pregnant women. Between 80 and 100 families are attended to per year within the framework of the project (DifU 2011).

3.4 Recreational settings

Prevention measures carried out in recreational settings offer the possibility of addressing a very heterogeneous group of children and teenagers. These may be teenagers meeting in a youth centre, early school leavers in a youth welfare centre or clubbers. Among them often are teenagers with drug use experience, socially disadvantaged youth or juvenile delinquents who require different prevention responses than youth without substance use experience.

Generally speaking, recreational settings may be split into an organized and a non-organized area. The prevention measures undertaken in the organized area (youth aid institutions, church-run organisations, community-based youth centres) are often derived from the Law on children and youth welfare (Social Security Codes, SGB VIII). These measures mainly aim at promoting children and teenagers in their development and helping them to become social individuals capable of living in a community.

The described heterogeneity clearly shows the importance of taking into account the different life spheres of the adolescents and not restricting prevention measures merely to achieving abstinence or use reduction but aiming them instead at teaching risk competence and risk

⁵⁹ <http://kommunale-suchtpraevention.de/wettbewerb-2010-2011/marburg-biedenkopf.html>

management skills.

In the non-organized area, prevention of addiction is more open. This means that activities and offers are low-threshold and generally voluntary. They mainly aim at minimizing behaviours that are harmful to health and at promoting responsible substance use. In the non-organized area, prevention work is based among others on the guidelines of acceptance-based drug work and resource-oriented prevention. These approaches are to be found in numerous scene- or party-based projects offered in many, mostly larger cities. Activities undertaken within the frame of such party projects are mostly carried out by drug agencies or addiction prevention facilities respectively in cooperation with local clubs, discotheques or organizers of music and party events.

In view of the developments in the use of alcohol and cannabis among adolescents and young adults (BZgA 2009a, BZgA 2010), it is imperative to create new ways of access to the target group of the young people in order to provide early and continual prevention. In order to recognize and address teenagers with problematic substance use and conspicuous drug addicts, selective prevention in the recreational setting is the instrument of choice. An example for this is the mobile prevention instrument “Bonn event sprinter“ that is to be found at various public events in the area of Bonn. By making differentiated offers in public areas and the social living areas of the adolescents, the “Bonn event sprinter“ is to facilitate early recognition and early intervention. By using proven youth-relevant measures (e.g. a alcohol parcours, alcohol test, safe packs etc.), the instrument aims at motivating adolescents and risky users of alcohol and illicit drugs to reflect on and change their use behaviour. After a short informative talk at the stall, the adolescents are offered further counselling in the drug addiction prevention centre. This recreational setting also lends itself to establishing contact with persons of reference.

In the year 2010, the “Bonn event sprinter“ had 75 missions and made contact with 18,600 people. The team is mainly made up of addiction prevention professionals and specially trained teenagers, the so-called peers, who provide an effective access to the target group. The “Bonn event sprinter“ is a cooperation project run by the Evangelic Youth Help Godesheim GmbH and the Ambulatory Addiction Help Centre of the Caritas Association/Diakonisches Werk (Social Service Agency of the Protestant Church of Germany) – Update Centre for Addiction Prevention. The city Bonn supports the project financially and conceptually (Ammelung et al. 2011)⁶⁰.

3.5 Indicated prevention

The target group of indicated prevention measures are persons who have a high risk of developing addiction. In this connection, the necessity of indicated prevention measures is derived from the existence of important individually attributable indicators that promote the

⁶⁰ www.beratung-caritasnet.de/index.php?id=920&L=0&type=98;
www.bonn.de/umwelt_gesundheit_planen_bauen_wohnen/gesundheitsportal/sucht/bonner_event_sprinter/index.html?lang=de

later development of addiction. In contrast to selective prevention, indicated prevention is generally carried out at an individual level, and this means it is not about the identification of groups of persons who fit the mentioned criteria (EMCDDA 2009b).

3.5.1 Children and teenagers at risk with individually attributable risk factors

Behavioural disorders in children are a central risk factor for the development of addiction-related problems at teenage and adult age. There are indications of psychological problems for a total of about a fifth of all children and teenagers. About 10% are displaying psychological problems, i.e. specific disorders ranging from anxieties over depression to social behaviour disorders (RKI 2007b). Psychological disorders are significantly more common in children and teenagers with a lower socio-economic background than in children and teenagers with a higher socio-economic background. These children and teenagers generally have lower social and personal resources and are thus running up against additional problems (cf. also the passage on socially disadvantaged youth).

Explanatory models of psychological disorders meanwhile comprise both risk factors and protection factors. Family cohesion has a protective effect with respect to psychological disorders, i.e. it considerably lowers the risk of developing psychological disorders. Family cohesion is also a central protection factor with regard to the development of substance-related addictions. These risk and protection factors should by all means be taken into account both in the prevention of addiction and in the treatment of behavioural disorders in children and teenagers.

3.5.2 Children with ADHD

It is currently estimated that about 3-10% children and teenagers are affected by an attention deficit/hyperactivity disorder. Numerous studies showed that children with ADHD run a significantly higher risk of developing an addictive disorder (Thomasius et al. 2008).

Survey findings were already presented in previous Reitox Reports. There is currently no information available on further prevention measures currently carried out for children and teenagers with ADHD.

3.5.3 Early recognition and early intervention

At the interface between indicated prevention and therapy, measures have meanwhile been established which are assignable to the term "early intervention". The target group of early intervention measures is characterized by problems caused by increased substance use and/or problems that are closely linked to it. This group of people has a very high risk of developing addiction. However, at the time of the intervention, it does not meet the DSM-IV or ICD-10 criteria (yet) (EMCDDA 2009b). In general, treatment can only be initiated if dependence has been established by a diagnosis according to DSM-IV or ICD-10.

Early recognition and early intervention measures form an integral part of the prevention activities undertaken in Germany, like for example the early intervention programme for drug

users who have come to the notice of police for the first time: “FreD”. Since its launch 10 years ago, “FreD” has been scientifically accompanied by the Society for Research and Counselling in Health and Social Affairs (Gesellschaft fuer Forschung und Beratung im Gesundheits- und Sozialbereich, FOGS) in Cologne and has been evaluated three times with positive results (cf. also REITOX Report 2008). “FreD” produces good results with a relatively low use of human and financial resources. The short and early intervention measure invokes important changes in the course participants reaching from an improved risk assessment to the reduction of the use of illicit substances or abstinence. Moreover, the drug users reached by the early intervention “FreD”, attach great personal importance to the participation in the project⁶¹.

Early intervention programmes account for approximately 30% of the overall addiction prevention measures undertaken per year. According to the data recorded in Dot.sys, 54% of the early intervention measures were geared to final addresses in 2010. The number of measures targeting multipliers is somewhat lower with 44%. The measures mainly address the substances alcohol (43%) and cannabis (28%).

„FreD goes net“ is the European continuation and transfer of the German demonstration project “FreD – early intervention in drug users who have come to the notice of police for the first time” into countries of the European Union. “FreD goes net” was carried out by the LWL-Coordination Centre Addiction between November 2007 and October 2010 and scientifically evaluated by the Cologne Society for Research and Counselling in Health and Social Affairs (Gesellschaft fuer Forschung und Beratung im Gesundheits- und Sozialbereich, FOGS). The project was jointly funded by the European Commission and the participating member states as well as by the Federal Ministry for Health. The programme pursues goals at two levels: at the structural level, new cooperation networks are built up between (drug) counselling facilities and settings in which teenagers make themselves conspicuous with their substance use (police/judiciary, school, work). At the behavioural level, the programme makes a group offer to teenagers with risky alcohol and or illicit drug use with a view to motivate them to reflect on their use behaviour in order to prevent them from gliding into addiction.

“FreD goes net” could successfully be implemented in 11 European pilot countries⁶². The results of the external evaluation show that the programme was successful not only in building cooperations but also in bringing about positive changes in the use behaviour of the participants.

In order to take account of the growing importance of the Internet in the everyday world of teenagers and young adults, the BZgA has been offering the Internet-based short intervention programme “quit the shit” for young cannabis users since the year 2004. Within the framework of “quit the shit”, these users are offered the possibility of being professionally supported in their attempt to reduce cannabis use or give it up completely. A control group study was undertaken from 2006 to 2008 to investigate the effects of “quit the shit”. The final

⁶¹ https://zzz.lwl.org/LWL/Jugend/lwl_ks/Projekte_KS1/FreD/

⁶² http://www.lwl.org/LWL/Jugend/lwl_ks/Projekte_KS1/Fgn-english/Fgn-english_Projectpartners

report of the controlled study on the effects of the reduction and cessation programme for cannabis users “quit the shit” shows that a complete programme use of at least 45 days is associated with a considerably higher probability of significantly lowering cannabis use. Both use frequency and quantity could be lowered by more than half on average. Slightly more than a quarter of the “quit the shit“-participants refrain from using cannabis after the participation in the programme. Programme participants have a six times higher probability of reaching abstinence than the untreated control group. Analyses of the follow-up surveys show moreover that a participation in the counselling programme significantly increases the psychological wellbeing of the former cannabis users. To conclude, it can be stated that “quit the shit“ is an effective support for those who want to reduce or stop their cannabis use (Tossmann et al. 2011, Tossmann et al. 2009).

Out of the multitude of intervention programmes offered in Germany, “CaBS – Casemanagement und Beratung fuer cannabiskonsumierende Schueler“ (Casemanagement and counselling for cannabis using students)⁶³ and the “Self control training SKOLL“ are presented as examples in the following. The project “SKOLL“ is used countrywide, “CaBS“ is addressed to students of secondary and vocational schools in Frankfurt /Main.

Initiated by the drug department of the city of Frankfurt in November 2005, the project “CaBS“ is an award winner of the fifth communal competition in addiction prevention (cf. 3.2.3). It is addressed to teenagers and young adults who intensely use cannabis and/or other addictive substances. With “CaBS“ it was possible to close a gap in the offer of the local addiction and drug aid institutions since the project gives better access to the circle of users at an as early as possible stage⁶⁴. With 19 years, the average of the participants to “CaBS“ lies 4 years above the average age of users who enter into contact with the help system for the first time.

The main goal of “CaBS“ is to reduce cannabis use among teenagers or respectively achieve abstinence in dependent users. “CaBS“ moreover supports the teenagers in expanding their social skills, improving their performance and reintegrating into school⁶⁵. “CaBS“ also serves as a supporting conflict management tool for teachers (Jugendberatung und Suchthilfe “Am Merianplatz“ 2010).

It is often teachers or relatives who refer the teenagers to individual counselling in “CaBS“. The individual needs are jointly assessed by a “CaBS“-staff member and the client in a sheltered setting. In the case that the needs of the clients exceed the possibilities of individual counselling, “CaBS“ refers to further help institutions. While the project „FreD“ is addressed to drug users aged between 14 and 25 years who came to the notice of police for the first time, “CaBS“ targets teenagers and young adults who also intensely use cannabis

⁶³ <http://www.jj-ev.de/deutsch/1/10/18/30002/design3.html>

⁶⁴ cf. ESPAD study (www.espad.org), MoSyD study: These studies investigated among others the prevalence of cannabis use in the different types of schools. It was found that intense cannabis use tends to be more prevalent at vocational schools than at other school types.

⁶⁵ <http://kommunale-suchtpraevention.de/node/164/1431>

but who have not (yet) come to the notice of police. Continual observation and analysis of the project course of “CaBS” has shown that notably (young) people in special life circumstances are reached. Essential for the success of “CaBS” is the cooperation with the cooperation partners (Jugendberatung und Suchthilfe "Am Merianplatz" 2010).

The self control training “SKOLL”⁶⁶ is a demonstration project funded by the Federal Ministry for Health with the goal to motivate teenagers and young adults with risky use to adopt a more responsible use behaviour. “SKOLL” pursues a cross-substance strategy: People of all age groups with risky use of different substances like for example alcohol or cannabis and different use patterns as well as people with behavioural disorders can join in and become active in the group. In a ten-week training, the participants question their own licit, illicit and unspecific substance use and/or other risky behaviours. For each participant, an individual training plan is set up and behavioural alternatives are developed. A central element of the training is self-reflection. The goal of “SKOLL” is to stabilize, reduce or, ideally, stop use completely. The self control training serves to initiate change processes in people with risky use and to draw the attention to further help possibilities. The low-threshold “self control training teaches general self-management skills across substances, age, gender and social strata” (Boesing & Kliche 2009). Thanks to the cross-substance concept, the approach is particularly suited for counselling centres in rural regions.

So far, 45 drug addiction centres from the whole of Germany were integrated into the project. In more than 70 trainings, approximately 700 teenagers and adults were reached. The evaluation of the project that was launched in 2008 is performed by the University clinic Hamburg-Eppendorf. The scientific evaluation of the project is to contribute to an evidence-based approach that can be implemented in the counselling facilities in the whole of Germany after the completion of the project in October 2011.

3.6 National and regional media campaigns

National and regional media campaigns are instruments of universal prevention activities. Providing information on risks that emanate from a substance forms an integral part of a multi-level prevention strategy. Taking in and processing information and potentially changing ones behaviour is all the more easier if the information is provided in an interactive manner. For this reason, it is necessary to support the provision of information by mass media and strengthen it by a targeted interactive internet offer.

The campaigns undertaken by the BZgA on the prevention of abusive alcohol consumption have been further intensified in the reporting period. The campaign “Alcohol? Know your limit”⁶⁷ which was already presented in last year’s report, was expanded by mass media communication elements in the social networks in 2010. Since July 2010, the profile of the campaign is staged on facebook. The profiles on web-based social networks like “schuelerVZ”, “studiVZ”, “meinVZ” followed in November 2010. Thanks to continual updates,

⁶⁶ www.skoll.de/

⁶⁷ www.kenn-dein-limit.info

youth-relevant offers and online marketing, the campaign managed to win in total more than 55,000 fans in the networks in a little less than a year (July 2010 – June 2011). From the response rate in form of comments, discussions and participation in actions, the interaction with and among the users on the topic of “responsible use of alcohol“ can be rated as very successful.

With the slogan “Alcohol? Know your limit?“ the BZgA also addresses the adult general population. To complement the mass media approach based on Internet and information material, the information tour “Alcohol? – Know your limit“ was developed for this target group. The interactive personal communication modules of this mobile offer can be flexibly used in areas with high public traffic (e.g. shopping malls, trade shows, museums, a.o.) and individually adapted to the size and form of the available spaces. The info tour started in March 2011 and will be continued in seven other locations in Germany in the course of the year. The tour will also be continued in 2012⁶⁸.

⁶⁸ www.kenndeinlimit.de/informationstour/

4 Problem drug use

4.1 Introduction

The term “problem drug use“

There is no uniform definition of the term ‘problem use’. However, there are practical definitions for specific areas (e.g. the prevalence estimation of the EMCDDA). Generally speaking, consumption is regarded as problematic if at least one of the following criteria is fulfilled:

- risk carrying use (risky use),
- harmful use (F1x.1) or addiction (F1x.2) in respect of a clinical diagnosis (ICD or DSM)
- harm inflicted on other persons
- negative social consequences or delinquency.

In addition to the collection of clinical diagnoses "dependent use" and "harmful use", for which the international criteria of the ICD-10 (Dilling et al. 2005) apply, the German Core Data Set proposes a definition for "risky drug use" (German Centre for Addiction Issues, DHS). According to expert opinion, "risky drug use" shall be recorded for any substance or disorder, if neither the ICD-criteria for addiction nor for harmful use are fulfilled and thus no diagnosis can be made and if at the same time the number of consumption days during the last 30 days is bigger than zero. In this case, the recommendations of the WHO, the British Medical Association and the board of trustees of the DHS apply to the evaluation of the individual "risky alcohol consumption". For other substances, there are currently no binding recommendations.

Irrespective of the above definitions, consumption can also be problematic if the user himself experiences it as problematic and for example considers himself as being addicted without having an objective diagnostic classification of addiction (Kleiber & Soellner 1998). The working definitions used at different places respectively comprise different subsets of the described total group. Only the terms based on clinical classification systems are clearly defined. As for other terms like for example ‘risky drug use’, definition and understanding of the concept vary considerably.

Measuring and estimation methods

Sometimes there are considerable methodological difficulties in evaluating data from specific collection systems or studies with regard to problematic use in terms of addiction. Whereas with police records only the higher probability of intense drug users to be picked up by police can be interpreted as an indication of problem drug use, surveys make use of additional information (frequency of use, accompanying circumstances, diagnostic criteria) or adapted clinical tests to differentiate. A relatively safe classification is possible in therapy facilities where staff has been trained or has experience in diagnosing such cases. The

abovementioned definition of “risky consumption” in the German Core Data Set excludes any consumption (within the last 30 days) of a substance of the categories F11 (opioids) – F19 (multiple substance use and other substances) of the ICD-10 classification. Concretely defined threshold values only exist for alcohol (F10).

In addition to content-related and general methodological difficulties in defining problem drug use, specific difficulties arise when collecting data on illicit drugs. A series of surveys shows that users of drugs like heroin or cocaine tend to report only the consumption of ‘soft’ drugs like for example cannabis correctly while denying using for example heroin or correcting down intensity and frequency of use.

While population surveys allow for valid statements to be made on experimental drug use and lighter forms of multiple or sustained drug use, intense or regular users are generally underrepresented in the population sample. Moreover, in their case, the extent of the problem is under-reported. Methodological problems have been described by Kraus et al. (1998) and Rehm et al. (2005).

Based on a literature review on the epidemiology of multiple use of illicit drugs in Hamburg, Ilse and colleagues (2007) conclude that in view of frequently occurring poly-drug use, the diagnostic methods should be further developed and adapted to the complexity of consumption patterns. Furthermore, discriminating between licit/illicit substances and focusing on the concept of problem use of a primary drug or respectively a medical classification of a main drug is - according to the authors - not sufficient. These difficulties are of special relevance in particular for extrapolations which are based on treatment data.

National and local estimates of drug use

The EMCDDA has collected a series of methods for estimating the prevalence of problem drug use at national level and has developed them further. The selection of the target groups of these methods are based on the definition of problem drug use as an “intravenous or long-term/regular use of opioids, cocaine or amphetamines” (Kraus et al. 2003).

However, as it would not have been possible to exclude multiple mentions in police records when reviewing several substances, and as valid mortality estimates are only available for heroin users, the prevalence estimates for Germany were restricted to the target group of heroin users.

In view of the particular risks carried by intravenous drug use, this use pattern is of particular interest when trying to minimize secondary harm. Although injecting drug use has been on the decline among the patients of addiction aid facilities in Germany for several years now, it continues to be strongly linked to heroin. Therefore, differentiation among user groups for estimating prevalences and describing patients is done in terms of main drug and not in terms of administration route.

4.2 Prevalence and incidence estimate of PDU⁶⁹

4.2.1 EMCDDA estimate methods (indirect estimates)

For the year 2010, two multiplier methods were recalculated and based also on results of the previous years:

- Estimate based on police contacts
Assuming an average consumption period of 8 to 10 years, the numbers of heroin users who have come to the notice of the police for the first time (incidence), are summed up over the respective years. The portion of persons in drug-related death cases already known to police is used respectively to calculate the estimated number of unknown cases.
- Estimate based on drug-related deaths
The number of drug-related deaths in the reference year is extrapolated to the overall figure of opiate users in the population using the quota of drug-related deaths in outpatient clients per year.

Moreover, the estimate based on the treatment data of the year 2009 was recalculated. Since some of the data (diagnostic data of the patients in hospitals) that are needed for the estimation calculation, are generally made available only with considerable delay, it is not possible for the current Reitox Report to venture an estimate for this multiplier based on the data for the year 2009.

- Estimate based on treatment admissions
The overall figure of treated cases is calculated on the basis of recorded client figures in outpatient and inpatient treatment, the total figure of counselling facilities as well as a multiplier for reaching the target group.

All results are only to be taken as a rough approximation since different preconditions are to be presupposed. Especially the multipliers used have only limited validity as they are based on small case figures and selective samples. The methods have been described elsewhere. All multiplier methods as such are subject to considerable qualifications. Changes in prevalences for example, are not necessarily reflected by the therapy demand. The collection of data on users who come to the notice of the police for the first time, is significantly influenced by the prosecution pressure exercised by the police. The absolute figures of drug-related deaths only allow cautious interpretation. Other estimation methods (e.g. capture-recapture studies or other multiplier methods) have not been used since necessary parameters were not available in a timely, empirically evidenced form.

The individual estimates can be found in standard table 7.

⁶⁹ Problem Drug Use.

Results of the prevalence estimates

Calculations based on figures collected from treatment, police contacts and drug-related deaths lead to an estimated figure of problem heroin users ranging between 81,000 and 171,000 persons (with the estimates of the year 2009 serving as a calculation basis). This corresponds to a quota of 1.5 to 3.2 persons in 1,000 inhabitants in the age of 15 to 64 years (Table 4.1).

Table 4.1 Prevalence estimates of problem opioid use from 2005 to 2010 (figure in 1,000, age group 15-64 years)

Data source	Reference year						Prevalence
	2005	2006	2007	2008	2009	2010	per 1.000
Treatment	155-184	136-162	131-156	155-184 ¹⁾	144-171 ¹⁾	²⁾	2.7-3.2
Police contacts	128-166	117-159	108-149	99-137	89-127	81-117	1.5-2.2
Drug-related deaths ³⁾	79-96	103-130	99-113	117-178	91-119	82-137	1.5-2.6

1) New calculation basis: Facility register of the DBDD (N=1,332 outpatient facilities)

2) Cf. chapter 4.2.1 on the missing calculation of the estimate based on therapy data for 2010.

3) Previous year's values of the estimates were methodologically revised and adjusted.

DBDD 2011, special calculation.

In comparison with 2008, the estimate for the year 2009 is somewhat lower as a result of the multiplier "therapy demand". This is mainly attributable to the fact that the number of therapy admissions declined from 2008 to 2009. For the year 2009, the methodological basis for the calculation of the estimate of the total number of outpatient facilities was partially adjusted in the extrapolation (Suess & Pfeiffer-Gerschel 2009). A more detailed presentation of the methods can be found in the REITOX Report 2010.

The number of heroin users who have come to the notice of the police for the first time has been on a strong decline for years (2000: 7.914; 2010: 3.201). At the same time, the portion of drug-related deaths that had been recorded before as users who had come to the notice of the police for the first time, remained constant between 2005 and 2008 and continued to be unchanged since a slight reduction in the year 2009. Therefore, the estimates based on this indicator have been on a continual decline. The number of drug-related deaths slightly decreased in 2010 in respect of 2009 (at an only minimally changed mortality rate in the outpatients). The estimates based on this multiplier are among others referred to the mortality of the patients treated in the outpatient setting. Since this range expanded downwards in comparison with the last year (2009: 1.1%-1.5%; 2010: 0.9%-1.5%), the estimated interval of the number of heroin/opioid users lies in the same range of values as in the last year, but is in total larger for the year 2010, thus also more imprecise.

The estimates for the multipliers therapy demand and police contacts have been on the decline since 2008. The same applies to the multiplier drug-related deaths for the last years. In the year 2010, this value remained stable, however within a larger interval. To summarize,

it can be stated that that estimated number of heroin/opioid users has been continually declining since the year 2008.

The range of values (1.5-3.2/1,000) still lies within the prevalence range that a European meta study calculated for the dependence on illicit substances for the age group 18 to 65 years (3.0/1,000; threshold values: 2.0-6.0) (Wittchen & Jacobi 2005). Further details are contained in chapter 4.2.2.

When choosing a broader definition of the target group including users of opioids, cocaine, crack and amphetamines, the following problem arises: these substances do comply with the definition of the target group by the EMCDDA. However, there is no possibility to verify injecting or highly frequent consumption of these substances with the data sources available. In this way, an unknown number of persons whose problems with drug use might be less severe would be taken into account possibly leading to an overestimation of the prevalence.

Updated calculations based on treatment data from the year 2009 including clients with cocaine and amphetamine problems, produce a prevalence of 182,000-217,000 (2008: 197,000-234,000). This corresponds to a prevalence of 3.4-4.0 (in 1,000 inhabitants) among the 15-64 year olds (2008: 3.6-4.3) that slightly declined. Estimates based on police data and drug-related deaths are not performed for the extended target group because of the reasons described above.

The results of the national prevalence estimates are contained in standard table 7 and of the local prevalence estimates in standard table 8.

4.2.2 Incidence prevalences on the use of problem drug use

The incidence of problematic opioid consumption (the number of new cases registered in a specific year) makes it possible to exactly measure changes over time serving as an early indication of future developments with respect to prevalences and treatment demand. However, the estimation models used are based on several assumptions and only make it possible to perform partial incidence estimates since they are solely based on cases that have been registered by the drug treatment facilities. The EMCDDA developed guidelines for incidence estimates in cooperation with a group of European experts with a view to stimulate further progress in this area (Scalia Tomba et al. 2008). No new studies have been conducted in Germany on the subject matter.

4.3 Data on PDUs from non-treatment sources

General population estimates

The data on cannabis-, cocaine- and amphetamine-related disorders that were collected within the framework of the last Epidemiological Addiction Survey (ESA) in the year 2009 according to the Severity of Dependence Scale (SDS) have already been presented in the last REITOX Report.

Estimates on problem drug use in prisons

Estimates on problem drug use in prisons are presented in-depth in this year's Selected Issue 11.

4.4 Intensive frequent, long-term and other problematic forms of drug use

4.4.1 Description of the forms of use falling outside of the EMCDDA's PDU-definition

Various studies have been conducted recently to collect data on "problematic" or "risky" use of cannabis. However, terminology and operationalisation differ from study to study so that data comparability is very restricted. It appears nevertheless necessary to include cannabis use in the investigation of problem and risky use patterns given the data available on the possible long-term effects of cannabis use.

The findings of the most recent study conducted by the Federal Centre for Health Education, (Bundeszentrale fuer gesundheitliche Aufklaerung, BZgA) on cannabis use among teenagers and young adults (BZgA 2011c) 0.6% of the 12- to 17-year olds "regularly" (more than 10 times) used drugs in the last twelve months. Among the 18- to 25-year olds, the portion amounts to 3.2%. In the age groups of the 14- to 17-year olds, the 18- to 21-year olds and the 22- to 25-year olds significant gender differences were found. According to the survey, regular cannabis use among male teenagers and young adults is more widely spread than among their female counterparts.

The findings of the last European School Survey on Alcohol and other Drugs (ESPAD) conducted in 2007 on the prevalence and factors of cannabis-related problems in teenagers were already presented in the REITOX Report 2010.

Kraus and colleagues (2010) also investigated the use trends and substance-related disorders of cannabis between 1995 and 2009. Data were provided by six data collection rounds performed within the framework of ESA between 1995 and 2009. The portions of people with cannabis dependence according to the SDS did not show any significant changes between 2006 and 2009 neither in respect of the total sample (1.5% vs. 1.3%) nor in respect of the cannabis users in the last 12-month category (33.1% vs. 29.8%).

Piontek and colleagues (2011) investigated the validity of the diagnostic criteria of the DSM-IV for abuse of and dependence on cannabis taking a sample among 17- to 19-year olds⁷⁰. The authors arrive at the conclusion that the diagnostic criteria of the DSM-IV do not differentiate between two different aspects (abuse and dependence) of cannabis-related problems with different degrees of severity. The four abuse and seven dependence criteria of the DSM-IV appear only to measure one single underlying disorder. In the surveyed sample,

⁷⁰ The data are based on a cross section survey conducted on N=3,641 persons aged between 17 and 19 years who had reported cannabis use in the last 12 months before the survey. The diagnostics were performed by using the Munich-Composite International Diagnostic Interview (M-CIDI), as additional cannabis-specific indicators "daily use", "use without presence of others" and "use before noon" were surveyed. Analyses performed were the confirmatory factor analyses and 2-parameter logistic IRT-models (Item Response Theory).

the abuse criterion “legal problems“ represented the largest extent of problems, while for the dependence criterion “tolerance“ less severe problems were recorded. The indicators analysed additionally to the DSM IV-criteria lead to an improvement of the precision of the diagnostic methods. Furthermore, for some of the criteria, gender-specific differences were found (tolerance development, withdrawal symptoms, use before noon). The authors conclude that the current DSM-IV concept distinguishing between two types of disorders with different levels of severity for cannabis-related disorders in teenagers has an insufficient validity and recommend for future revisions of the DSM to revise or exclude some of the criteria and to include new indicators and gender-specific differences.

4.4.2 Prevalence estimates of intensive, frequent, long-term and other problematic forms of use not included in the PDU definition

Other data on teenagers and young adults

In the following, selected findings from the most recent studies analyzing the connections between problematic, risky or regular use and the later onset of substance-related disorders will be reported to complement the already presented data from the repeat surveys. The high-risk phases for first substance use and the onset of regular consumption and substance use disorders (substance abuse and dependence) lie in the second decade of life. It is of note that large parts of the transitions from initial use to regular use and from initial use to substance use disorders occur in the first few years after initial consumption. In this context, the shortest transition period was found for cannabis (in comparison with alcohol or nicotine). After initial use, the age range from 15 to 18 years is the decisive period in which the transition to substance use disorders takes place (Wittchen et al. 2008b). Behrendt and colleagues (2009) could not only show for cannabis but also for alcohol and nicotine that an early onset of substance use in adolescence compared to a later start of substance use in adolescence is connected with a higher risk of developing substance abuse and dependence. However, cannabis use is not necessarily a transitory youth phenomenon: in people with a raised use frequency during adolescence, cannabis use persists into the third or fourth decade of life. Alcohol dependence and straining life circumstances also form risk factors for the persistence of cannabis use into the third or fourth decade of life (Perkonig et al. 2008a).

4.4.3 Medical drug abuse

Introduction

Estimates of the prevalence of dependence on medical drugs range between 700,000 (Schwabe 2007) and 1.9 million people addicted to pharmaceuticals in Germany (Kraus & Augustin 2001; Soyka et al. 2005). According to the results found by the Epidemiological Survey on Substance Abuse 2006, almost 5% of all people interviewed in the age group from 18 to 64 years display problematic use of medical drugs according to the criteria of the short questionnaire on the use of medical drugs (Watzl et al. 1991). Despite the high prevalences

of the dependence on medical drugs, the disease - often named "quiet addiction", is hardly perceived by the public in contrast to drug and alcohol addiction (Rabbata 2005). Mostly older people (Ruhwinkel 2009) and women (Simoni-Wastila et al. 2004) are dependent on medical drugs. But also teenagers, young adults and people afflicted by psychopathological disorders as well as people with substance use disorders represent important groups at risk of developing disorders in connection with medical drug abuse. For opioid addicts, for example, it is easier to get access to the black market. They have a higher tendency of misusing pharmaceuticals as effect modulators for drugs (Kuefner & Roesner 2008).

Even if especially disorders caused by the use of benzodiazepines are not a new topic any more, benzodiazepine addicts – and people dependent on other drugs – very seldom undergo addiction-specific medical treatment. Holzbach (2008) surmises that the reasons for the countrywide low usage of withdrawal treatment by medical drug addicts are connected with the absent balancing of the pros and cons of long-term treatment and the overestimation of the difficulties and distress associated with the withdrawal treatment. Medical drug addicts represent a group in their own right among dependent patients since they differ from for example alcohol addicted patients in terms of onset and processing of the disease. Dependence on medical drugs often remains much longer undetected due to the socially inconspicuous behaviour of the people affected and is also often negated by the dependents. Generally, medical drug addicts gain access to medical drugs through the contact with the medical care system and not via black markets or the free market.

Changes of conceptual framework conditions possibly also have an influence on the misuse of medical drugs. The quantities of substitution drugs prescribed in Germany (methadone, buprenorphine) have continually increased in parallel to the extension of the substitution treatment offers made in Germany over the last years (Boeger & Schmidt 2010). But the prescribed quantities of other medical drugs (especially opioids/analgesics) have as well substantially increased over the last years (Boeger & Schmidt 2010), so that a higher availability of these groups of medical drugs – also on the black market – is to be assumed.

In addition to the problem posed by the misuse of analgesics and benzodiazepines that has been known for many years, new trends have been recently discovered in the misuse of medical drugs like for example the misuse of antidepressants (Kuefner et al. 2009) or the misuse of performance enhancing (doping) drugs (Die Drogenbeauftragte der Bundesregierung 2009). Doping at work has developed into a new phenomenon of medical drug abuse over the last years. It is estimated that more than 2 million people in Germany have taken medical drugs at least once in their lifetime to enhance their performance at work (Die Drogenbeauftragte der Bundesregierung 2009). As a reaction to this new trend, the Act on Improving the Fight against Doping in Sports and the Regulation on Doping Drugs Amounts have been passed in 2007. The main goal of the anti-drug act and regulations is to curb the activities of the internationally linked criminal structures.

In the year 2010, substances used for gene doping were recorded for the first time. The Federal Government will present a report on the effects of the Act in 2012 (Die Drogenbeauftragte der Bundesregierung 2011).

The Epidemiological Addiction Survey (ESA) 2009 found that little less than 4% of all interviewees in the age between 18 and 64 years display problematic medical drug use (Pabst et al. 2010) in respect of the criteria of the short questionnaire on medical drug abuse (KFM, Watzl et al. 1991 RM 303). The use trends of medical drugs were also analysed by Kraus and colleagues (2010) on the basis of the last six ESA surveys. To this purpose, the use prevalence in the last 30 days before the survey was surveyed for pain killers, sleeping drugs, tranquilizers, stimulants and appetite depressants. Problematic medical drug use was surveyed by using the short questionnaire on medical drugs use by Watzl et al. (1991). This questionnaire allows to survey problematic use patterns that do not necessarily fulfil the criteria of abuse and dependence. Four positive answers in the short questionnaire are taken as a cut-off value indicating problematic medical drug use in the last twelve months. Over a period of 15 years, the use of painkillers shows a significant increase in the adult population in both genders. A declining trend, in contrast, was found for sleeping drugs, tranquilizers, stimulants and appetite depressants. After having followed a constant course, the use of pain killers increased between 2006 and 2009 while the prevalences for other substance groups remained at a constant level after a decline between 1995 and 2000. The gender-specific analysis reveals only slight differences. There were hardly any changes found in the portion of persons with problematic use patterns. Here, only the portion of men and, as a result, the overall value showed a significant increase between 2000 and 2009. Related to the group of medical drug users, the portion of persons with problematic use remained unchanged over the years.

Data from the monitoring system Phar-Mon

Funded by the BMB, the Phar-Mon project has been investigating medical drug abuse among clients of a random sample drawn among outpatient addiction counselling facilities in Germany since 1988. The goal of the project is to collect data on the misuse and addiction potential of medical drugs and to contribute to the identification of trends of medical drug abuse.

For the period from January to December 2010, data were collected from N=35 reference facilities participating in the project. Out of the 35 facilities, that were invited to participate, 26 reported a total of N=467 recordings of medical drug abuse by N=338 clients. These are for the most part male (72.5%). As regards the main diagnosis, the group of the opioid addicts plays a predominant role (66.0%).

Mentions of abuse by clients of the main diagnosis group opioids were mainly related to substitution substances (5.8%) and sedatives/hypnotics (31.0%). With regard to the abuse of substitution substances, methadone and buprenorphine play a dominant role. Compared to the previous year, the percentage of the mentions of methadone (2009: 26.4%; 2010: 31.0%) increased somewhat more strongly than the percentage of buprenorphine mentions (2009: 18.5%; 2010: 20.5%) while the mentions of levomethadon continued to account for a very small portion (2009: 5.8%; 2010: 4.3%). The high figure of mentions of substitution substance abuse correlates with the significantly increasing numbers of prescriptions

(Boeger & Schmidt 2010). The abuse of sedatives/hypnotics in this main diagnosis group was almost exclusively related to benzodiazepines (98.9%), among them notably diazepam (18.8% of all mentions).

In the group with one main diagnosis from the area abuse of or dependence on sedatives/hypnotics, this group of medical drugs naturally forms the largest part (67.6%). Contrary to the previous years, lorazepam with a medium duration of action is mentioned most frequently (23.5%) as an individual substance in 2010 directly followed by diazepam (20,6%) with a long-term duration of action. Alongside sedatives/hypnotics, mentions of abuse of analgetics come second in this group accounting for 14,7%, out of which 8.8% are opioid analgetics and 5.9% non-opioid analgetics.

Apart from the already mentioned medical drug groups, there are also mentions of abuse of antidepressants, neuroleptics and antiepileptics in other diagnosis groups. There have been recent indications of a high abuse potential of the antiepileptic pregabalin (Schifano et al. 2011) that however appears with only one entry in the Phar-Mon sample.

Seen across all clients groups, the majority of mentions are from the medical drug groups substitution drugs (40.0% of all mentions) and sedatives/hypnotics (33.6% of all mentions). Substitution drugs are virtually exclusively used by clients with an opioid diagnosis who also represent the largest individual group among the clients. Abuse of sedatives and hypnotics, by way of contrast, that is almost exclusively related to the abuse of benzodiazepines in the Phar-Mon sample, does not only play an important role in the group of the opioid addicts but is also of high relevance especially with regard to the therapy of this patient group. Survey findings indicate that the by-use of benzodiazepines during a substitution-assisted therapy of opioid addicts has a negative impact on the therapy outcome and also correlates with more health and psychosocial problems (z.B. Eiroa-Orosa et al. 2010a).

With regard to the therapy of clients with benzodiazepine dependence, is currently discussed whether it is possible to use benzodiazepines with long duration of action in substitution therapy (Liebrenz et al. 2010). There is however controversy over the approach (Soyka 2010).

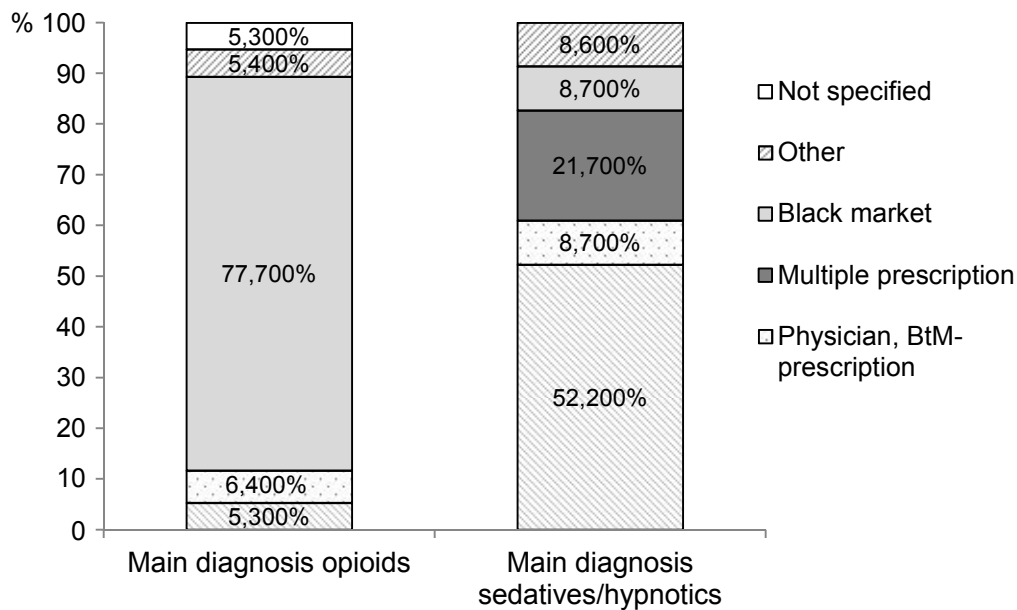


Figure 4.1 Sources of sedatives/hypnotics broken down by main diagnosis group

To get a better understanding of the sources of abused sedatives and hypnotics, an analysis of the reported main sources was carried out. According to this analysis, sedatives and hypnotics are mainly obtained from a doctor (26.8%) or from the black market (51.0%), but it needs to be added that there are considerable differences between the individual patient groups. The high percentage of procurement via the black market is on the one hand possibly attributable to the declining prescription figures for benzodiazepines with long duration action (Lohse & Mueller-Oerlinghausen 2008) and explains on the other why the lower prescription figures are not reflected by the Phar-Mon-sample. Looking at the sources broken down by main diagnoses, one gets an interesting picture (see Figure 4.1). While clients of the main diagnosis group sedatives/hypnotics procure the medial drugs mainly by using a normal prescription from one doctor (52.2%) or by several prescriptions from several doctors (21.7%), clients from the main diagnosis group opioid sedatives/hypnotics mainly procure their drugs from the black market (77.7%). The fact that clients with sedatives/hypnotics-related problems often resort to multiple prescriptions issued by different doctors, may be interpreted as an indication that some doctors recognize the addiction and refuse to issue more prescriptions. Nevertheless, the majority procure the sedatives/hypnotics from one doctor, which shows that the problem often remains undiscovered or is not reacted to adequately. The reason why clients of the main diagnosis group opioid sedatives/hypnotics mainly procure the drugs from the black market may be one the one hand that users of illicit drugs are anyway in contact with the black market. On the other, the result can also be interpreted as an indication of a reluctance of the doctors to prescribe benzodiazepines to opioid dependent patients because of the high addiction potential according to the general guidelines.

Other current developments

Commissioned by Federal Ministry for Health, the Robert Koch Institute conducted a study to identify use patterns of user groups of performance enhancing substances (including doping drugs) between March and June 2010 (RKI 2011c). In total, 9.5% of the interviewees used a performance enhancing substance (including doping substances) within the last 12 months without medical indication. The study placed the focus on the differences in the use patterns of different sport settings. The study showed that interviewees who work out in the gym take performance enhancing substances more often than interviewees who do not go to the gym. The risk for men who go more than four times to a gym, is six times higher than for men going to a sports club or not doing any sports. The prevalence of taking prescription drugs for neuroenhancement was at 1.5% in the overall population. According to the study, especially females, economically active people aged between 18 and 44 years with an average weekly working time of more than 40 hours have an increased risk of taking psychotropic and neuro-active prescription drugs to enhance their cognitive and social skills. All in all, the study showed that the portion of the overall population that uses performance enhancing substances, is relatively small. However, when looking at specific subgroups of the population, one can recognize distinct use patterns. Therefore, prevention measures geared to specific target groups like for example gym goers could be more effective than those addressing the general population. An improvement of the working conditions could also contribute to reducing the use of prescription drugs for neuroenhancement.

In summer 2011, Reimer (2011b) presented the final report on a study conducted on the unintended use of substitution drugs in Germany that follows up on a study of the year 2009⁷¹. Within the framework of the study, scene surveys (n=420 persons) and surveys in substitution practices/ambulatories (n=404 interviewees) were conducted in ten cities. Depending on the substitution status, the participants were subdivided into substituted (N=667) and non-substituted (N=157) interviewees. In the total group, 9.3% and respectively 21.9% of the interviewed persons (N=824) reported unintended use of substitution drugs in the last 24 hours and respectively 30 days. The comparison between the two survey groups (substitution facilities/scene) revealed significant differences: 15.4% of the persons interviewed within the framework of the scene surveys reported use of unprescribed substitution drugs significantly more often than people interviewed in the substitution practice setting (2.8%). The 30-day prevalence for the use of unprescribed substitution drugs gives a similar picture with 32.9% (scene) to 10.2% (practices). When comparing substituted interviewees with non-substituted ones, one finds that substitution drugs are less seldom used for unintended purposes by the substituted interviewees (last 24h: 6.0%, last 30 days:

⁷¹ All persons interviewed in the practice setting were undergoing substitution treatment when the survey was carried out. The interviews were for the most part done by trained interviewers, in the case of the scene surveys, interviewing was performed in cooperation with drug consumption rooms in two cities. Interviewing took place between December 2010 and March 2011. In addition to the interview material, data provided by the Federal Criminal Police Office (Bundeskriminalamt, BKA) was analysed to investigate the mortality in connection with the use of substitution drugs. The data provided by the BKA were based on BKA reports from the years 2006-2009.

16.0%) than by then non-substituted ones (last 24h: 23.2%, last 30 days: 47.1%). Differentiating by substitution drug, it shows that in both groups (practice/scene) Methadone/Polamidone®, available as a ready-to drink solution, and Methaddict®, that are available in the form of tablets, are used much more often in the last 30 days without prescription than Subutex® und Suboxone®. In relation to the market share, the use of the substitution drugs Methaddict® and Subutex®/Suboxone® that come in the form of tablets would appear higher than average. Reasons given for the procurement of substitution drugs for unintended purposes by patients of substitution practices were too low a dosage (20.5%), no availability of heroin (19.5%), no availability of a substituting doctor (16%) and the low price (10.7%) (Reimer 2011a).

5 Drug-related treatment: treatment demand and treatment availability

5.1 Introduction

Treatment phases

People willing to overcome their substance dependency with professional support are offered a wide range of cessation counselling and therapeutic services. On the one hand, there are substitution offers with a limited target orientation aiming at stabilizing the overall condition, and, on the other, abstinence-oriented treatment offers. The two concepts complement each other, since, in the long term, substitution too, aims at abstinence from drugs, where possible.

Based on the present state of knowledge, abstinence-oriented therapy can be subdivided in four basic phases ("phase model"):

- contact and motivation phase
- withdrawal phase
- rehabilitation phase
- integration and after care phase.

The therapy is structured according to the above phase model. The goal of the *contact phase* is to develop, maintain and strengthen the motivation to have the addictive disease treated. All measures undertaken should be embedded in a treatment and help plan for the therapy that should start with counselling comprising medical, psychological and social diagnostics and case history. The help plan should take account of therapy and health care offers available at regional level in order to select the measures that are best suited for the individual case.

In the *withdrawal phase*, multi-professional teams assist in working on addiction with all its aspects in a 'qualified withdrawal' programme. The duration of the withdrawal phase may vary, depending on the individual circumstances, between two to six weeks.

The goal of the *rehabilitation phase* is to stabilize the abstinence achieved in the detoxification phase and to put a definitive end to addiction. Rehabilitation therapies can be carried out in an outpatient, inpatient- or a day-patient setting. The standard therapy duration is six months.

The *integration and after-care phase* comprises, on the one hand, a "phase of assimilation", and, on the other, assisted living or other outpatient after-care measures. In the assimilation phase, individual therapeutic measures move into the background in favour of an outward orientation with a view to promote integration into work and society. In the integration phase, clients receive support from the special service departments of the job agencies as well as from the social security administration.

Data sources

Information on the characteristics and consumption patterns of clients in treatment is available from various sources.

Based on the German Core Data Set on the Documentation of Addiction Treatment (Deutscher Kerndatensatz, KDS), the German Statistical Report on Treatment Centres for Substance Use Disorders (Deutsche Suchthilfestatistik, DSHS) (Pfeiffer-Gerschel et al. 2011b) provides extensive data on outpatients from the large majority (2010: N=777; 2009: N=779) of the outpatient facilities funded by the *Laender* and municipalities. Since January 2007, most of the addiction aid facilities in Germany use the new Core Data Set (DHS 2008). Due to revisions made in connection with the introduction of the new Core Data Set, the results of the evaluations of the statistical report for the out- and inpatient facilities from 2007 onwards may only be cautiously set in relation to the data of the previous years (on the introduction of the new core data set see also REITOX Report 2008, chapter 4.3).

In the below reported DSHS-data from the year 2010, no facility was excluded due to too high a missing quota⁷² (>33%) – contrary to previous years – 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 data of 2010 with the ones of the years 2007 to 2009.

The “Treatment Demand Indicator (TDI)” of the EMCDDA is integrated in the Core Data Set. However, there are still divergences between the TDI and the Core Data Set because the German treatment system orients itself to the ICD-10 classification, which renders substance-based analyses difficult or impossible.

The DSHS is also a rich statistical source for data from the inpatient setting. N=189 (2009: N=157) facilities took part in the national evaluation 2010 of the DSHS (Pfeiffer-Gerschel et al. 2011e).

A lot of the larger, especially psychiatric clinics which also offer addiction-specific treatment are not represented in the DSHS. In order to fill these gaps as far as possible, two other sources were tapped for data on clients with addiction problems in inpatient therapy.

- The Statistical Report on Hospital Diagnoses, whose most recent data are available for the reporting year 2008 (Statistisches Bundesamt 2009a), documents the diagnoses on the discharge of all patients from inpatient facilities. Apart from the main diagnosis it also records age and gender. The Report of the Federal Statistical Office thus serves as an information basis for the data from the DSHS. Though complete, the Statistical Report on Hospital Diagnoses is not addiction-specific and offers little detailed information for the

⁷² By default, a facility-related missing quota of 33% or less is required for an inclusion in the overall evaluation for all tables with single choice questions. Facilities with a missing quota of more than 33% in such a table are not taken account of in the data merge in order to prevent that overall data quality is overproportionally impacted by few facilities with a high missing quota. Although this will inevitably lead to a reduction of the facility sample (N) for the respective table, this can be disregarded in the interpretation of the results due to the higher validity of the included data (Pfeiffer-Gerschel et al. 2010b).

area of interest. It does however allow a differentiation of the number of cases according to the ICD-classification (F10-F19). Apart from accounting information on services provided by hospitals, there is no systematic compilation of comprehensive statistical data on hospital treatments. However, general documentation standards do exist for example for psychiatric clinics or facilities for child or adolescent psychiatry. These contain information on the treatment of patients with addiction problems. So far, no systematic analysis has been carried out on the transfer of these data into the standard of the Core Data Set.

- The statistics from the German Statutory Pension Insurance (Deutsche Rentenversicherung, DRV 2011) document all cases for which the costs were borne by the pension insurer. However, the part of inpatient therapies which were acute treatments or which were financed by other sources, is missing.
- The distribution of main diagnoses in the two statistical reports is identical to a large extent, if one takes into account the substantially higher portion of undifferentiated diagnoses in respect of F19 (multiple substance use and consumption of other psychotropic substances) in the data recorded by the DRV.
- Since 1 July 2002, data on substitution therapy is recorded by the substitution register with the purpose to avoid double prescriptions of substitution drugs and to monitor the implementation of specific quality standards in therapy. The short-term use of substitution drugs in detoxification is not recorded by this register. For 2010, this data source provides information on the number and gender distribution of treated clients and on the substitution drugs used, complete with a list of names of the doctors in charge of therapy.
- Data from regional monitoring systems, can, insofar as they use the German Core Data Set, be compared to the federal data. Partly based on the original data and covering whole regions, these evaluations are a valuable complement to the national statistical reports.

As a result of the different data sources, it is more difficult to describe the profile of drug-addicted patients in treatment than of drug-addicted patients out of treatment. While it is necessary to use various sources at the same time, one needs to bear in mind that each source has a different type of selectivity.

Information on the characteristics of the treated drug users are to be found in standard table 3.

5.2 Strategy, policy

According to the facility register of the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (Deutschen Beobachtungsstelle fuer Drogen und Drogensucht (DBDD), that has been built up since 2006 with the support of the Federal ministry for Health, the charity organizations, the *Laender* and specialized drug treatment facilities (Suess & Pfeiffer-Gerschel 2009), there are about 1,300 specialized ambulatory addiction counselling facilities operating in Germany, in which notably substance-related

disorders are treated⁷³. In approximately 300 specialized hospital wards at least 7,500 beds are provided for people with substance use disorders. More than 190 facilities (>2,000 treatment slots) provide qualified withdrawal treatment (OPS 8-985). At least 320 facilities (>13,200 treatment slots) offer inpatient rehabilitation measures and more than 100 facilities (>1,000 treatment slots) daycare rehabilitation measures (including alcohol and other measures). These measures are complemented by more than 115 adaptation facilities (>1,200 therapy slots), 268 inpatient (>10,700 slots) and 112 daycare (>1,200 slots) social therapy facilities as well as by services provided in the area of assisted living (in at least 460 facilities >12,000 places) and more than 250 job and employment projects (>4,800 places) (Floeter & Pfeiffer-Gerschel 2011). The majority of the help facilities are independent non-profit organizations. Public and private providers can especially be found in the area of inpatient therapy.

Low-threshold and counselling services (approximately 300 facilities countrywide) are, for the most part, funded by the Federal Government. However, a relevant portion of the costs of outpatient facilities is borne by the legally and economically responsible providers themselves. Except for the therapeutic treatment, outpatient addiction support is, for the most part, voluntarily funded by the *Laender* and municipalities. However, the institutions have no legal claim to these funds.

Acute treatments of drug-related problems and withdrawal treatments are generally carried out in hospitals. The costs for this withdrawal phase are in general borne by the statutory health insurance. The main diagnosis for all patients treated in German hospitals is reported to the Federal Statistical Office which regularly publishes these data (Statistical Report on Hospital Diagnoses).

Rehabilitation is to stabilize long-term abstinence and to restore the earning capacity of the patient. Therefore, the costs of rehabilitation are generally borne by the statutory health insurers. These also decide on the type, scope and duration of the therapy. Statistical data on the services rendered are available from the social administration authorities.

The addiction departments of specialized psychiatric clinics and the psychiatric departments of general hospitals university clinics are - alongside the counselling and rehabilitation centres - the second mainstay of the addiction care system in Germany. In addition to low-threshold qualified withdrawal treatment, they also provide emergency care services, crisis intervention and treatment of comorbidity. Closely linked with these services are in-depth diagnostics and re-integration planning. In the addiction psychiatric facilities, all forms of addiction are treated either in an inpatient, outpatient or daycare setting by a multi-professional team. In this way, medical, psycho-social and psychotherapeutic care is guaranteed. Holding consultations and improving the cooperation with the addiction help system also form an integral part of the areas of work.

⁷³ This is an estimate of the total number of outpatient psycho-social counselling centres among which facilities that exclusively or primarily treat users of illicit drugs, represent a minority.

The data on the addicted patients treated in psychiatric facilities is currently incomplete. A survey is planned to be conducted in psychiatric hospitals, psychiatric departments of hospitals and university clinics in the year 2011. According to the extrapolation of the figures voluntarily documented by the specialized clinics, the inpatient addiction psychiatric facilities amount to approximately 300. These treat around 220,000 addicts in the course of one year. To be added are the approximately 100,000 quarterly treatments that are performed in a year by little less than 300 psychiatric institutional ambulatories⁷⁴ (quoted from: Die Drogenbeauftragte der Bundesregierung 2011).

A shift in treatment demand towards increasingly intensive treatment forms has been observed for a long time. Outpatient care of addicted people in psychiatric facilities has been strongly expanded especially through the set-up of psychiatric ambulatories in institutes tasked to carry out treatment for addicts.

At the local and regional level, psychiatric-psychotherapeutic facilities closely cooperate with the psychosocial counselling facilities and the out- and inpatient rehabilitation facilities. In some *Laender*, like for example in Baden-Wuerttemberg, well-structured help-networks for drug patients have meanwhile been established at a local level.

Except for a few specific cases, there is no legal funding basis provided by the Social Security Codes (SGB IV and XII) for the integration or after-care phase. Here, the legally and economically responsible bodies of the facilities have to resort to financing models tapping federal government budgets or budgets of the social security funds and job agencies.

5.3 Treatment systems

The German treatment system for people with drug-related problems or their relatives is – as described above – very elaborate ranging from institutions offering first low-threshold contacts over counselling services to intensive treatment and therapy in specialized inpatient facilities and a large offer of substitution treatments. Planning of the treatment demand in the various segments of the medical and/or social help system at a national level does however not match with the federal structure of the Federal Republic of Germany. Planning is done instead at *Laender* or community level.

A differentiation between drug-free and pharmacologically assisted treatment – especially substitution - is not very useful to describe the therapy system in Germany. The question as to whether psycho-social counselling facilities, which play a central role in the care for drug addicts, are to be assigned to drug-free or pharmacologically-assisted treatment, is problematic to answer especially in the case of psycho-social care provided within the framework of substitution programmes (with the exception of a few cases in which the counselling facilities themselves administer the substitution drugs). Generally, medical substitution treatment takes place outside of the counselling facilities. Psychosocial care or therapy, by contrast, take place in the counselling facilities and are thus, per se, neither

⁷⁴ www.psychiatrie.de/apk/veroeffentlichungen

obligated to a drug-free nor a medication-assisted approach.

There is also a host of self-help organisations working in parallel or cooperating with professional help services in the area of addiction. So far however, they have mostly been addressed to alcohol addicts and older target groups.

5.3.1 Organisation and quality assurance

Organisation

Contact, motivation and outpatient treatment are mainly offered by outpatient counselling facilities; withdrawal treatments/detoxifications are for the most part done in general hospitals but also in a few specialized clinics (often in the psychiatric ward). In the withdrawal treatment of opioid addicts, methadone and buprenorphine are, among others, temporarily used to reduce negative concomitant symptoms. Because of minimal side effects and less severe withdrawal symptoms the latter finds increasing usage. Statistical data on this type of treatment are not available in a differentiated form. However, the cases are contained in the Statistical Report on Hospital Diagnoses.

Outpatient counselling facilities are the first place of call for drug users insofar as their drug problems are not treated by primary care, i.e. generally speaking by office-based doctors. In most cases, counselling is free of charge. The facilities are mainly funded by the municipalities and *Laender* as well as by their, non-inconsiderable, own resources (donations, church taxes, etc.).

If drug problems and concomitant symptoms are too problematic, consequences too massive and the general situation for the drug addict himself and his environment too stressful, the patient will be admitted to inpatient therapy. However, the transfer from outpatient to inpatient therapy is associated with some administrative effort and it needs to be clarified who will take over the costs for inpatient therapy (generally the statutory pension insurance fund, patients without employment are subject to other regulations). In some cases, inpatient therapy does not suit the client's situation - if for example existing employment would be jeopardized or no adequate care for the children of an addicted mother can be found. The transfer from outpatient to inpatient care also has the effect of a filter mechanism. Patients in inpatient therapy do not only differ from outpatient ones in the severity of the addiction problem but also in the gender distribution.

Withdrawal treatments are carried out by specialized clinics or therapeutic communities. In the integration and after-care phase, a varied offer specifically geared to the needs of the clients is made with regard to employment, housing and re-integration into society. All fields of work are staffed with specialists who, for a major part, have received work-field-specific supplementary training. All offers made aim at stabilizing abstinence from drugs.

Since 2001, drug-maintenance therapy is regulated in detail by the Narcotics Law and is meanwhile a medically fully recognized treatment form. Substitution therapy has been part of the standard treatment of opioid addicts for many years. This treatment offer reaches a large

number of drug addicts and has proven to produce beneficial effects on the psychological and physical well-being of the patients within the framework of numerous studies (Michels et al. 2007). The recently published results of a study conducted by Wittchen and colleagues (2008a) underline again the effectiveness of various types of substitution treatments with methadone and buprenorphine and show a retention quote of the patients undergoing substitution treatment that is comparable to the results of controlled clinical studies. Co-consumption (especially of cannabis and benzodiazepines as well as of opioids and cocaine) is in many cases the decisive factor for dropping out of therapy or other complications occurring during therapy. Patients in long-term substitution therapy appear furthermore to be a group of patients subject to an extremely high level of distress caused by somatic and psychological disorders.

The state of the art in opiate substitution treatment (OST) has already been established in 2002 by the guidelines passed by the German Medical Association (Bundesärztekammer, BÄK). In 2010, a revised version of the guidelines was presented by the BÄK (cf. also chapters 1.2.2, 5.5.2 and chapter 11 of the REITOX Report 2010). In 2003, OST was acknowledged by the statutory health insurance without any qualification as a SHI-accredited care service to be borne by the SHI. Substances eligible for substitution therapy in Germany are levomethadone, methadone and buprenorphine. Codeine and DHC can only be prescribed in exceptional cases for this type of treatment. In July 2009, legal provisions were also passed on diamorphine-based substitution (cf. chapter 1.2.2 in the REITOX Report 2009).

The majority of substituted patients are treated by office-based doctors or in specialized ambulatories. Doctors carrying out substitution therapy need to be qualified in addiction medicine. If they do not have this additional qualification they may treat up to three patients under supervision of a colleague. Meanwhile, a few inpatient facilities have started to accept patients for opiate substitution therapy.

In the current discussion on opiate substitution therapy, that is firmly established in the care system, the question as to what goals are to be pursued by drug-related therapy continues to play an important role. The success criteria diverge indeed with the perspective adopted by the viewer. The reduction of co-consumption of other psychotropic substances can be rated as much a success as the (long-term) termination of opioid dependence or the successful treatment of other (somatic and psychological) disorders.

Psychosocial care has been established as a part of OST by the Regulations on the Prescription of Narcotic Drugs and the guidelines passed by the Common Federal Committee and the National Medical Association in so far as it is regarded "necessary". As a result of diverging interpretations of psychosocial care in the *Laender* and communities, psychosocial care is at national level subject to great variations in terms of organisation, funding and treatment offer.

The revised guidelines of the German Medical Association of 2010 (BÄK 2010) concretize type and scope of psychosocial care noting that the provision and integration of measures

suitable to eliminate psychosocial problems is mandatory for the treatment of opiate addiction. The guidelines furthermore underline the necessity of coordinating psychosocial care and medical care (see also chapter 1.2.2 and 5.5.2 of the REITOX Report 2010).

It was confirmed by a judgement of the Hamburg Administrative Court in April 2008 that there is a legal claim to the service of necessary psychosocial counselling/care for substitution patients (provided the necessary preconditions according to SGB XII are fulfilled) to be provided by the local social administration authorities.

The status of integration between general health care and special drug care nationwide is still rather dissatisfying. At regional level however, cooperation and coordination of the offers are clearly better. Any attempt to give an overview of the care situation in Germany is associated with major problems as a result of the diverging goals and the regional differences they bring about.

Quality assurance

Various professional societies and experts have worked together over the last years to develop guidelines for the treatment of drug dependence and addiction problems (see also chapter 11 of the REITOX Report 2010). These publications are a condensed summary of the current state of knowledge and provide practical guidance for carrying out treatments under consideration of the quality of the empirical basis for the individual statements. Meanwhile, guidelines have been published for the acute treatment of opioid-related disorders (Reymann et al. 2002), for the post-acute treatment of opioid addicts (Havemann-Reinicke et al. 2006), for patients with cannabis-related disorders (Bonnet et al. 2006) as well as behavioural disorders caused by cocaine, amphetamines, ecstasy and hallucinogens (Thomasius & Gouzoulis-Mayfrank 2004). In the year 2006, the Working Group of the Scientific Medical Professional Societies (Arbeitsgemeinschaft der medizinisch-wissenschaftlichen Fachgesellschaften, AWMF) published the AWMF-guidelines on the diagnostics and therapy of substance-related disorders under the title "Evidence-based addiction medicine – treatment guide for substance-related disorders" (Evidenzbasierte Suchtmedizin – Behandlungsleitlinie substanzbezogene Störungen). The evidence-based guidelines are to make treatment of drug addicts more transparent and de-emotionalize the scientific controversies over the most efficient therapy approaches (Schmidt et al. (ed.) 2006).

At a consensus conference held in 2006, the guidelines of the German Society for Addiction Medicine (Deutschen Gesellschaft fuer Suchtmedizin, DGS e.V.) for the therapy of chronic hepatitis C in injecting substance users were passed (Backmund et al. 2006).

Moreover, the revised version of the S3-Guideline of 2004 on „Prophylaxis, diagnostics and therapy of the Hepatitis-C-virus (HCV)-Infection, AWMF-Register No. 021/012" of the German Society for Digestion and Metabolic Diseases (DGVS) was published in 2010 (Sarrazin et al. 2010) (see also chapter 7.3 of the REITOX Report 2010).

Addiction therapy may only be provided by adequately skilled staff with work-field-specific

supplementary training. In this context, the German Pension Insurance Fund has passed guidelines for the supplementary training of therapy staff working in individual and group therapy within the framework of medical rehabilitation of drug addicts, serving as a “recommendation for the acknowledgement” of the respective advanced training courses. As part of the restructuring of the university education system in Germany according to European standards (introduction of Master and Bachelor programmes at universities and technical colleges) work specifications for therapeutic staff in addiction aid have to be newly developed and defined. At present, a lot of university or college courses are restructured in Germany and in many other European countries. In the meantime, it has already become possible to do a post-graduate course and earn a Master’s degree (Master of Science) in substance abuse and addiction counselling. In the restructuring of the courses for social workers, psychologists and medical staff in the area of addiction aid, post-graduate education plays a very important role.

Cooperation between different professional groups from social work/education, psychology, psychiatry and other medical fields forms an integral part of the addiction treatment standards. As for outpatient offers (outpatient treatment centres and others), quality assurance and technical monitoring are mainly in the hands of the supporting organs of the facilities or respectively of the *Laender* and municipalities. The responsibility for detoxification and rehabilitation however lies with the respective insurance carriers (statutory health and pension insurance organizations). With also outpatient treatment offers being increasingly funded by social security administration, the abovementioned standards have also gained in importance in this setting, especially in the area of alcohol, but not so much with regard to drugs. In many *Laender*, cooperation between the different fields of work and organizations is promoted by *Laender*-financed institutions.

Rumpf and Kiefer (2011) recently presented the changes to the addiction area in the draft released by the American Psychiatric Association (APA) for the fifth edition of the classification system “Diagnostic and Statistical Manual of Mental Disorders (DSM)“. According to the draft, the former category “substance use disorder“ will be replaced by the term “addictions and related disorders“. Both substance-related and non-substance-related disorders will be subsumed under this new category. Pathological gambling was added to the classification system as the first non-substance-related disorder. Another far-reaching change is that the differentiation between abuse and dependence was given up in order to define a substance use order instead. The authors prognosticate that the elimination of the terms “dependence“ and “abuse“ that are firmly embedded in general language usage and in the everyday work of addiction care will be odd, but will hold a chance of developing views and therapeutic approaches further.

In March 2011, the Bavarian Land Medical Association set up a Quality Assurance Commission for Substitution Consultation whose task is to provide consultancy for substituting doctors and assure quality of treatment. The commission advises substituting doctors on all aspects and problems related to substitution assisted treatment as well as substituting doctors providing consultation or working as locum tenens for the originally

substituting doctors who are absent and cannot be contacted. The commission moreover defines criteria for quality assurance in substitution assisted treatment and its assessment assuring the provision of a second opinion on clients in diamorphine-assisted therapy by a qualified doctor after two years. The commission also strives for a close cooperation with the quality assurance commission of the Association of SHI-Accredited Physicians of Bavaria and has announced its intention to consult representatives of the drug help system or other experts in case corresponding questions arise (Bayerische Landesärztekammer 2011).

In 2011, the World Federation of Societies of Biological Psychiatry (WFSBP) presented the evidence-based guidelines for the pharmacological treatment of opiate dependence and abuse. The data used for developing the guidelines are mainly based on the national treatment guidelines as well as on meta-analyses, reviews and publications of randomized controlled clinical studies. Based on a sufficiently high number of qualitative data, it was possible to formulate a series of medical treatment approaches on the treatment of opiate dependence and abuse. This applies in particular to the opiate agonists methadone and buprenorphine (Soyka et al. 2011).

Lindow and colleagues (2011) recently reported on current developments in rehabilitation quality assurance. According to the authors, the basis for quality assurance is formed by regular facility-related reporting. As an important goal of quality assurance the authors mention – alongside transparency and improvement – the reduction of the empirical and plausible variance between the different facilities. In this connection, new quality assurance instruments and methods continually expand the spectrum of existing quality aspects. Applying the concept of quality assessment of rehabilitation facilities to as many quality assurance instruments as possible, creates, according to the authors, transparency and promotes fair comparisons between the facilities. In an expert paper, Korsukéwitz (2010) underlines the necessity of further developing addiction rehabilitation. The changes in use patterns, the appearance of new substances or non-substance-related behavioural disorders as well as scientific findings on prevention, diagnostics, treatment and after care transform the treatment offer of therapeutic facilities. The author stresses the necessity of setting up special services in the area of rehabilitation in order to have the possibility of therapeutically treating specific topics but also to build up skills on the part of the staff. The author points out that it is important in this context that these developments support the overall system and that the experience currently made in certain specialized clinics are widely transferred. According to the author, addiction help also plays an important role in the area of the social services and the health system and should be used in fields where care deficits currently impede the timely recognition and treatment of addictive diseases.

In an expert paper, Lindenmeyer (2010) points to the fact that, contrary to the trend of standardized allocation rules, the question as to which treatment is appropriate and necessary for which patients still needs to be regarded as unanswered. According to the author, all attempts undertaken so far to simplify and standardize allocation are, at least empirically, not sufficiently substantiated. So far, these attempts did not possess sufficient evidence and failed to consider important conditions. Lindenmeyer concludes that at the

present there is no empirical basis for transferring standardized allocation procedures into the German addiction help system. According to the author, the qualitatively best allocation decision is for the time being that treater and patient take a decision together in the individual case taking into account the individual treatment needs, the treatment resources that are available in a timely manner and the desire of the patient for a change.

5.3.2 Availability and diversification of treatment

Planning of the treatment demand in the various segments of the medical and/or social help system at a national level does not match with the federal structure of the Federal Republic of Germany. Planning is done instead at *Laender* or community level. A detailed presentation of the generally available treatment forms has already been given above (see chapters 5.1, 5.2 and 5.3.1) and shall not be repeated here. With regard to the availability of treatment and help offers, there are differences to be found between the *Laender*. For example, not all *Laender* offer consumption rooms as an element of harm reduction measures. It has moreover repeatedly been reported that there are difficulties in providing region-wide care for patients who would like to undergo substitution treatment in rural areas (in particular in the eastern *Laender*).

All in all, the situation with regard to the help offers made has not much changed recently. The only partially existing legal basis for the funding of outpatient services continues to lead to financing problems. The municipalities that provide the funds for most of these services are struggling with extremely tight budgets. Since the municipalities are not legally obliged to provide funds for outpatient addiction support, a lot of offers are cut down at various locations. At the same time however, facilities have started to engage in a professionalization of their operational and technical procedures.

Based on the data from the German statistical report on treatment centres for substance use disorders (Deutsche Suchthilfestatistik, DSHS), Hildebrand and colleagues (2009) reported estimates of the quota of drug users reached by out- and inpatient addiction help facilities. According to these estimates, the specialized addiction help system is able to reach between 45% and 60% of the estimated persons with harmful use or opioid dependence but only between approximately 4% and 8% of the cannabis users. The information on the availability of treatment can be found in standard table 24.

The offers made by counselling and treatment facilities are, especially in the outpatient setting, not exclusively limited to users of specific substance groups. The large majority of the therapy services provided by specialized drug aid facilities are related to primary alcohol problems (approximately half of the outpatient therapies documented within the framework of the DSHS and about three quarters of the treatment episodes in the inpatient setting with specialized treatment facilities). But also people with problems related to the use of illicit drugs and other disorders (e.g. eating disorders, pathological gambling, tobacco dependence) are treated. Correspondingly, most of the facilities hold offers in readiness for very different user groups, taking into account not only substance-specific aspects but also a series of psychological, social and health aspects that are – irrespective of the respective

substance involved – in part associated with certain periods of life or age groups (e.g. adolescents and young adults, pregnant women and elderly users). There exist very different counselling and treatment concepts within the framework of person-centred addiction help. One task of the addiction help facilities is to define very different problem fields with the respective counselling and treatment needs together with different intervention goals. The underlying broad conception of treatment comprises various forms of intervention in very different areas and denotes the reduction or cessation of substance use and the combat against associated problems as equally valid therapy goals. Such an understanding of intervention can be transferred to the treatment of all substance-related problems and all types of addictive diseases (DHS 2001).

Given the significant increase in the prevalences of cannabis use especially at the end of 90s of the last century (until about 2003), a series of studies and projects dedicated to the development of specific intervention concepts for cannabis users under various framework conditions were launched. Many of these projects (e.g. “realize it!”⁷⁵, INCANT⁷⁶, CANDIS⁷⁷, CAN stop⁷⁸, AVerCa⁷⁹ or “Quit the shit”⁸⁰) were already presented in the REITOX Reports of last years. Although all projects have (problematic) cannabis use as a starting point for intervention, some of them are very complex programmes whose goals go far beyond the goal of abstinence or use reduction.

Diamorphine-assisted therapy, addressed to the group of heavily dependent opioid users, is also a further development of an intervention that primarily defines itself over the disorder-relevant main substance, but which is linked to a series of psychosocial and health interventions.

Even though current intervention studies on other substance groups (e.g. stimulants, cocaine, LSD) are not available to a comparable extent, addiction aid facilities do offer well-founded, professional support to these substance users as well. Treatment guidelines do not only exist for opioid and cannabis-related disorders but also for psychological and behavioural disorders caused by cocaine, amphetamines, ecstasy and hallucinogens (see also the Selected Issue of the REITOX Report 2010 on the development, methods and implementation of national treatment guidelines).

In the following, findings of recent intervention studies are presented. Grouped by subjects, they are to give an overview of the current developments in treatment. The structuring of the presentation is not only oriented by the substance for which the intervention is carried out but also by certain target groups that are – irrespective of the individual substance used - in need of specific interventions.

⁷⁵ www.realize-it.org/

⁷⁶ www.incant.eu

⁷⁷ www.candis-projekt.de/

⁷⁸ www.canstop.med.uni-rostock.de/

⁷⁹ www.averca.de/

⁸⁰ www.drugcom.de/

Interventions for cannabis users

The findings Hoch and colleagues (2011) recently published the findings of the CANDIS study conducted on the treatment of cannabis-related disorders as an example of transnational research that was already presented in detail in last years' REITOX reports⁸¹. According to the authors the experience made within the framework of the study shows that it is possible to implement a pretentious plan to test the effectiveness of therapeutic interventions also in care institutions. It could be demonstrated furthermore that transfer questions with regard to adequacy, feasibility and acceptance of a therapy programme can be integrated into a scientific test concept (for the description of the CANDIS- Programmes see the REITOX Reports 2009 and 2010). In another transfer study conducted on CANDIS, Hoch and colleagues (2010) arrive at the conclusion that the findings demonstrate that the CANDIS therapy can be implemented in the outpatient addiction help system under the current treatment and framework conditions of existing facilities and that it can contribute to a significant improvement of cannabis disorders. The authors underline the importance of conducting analyses in the future to find out which other patient features correlate with a successful therapy outcome and which patients possibly need other treatment programmes.

Within the framework of the multicentre study Can Stop, which was already presented in the last Reitox Reports, Weymann and colleague (2011) investigated possible trainer effects in a group training for young cannabis users. The authors investigated the question in how far the intervention outcome can be predicted from trainer features and aspects related to the matching of trainer and patient variables. According to the findings of the study, the age of the trainer is a significant predictor for the chosen outcome criteria. As regards the reduction of symptoms, disagreement on the training goals (abstinence versus controlled use) between trainers and patients at the beginning of the intervention has a certain predictive value. According to the authors, the findings suggest that trainer variables play a role and that the inclusion of trainer and matching variables in the analysis of studies on the effectiveness of interventions may expand the understanding of working processes.

Dau and colleagues (2011) recently presented the results of a short intervention in the inpatient treatment of users of cannabis or party drugs that requires only a daily time investment of five minutes. They took an especially close look at the effectiveness of the short intervention as regards the depressive symptoms and the special needs of the patient group⁸². The authors conclude that the short intervention method represents an effective

⁸¹ In the first phase of the two-phase test concept, a manualized treatment programme for teenagers (>=16 years) and adults with cannabis disorders was developed and tested in the framework of a randomized controlled effectiveness study with N=97 participants. In the second phase, a multiphase, multicenter randomized controlled transfer study was conducted in N=11 outpatient addiction help facilities. Effectiveness, feasibility and acceptance were assessed in a sample of N=279 patients. The two phase concept could be implemented between 2004 and 2009 as an example of targeted transnational research on the application of fundamental intervention principles in a practice-relevant therapy programme.

⁸² To this purpose, N=104 patients aged 23 years, out of them 66 cannabis and 21 party drug users, undergoing inpatient treatment, were surveyed by means of standardized questionnaires and interviews in a quasi experimental design.

additional treatment in the inpatient setting. They found medium effect sizes for interpersonal problems and psychological distress.

In the year 2003, five European countries agreed to scientifically evaluate the effectiveness of the multidimensional family therapy (MDFT) for young cannabis users – which is an established therapy form in the USA - for the European territory within the framework of INCANT (see also the REITOX Reports of the last years). In a recently published study based on the data of INCANT, Phan and colleagues point to the relevance of the heterogeneity of the national treatment setting that is reflected by the in part significantly diverging study populations or treatment admissions (Phan et al. 2011).

Interventions in migrants

In a recently published contribution, Boehme and colleagues (2010) highlight the peculiarities of the inpatient treatment of addicted migrants from the Russian language territory. The authors differentiate between two sub-groups: migrants who had engaged in substance abuse while being fully socially integrated in their country of origin or who already suffered from addiction, migrants who already had psychological and social problems in their country of origin and wanted to achieve a solution to their problems with the migration. The authors state that each institution wanting to work with migrants needs in a first step to identify its own access barriers. They point out that migrants need treatment concepts that take account of their different socialization, their different disease concepts and family backgrounds. In this context, the use of the mother tongue plays an important role in the everyday treatment. However, the integration of the family into the treatment turns out to be difficult. According to the authors, there is a lack of a network of complementary institutions notably for migrants from the Russian language territory.

Specka and colleagues investigated the results of opiate detoxification treatments in relationship to the migration status of the patients⁸³. The authors observed significant differences between the groups in terms of sociodemographic data, history of drug use, treatment experience and response to current treatment. Irrespective of the migration status, young men turned out to be the most relevant problem group after the correction of the „age“ factor. Qualifyingly, the authors added that in this multicentre study significant effects of the study centres were observed that rendered the interpretation of the findings difficult (Specka et al. 2010).

5.4 Characteristics of treated clients

5.4.1 Outpatient treatment

The data presented in the following are based on the detailed data of the table volumes published within the framework of the German Statistical Report on Treatment Centres for Substance Use Disorders (Deutsche Suchthilfestatistik, DSHS) of the year 2010 (Pfeiffer-

⁸³ The study comprised N=893 patients. Among these were n=653 German patients, n=58 patients of Turkish descent and n=103 patients of Russian descent.

Gerschel et al. 2011a,b). The data used in the presentation are taken from the partial evaluation of outpatient counselling and treatment. The tables presented hereunder also contain references to the corresponding tables of the TDI. Detailed information on the variables of the treatment demand indicator (TDI) can be found in standard table 3. The presented tables include references to the relevant TDI tables. Information on clients undergoing treatment or receiving counselling while in prison and information on clients of low-threshold facilities is contained in chapters 11.3.1.

In the year 2010, data of a total of 314,083 therapies (without one-off contacts) carried out in N=777 outpatient facilities were collected within the framework of the DSHS. For this REITOX Report only data from clients primarily treated for illicit substance use (including sedatives/hypnotics and volatile solvents) were taken into account (patients treated primarily for alcohol-induced disorders accounted alone for 55% of all recorded cases in 2010).

Diagnostic data

For the year 2010, the German Statistical Report on Treatment Centres for Substance Use Disorders contains data on the main diagnoses of a total of 60,473 treatments from N=776 facilities that were started or completed in outpatient psychosocial addiction support centres because of problems with illicit drugs. The main diagnoses are based on the diagnostic categories of the international classification system of the WHO (ICD 10) for disorders caused by psychotropic substances (harmful use or dependence).

When looking at the DSHS data and confining oneself to illicit substances, one finds that meanwhile less than half of the clients (46.3%; 2009: 47.5%) sought treatment or counselling primarily for dependence on or harmful use of opioids⁸⁴. The portion of persons primarily treated for disorders in connection with the use of opioids has been on a continual decline since 2007. In more than a third of the cases (35.6%; 2009: 35.4%), clients were treated for primary cannabis problems. After having increased over the last years, this portion has stabilized. On the rise is the portion of clients who receive counselling and treatment because of problems connected to the use of stimulants (8.2%; 2009: 6.6%). The comparative values for cocaine (5.9%; 2009: 6.3%) and other substances practically remained unchanged in comparison with the previous year.

⁸⁴ The portions presented hereinafter were calculated on the basis of the values given by the TDI-tables 14.1.1 (all clients treated) and 14.1.2 (first clients) set up for the outpatient treatment centres for substance use disorders.

Table 5.1 Main diagnosis in outpatient therapy (DSHS outpatient data, 2010)

Main diagnosis harmful use/addiction ... (ICD10: F1x.1/F1x.2x)	All persons treated ¹⁾			Persons treated for the first time		
	Males ²⁾	Females ²⁾	Total ²⁾	Males ²⁾	Females ²⁾	Total ²⁾
Opioids	44.6%	52.7%	46.2%	16.6%	22.9%	17.7%
Cannabinoids	38.6%	24.2%	35.6%	63.6%	43.6%	59.8%
Sedatives/Hypnotics	1.1%	6.2%	2.2%	1.0%	7.0%	2.1%
Cocaine	6.3%	4.4%	5.9%	6.8%	5.9%	6.6%
Stimulants	7.7%	10.3%	8.2%	11.1%	18.6%	12.5%
Hallucinogenics	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%
Volatile substances	0.1%	0.2%	0.1%	0.1%	0.4%	0.2%
Multiple/other substances	1.4%	1.8%	1.5%	0.7%	1.6%	0.9%
Total (N)	47,984	12,414	60,398	12,053	2,781	14,834

1) All persons treated are in this case all patients newly admitted and patients who completed therapy in the reporting year.

2) The columns correspond to the categorisation of the TDI-tables: all patients treated: 12.1.1, 13.1.1, 14.1.1, patients treated for the first time: 12.1.2, 13.1.2 and 14.1.2.

Pfeiffer-Gerschel et al. 2011a,b.

Among the persons who underwent addiction therapy for the first time, cannabis clearly led the league with a nearly unchanged share in all substances (59.8%; 2009: 61.0% of all clients) and was followed at a clear distance by the portion of clients treated for opioids for the first time. Their portion continued to decline (17.7%; 2009: 18.3%), whereas the portion of users of stimulants (12.5%; 2009: 10.2%) increased (Table 5.1). The portion of persons with cocaine-related disorders declined also among the patients treated for the first time in comparison with the previous year (6.6%; 2009: 7.2%). The portions of all other substance groups practically remained unchanged in respect of the previous year.

Secondary addiction diagnoses made in addition to the main diagnosis are relatively common. Out of the clients with primary opioid-related problems⁸⁵ about one in four (24.3%) also displayed an alcohol-related disorder (dependence or harmful use) or a disorder in connection with the use of cocaine (20.6%) (Table 5.2) in 2010. Dependence on or harmful use of cannabis continued to represent the most common non-opioid secondary diagnosis in this patient group (31.8%).

Among clients with primary cocaine-related problems⁸⁶, cannabis, alcohol, amphetamines and ecstasy played a dominant role as substance-related secondary diagnoses. As in

⁸⁵ TDI-table 24.1.1; all subsequent data on clients with primary opioid-related problems are referred to a total number of N=22,355. A direct calculation of a total number from the TDI-tables is not possible since several entries are possible for the additional substance related diagnoses.

⁸⁶ TDI-Tabelle 24.1.1; referred to a total number of N=2.297.

previous years, almost one client in ten with a primary cocaine diagnosis additionally fulfilled the diagnostic criteria of a heroin-related disorder (10.8%).

Almost one in five of the clients with primary cannabis-related problems⁸⁷ also displayed harmful use of or dependence on amphetamines (19.1%). More than one client in ten with a cannabis-related main diagnosis showed also harmful use of or dependence on cocaine (10.1%). More than a quarter of the clients with a primary disorder caused by the use of cannabinoids also fulfilled the diagnostic criteria of an alcohol-related disorder.

Seen across the board of all substances, approximately more than a quarter of the clients had a disorder caused by the use of alcohol in addition to the primary reason for treatment admission (Pfeiffer-Gerschel et al. 2011b).

Table 5.2 Main diagnosis and additional substance-related diagnosis (DSHS outpatient data, 2010)

Single diagnosis ¹⁾	Main diagnosis				
	Opioids	Cannabinoids	Sed./Hypn.	Cocaine	Stimulants
Alcohol	24.3%	25.8%	34.2%	32.7%	27.9%
Heroin	85.7%	2.8%	5.9%	10.8%	4.7%
Methadone	37.4%	0.4%	1.7%	1.9%	0.5%
Buprenorphine	8.1%	0.3%	0.9%	0.4%	0.5%
Other opiates	10.3%	0.5%	4.5%	1.1%	0.8%
Cannabinoids	31.8%	99.9%	10.1%	43.6%	50.2%
Benzodiazepines	13.6%	1.1%	70.5%	3.2%	2.2%
Other sedatives/hypnotics	0.5%	0.2%	21.6%	0.4%	0.5%
Cocaine	20.6%	10.1%	4.7%	94.2%	14.4%
Crack	1.6%	0.3%	0.2%	6.3%	0.5%
Amphetamine	9.1%	19.1%	5.3%	20.2%	85.2%
MDMA	4.7%	7.0%	2.9%	10.2%	20.9%
Other Stimulants	0.5%	1.5%	1.2%	1.5%	13.9%
LSD	3.1%	2.7%	1.4%	3.9%	5.3%
Total (N)	22,355	17,202	1,151	2,297	4,482

1) Multiple entries possible.

The data correspond with the TDI-table 24.1.1.

Pfeiffer-Gerschel et al. 2011b.

⁸⁷ TDI-Tabelle 24.1.1; related to a total number of N=17.202 (main diagnosis: cannabinoids).

Socio-demographic information, consumption patterns and treatment duration

In 2010, 79.4%⁸⁸ (2009: 79.8%) of all outpatient clients N=60,473⁸⁹ with drug problems recorded within the framework of the German Statistical Report on Treatment Centres for Substance Use Disorders were male. 53.5% (2009: 54.8%) of all treated patients were between 15 and 29 years of age⁹⁰. 82.8% (2009: 84.1%) of them were of German nationality, 2.9% (2009: 3.0%) were from other countries of the European Union, 8.3% (2009: 8.5%) from non-EU countries such as Turkey or the former Soviet Union (unknown nationality: 6.0%). Since living conditions of the clients vary considerably depending on the main diagnosis or the drugs used, the characteristics presented in Table 5.3 are broken down by main drugs.

Further information can be found in standard tables 8 and 9 as well as in the TDI-tables.

Table 5.3 Socio-demographic data broken down by main drug (DSHS outpatient data, 2010)

Characteristics	Main diagnosis				
	Opioids	Cannabinoids	Cocaine	Stimulants	
Years of age when starting treatment (m) ¹⁾	34.5	24.3	31.9	26.5	
Years of age at first drug use (m) ²⁾	21.0	15.2	21.5	17.9	
Gender (ratio males) ³⁾	76.6%	86.0%	84.6%	74.2%	
Living alone ⁴⁾	51.7%	59.0%	43.5%	53.9%	
Working situation ⁵⁾					
	<i>without work</i>	63.6%	37.6%	39.7%	45.4%
	<i>in school/education</i>	3.1%	28.9%	6.4%	14.5%
Homeless ⁶⁾	2.5%	0.8%	1.0%	1.2%	

1) TDI-table 6.1.1 for data on all persons (not broken down by main drug)

2) TDI- table 23.1.1 for data on all persons (not broken down by main drug)

3) TDI- table: 12.1.1, 13.1.1 and 14.1.1 (for corresponding data)

4) TDI- table 7.1.1 for data on all persons (not broken down by main drug)

5) TDI- table 9.1.1 for data on all persons (not broken down by main drug); on the day before the start of therapy

6) TDI- table 8.1.1 on the stability of the life situation (no directly corresponding data): on the day before the start of therapy

Pfeiffer-Gerschel et al. 2011b.

Table 5.4 shows the most common use pattern for various substances. Heroin continues to be mainly injected by more than half of the clients; however, intravenous use of heroin has been on the decline since 2003, yielding to smoking (in 2003, heroin was still injected in two thirds of all cases). Injecting use was also found in every fifth cocaine user. All other

⁸⁸ TDI-Tabellen 12.1.1, 13.1.1 und 14.1.1

⁸⁹ For whom data on the gender and main diagnosis were available.

⁹⁰ TDI-Tabelle 14.1.1

substances are mainly orally consumed, sniffed (especially cocaine) or smoked (especially crack). The most diversified use pattern was found for amphetamines.

Table 5.4 Drug administration routes (DSHS outpatient data, 2010)

Substance	Form of application					Total
	Injection	Smoking	Oral	Inhalation	Other	
Heroin	57.8%	26.8%	5.1%	9.9%	0.5%	18,546
Methadone	2.8%	1.7%	94.2%	0.5%	0.7%	9,083
Buprenorphine	3.8%	2.4%	82.8%	7.3%	3.7%	1,812
Other Opioids	14.1%	9.7%	68.8%	3.8%	3.7%	2,334
Cocaine	19.1%	20.1%	1.2%	58.6%	0.9%	9,854
Crack	8.5%	77.8%	1.3%	10.2%	2.2%	1,337
Amphetamines	1.4%	10.5%	32.4%	53.8%	2.0%	9,574

1) Multiple entries possible.

2) TDI-table 17.1 (exception: TDI does not differentiate between buprenorphine and other opiates).

Pfeiffer-Gerschel et al. 2011b.

The DSHS also contains some basic data on the therapy intensity. The average number of contacts during therapy was the highest for opiate clients amounting to 21.8 (2009: 21.3) and the lowest for cannabis clients amounting to 9.8⁹¹ (2009: 10.0). Women who receive counselling or treatment because of substance-related problems apart from sedatives/hypnotics, generally have more contacts than men with comparable main diagnoses (Table 5.5). The average treatment duration corresponds in its distribution to the contact figures. On average, opioid clients have the longest treatment duration and cannabis clients the shortest⁹². Women generally have shorter (or only slightly longer⁹³) treatment durations in all substance categories than men despite of the higher contact figures. This is an indication of a higher treatment and counselling intensity in women.

⁹¹ The value is even lower in clients with primary problems in connection with hallucinogens; however, since the absolute case figure of the group is very small (n=66), no comparison was made here.

⁹² Clients with disorders caused by the use of volatile solvents are not taken into account because of the low case figure (n=42).

⁹³ Exception: opioids.

Table 5.5 Number of contacts and treatment duration (DSHS outpatient data, 2010)

Main diagnosis	Number of contacts (m)			Duration of treatment (m) ¹⁾		
	Males	Females	Total	Males	Females	Total
Opioids	21.2	23.9	21.8	47.2	55.4	49.0
Cannabinoids	9.4	12.0	9.8	26.1	26.8	26.2
Sedatives/Hypnotics	13.5	15.1	14.4	33.1	31.3	32.1
Cocaine	13.6	15.0	13.8	32.8	32.5	32.8
Stimulants	11.1	13.5	11.7	30.3	31.8	30.7
Hallucinogenics	12.7	34.7	18.0	33.1	48.0	37.1
Volatile substances	83.0	8.9	46.0	62.0	29.6	48.1
Mult./other substances	16.4	22.9	17.8	37.8	44.7	39.5

1) in weeks.

Pfeiffer-Gerschel et al. 2011b.

5.4.2 Inpatient treatment

In general, inpatient treatment in Germany is carried out under drug-free conditions. Since documentation standards discriminate by type of funding and not by type of treatment, all inpatient treatments carried out for persons with main diagnoses F11-F16 or F18-F19 are presented in the following, discriminating between acute hospital treatment (statistical report on hospital diagnoses) and rehabilitation therapy (statistical report of the German Statutory Health Insurance Scheme). There is moreover data available from the DSHS that provides information on some of the specialized clinics and facilities based on the Core Data Set.

Diagnostic data

Out of the total of 44,873 inpatients with substance-related disorders documented by the Statistical Report on Treatment Centres for Substance Use Disorders (Deutsche Suchthilfestatistik, DSHS) in the year 2010, 8,746 were treated for illicit substances (including sedatives/hypnotics and volatile solvents) (Pfeiffer-Gerschel et al. 2011e, f). Among them were 6,818 males, this corresponds to a male portion of 78.0% (2009: 89.8%). In three quarter of the cases (75.2%), alcohol-related reasons were the primary reason for inpatient therapy (29,569 therapies; 2009: 25,103). Only completed treatments were recorded. In the inpatient setting too, the main diagnoses are based on the diagnostic categories of the international classification system of the WHO.

According to the data recorded within the framework of the DSHS, clients with a main diagnosis based on dependence on or harmful use of opioids (without main diagnosis alcohol) still represent the largest single group in the inpatient setting (38.3%; 2009:

40.0%)⁹⁴. This portion has been on the decline since 2007 (48.6%). The second largest group is formed by clients with disorders caused by cannabis use (25.5%; 2009: 23.8%), whose portion has been continually increasing since 2007. Then follow patients with poly-drug use (15.0%; 2009: 14.9%). Their portion too, was found to increase over four years. Problems in connection with cocaine or stimulants were in 6.8% (2009: 8.1%) or respectively 9.7% (2009: 9.0%) of the cases the primary reason for treatment (Table 5.6).

Ahead of poly-drug use, cannabis-related disorders recorded in the DSHS have been the second common reason for therapy for four years. This is probably the expression of the increased importance of cannabis also in the inpatient setting of specialized clinics. Among the inpatients recorded within the framework of the DSHS, cannabis still plays a significantly minor role among women than among men: only 16.9% (2009: 15.4%) of the women vs. 25.5% (2009: 25.9%) of the men had a cannabis diagnosis. Gender differences of this scale are to be found in the DSHS only for sedatives/hypnotics for which the ratio is reversed almost by the factor 1:6 and for cocaine, which is to a larger extent the main reason for therapy in men (7.7% vs. 3.6%; 2009: 8.9% vs. 5.2%).

However, this distribution does not directly tally with data from rehabilitation and acute treatments where opioids and multiple substance use (that practically always correlates with the use of opioids) account for the large majority of the cases. In the acute setting (hospitals) about half of the drug cases (45.3%; 2008: 45.8%) were related to poly-drug use in 2009, in the statistics of the German Pension Insurance Fund (DRV) the figure even amounts to 54.9% (2008: 57.5%) of all cases in the same year. In both statistical reports however, this portion has been on a continual decline for several years. In the DSHS, the use of opioids is more often coded as the main reason for therapy⁹⁵. According to the data on acute treatments (statistical report on hospital diagnoses) and the statistical data from the DRV, the shares of clients treated for cannabis use are on the rise (but still account for a significantly smaller portion).

Intoxications caused by sedatives and hypnotics continue to be relatively common in acute treatment (Statistical Report on the Hospital Diagnoses). About one in ten addiction diagnoses in the hospital treatments is related to these substances. They play a rather minor role in rehabilitation treatments (DRV) and in the DSHS (Table 5.6).

⁹⁴ The portions presented hereinafter were calculated on the basis of the figures provided in the TDI-tables 14.1.1 (all patients treated) und 14.1.2 (all patients treated for the first time).

⁹⁵ This is partly due to the fact that the German Core Data Set that forms the basis for the DSHS (deliberately) provides a definition that deviates from ICD-10 for the classification of a F19 diagnosis, which leads to a lower portion of these diagnoses in the DSHS.

Table 5.6 Inpatients broken down by addiction diagnosis

Main diagnosis	Hospital	DRV	2009	DSHS		
	2009	2009		Total ¹⁾	Males ²⁾	Females ³⁾
Opioids	33.6%	23.6%	40.0%	38.3%	37.3%	42.1%
Cannabinoids	7.7%	12.0%	23.8%	25.5%	28.0%	16.9%
Sedatives/Hypnotics	9.7%	1.8%	4.0%	4.3%	2.1%	12.1%
Cocaine	1.1%	4.0%	8.1%	6.8%	7.7%	3.6%
Stimulants	2.0%	3.5%	9.0%	9.7%	9.7%	9.5%
Hallucinogenics	0.5%	0.1%	0.1%	0.1%	0.1%	0.0%
Volatile substances	0.2%	0.1%	0.1%	0.1%	0.1%	0.3%
Mult./Other substances	45.3%	54.9%	14.9%	15.0%	14.9%	15.5%
Total (N)	93,832	14,630	7,599	8,746	6,818	1,928

1) The data correspond with the TDI-table: 14.1.1.

2) The data correspond with the TDI-table: 12.1.1.

3) The data correspond with the TDI-table: 13.1.1.

DRV 2010b; Pfeiffer-Gerschel et al. 2011e; Statistisches Bundesamt 2011a.

When comparing the data from the inpatient facilities participating in the DSHS to the statistics on the acute treatments carried out in hospitals and the measures paid for by the German National Statutory Pension Insurance, one gets the following picture: opioids continue to rank first among the illicit substances in all sources. If one adds the cases of multiple-substance use which, in most cases, probably involves a combination of opioid addiction and cocaine- and other drug-related addiction problems, the portion amounts to 50%-80% of the clients treated in the inpatient setting. An exception is formed by the cases reported within the framework of the DSHS (which shows a considerably higher portion of patients with primary cannabis-related problems). It is very likely that – apart from the treatment orientation of the participating facilities – also different coding habits can be held responsible for the divergences found between the statistics.

Socio-demographic information and treatment duration

In analogy with the presentation of the data for the clients in outpatient treatment, Table 5.7 summarizes some socio-demographic characteristics of the inpatient treatments documented within the framework of the DSHS for the main diagnosis groups. In comparison with the outpatients recorded within the framework of the DSHS (see Table 5.3) the opioid users treated in the inpatient setting tend to be somewhat younger and cannabis users significantly older; differences between users of cocaine and stimulants tend to be minor. It is striking that the portion of the homeless among the inpatients with the main diagnosis opioids and cocaine doubled respectively and among the ones with the main diagnosis stimulants more than quadrupled in respect of the previous year. Indications that inpatients represent a

different group of clients can be inferred from the fact that there are more unemployed and single persons among them – in comparison with outpatients. A comprehensive comparison of the two client groups would however require a careful comparative analysis of the use parameters which would for example give more information about the intensity of use and thus about the severity of the substance-related disorder.

Table 5.7 Socio-demographic data broken down by main drug (DSHS inpatient data, 2010)

Characteristics	Main diagnosis				
	Opioids	Cannabinoids	Cocaine	Stimulants	
Years of age when starting treatment (m) ¹⁾	32.6	26.4	31.7	27.6	
Years of age at first drug use (m) ²⁾	20.7	14.9	20.7	17.5	
Gender (ratio males) ³⁾	75.8%	85.4%	88.3%	78.3%	
Living alone ⁴⁾	55.4%	63.2%	51.5%	62.2%	
Working status ⁵⁾					
	<i>without work</i>	66.8%	61.9%	58.6%	61.2%
	<i>in school/education</i>	1.0%	6.3%	0.7%	4.6%
Homeless ⁶⁾	2.0%	1.0%	1.8%	2.6%	

1) TDI-table 6.1.1 for data on all persons (not broken down by main drug)

2) TDI- table 23.1.1 for data on all persons (not broken down by main drug)

3) TDI- table: 12.1.1, 13.1.1 and 14.1.1 (for corresponding data)

4) TDI- table 7.1.1 for data on all persons (not broken down by main drug)

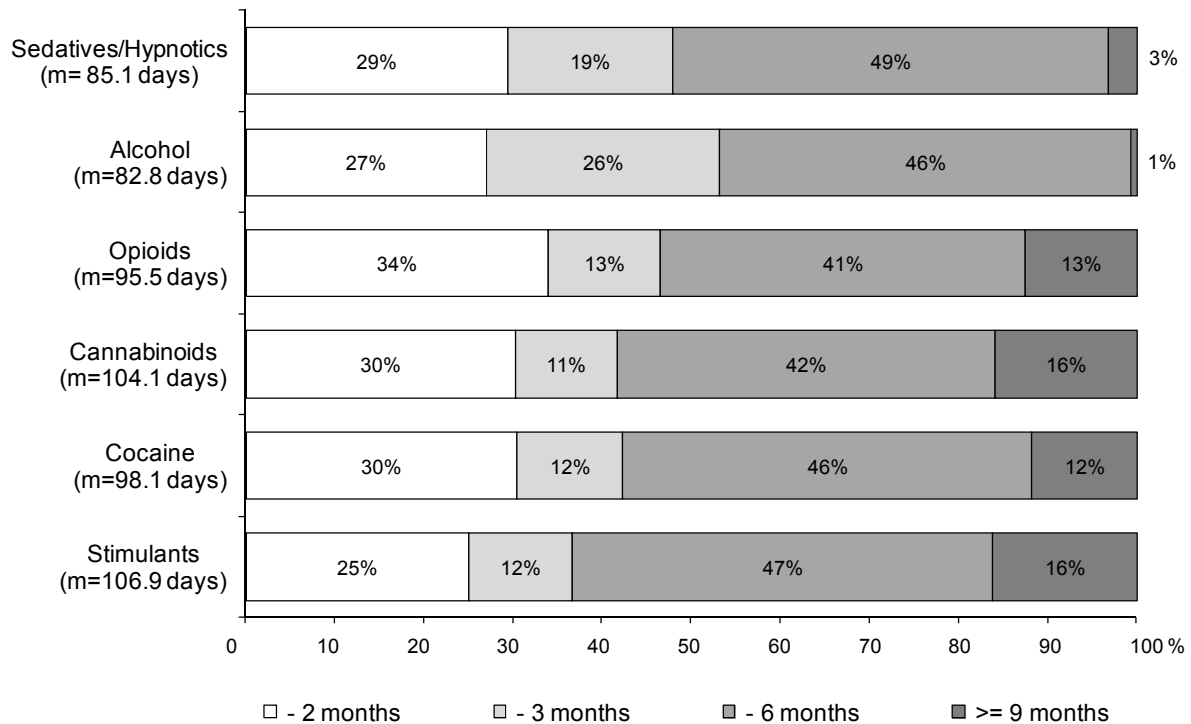
5) TDI- table 9.1.1 for data on all persons (not broken down by main drug); on the day before the start of therapy

6) TDI- table 8.1.1 on the stability of the life situation (no directly corresponding data): on the day before the start of therapy

Pfeiffer-Gerschel et al. 2011e.

The data from the DSHS shows significant differences in the average treatment duration broken down by main diagnoses (Figure 5.1). In 2010, the average treatment duration for patients with primary disorders caused by the use of cannabis was 14.9 weeks (2009: 14.1), 15.3 weeks (2009: 16.0) for stimulants, 14.0 weeks (2009: 15.3) for cocaine, 13.6 weeks (2009: 14.2) for opioids and 12.2 weeks (2009: 11.4) for sedatives/hypnotics. The treatment duration for alcohol, given as a comparative value, is on average 11.8 weeks (2009: 11.9).

Some of the treatment durations diverge considerably. Striking is that with 14-16 weeks, the average treatment duration for disorders caused by illicit substances is on average at least two weeks longer than for alcohol and sedatives/hypnotics. This is primarily attributable to the clearly smaller portion of patients with treatment durations ≥ 9 months for alcohol and sedatives/hypnotics. While the average treatment duration for alcohol-related disorders slightly declined for four years, the other substance groups do not show a clear trend in the same period of time.



Pfeiffer-Gerschel et al. 2011e.

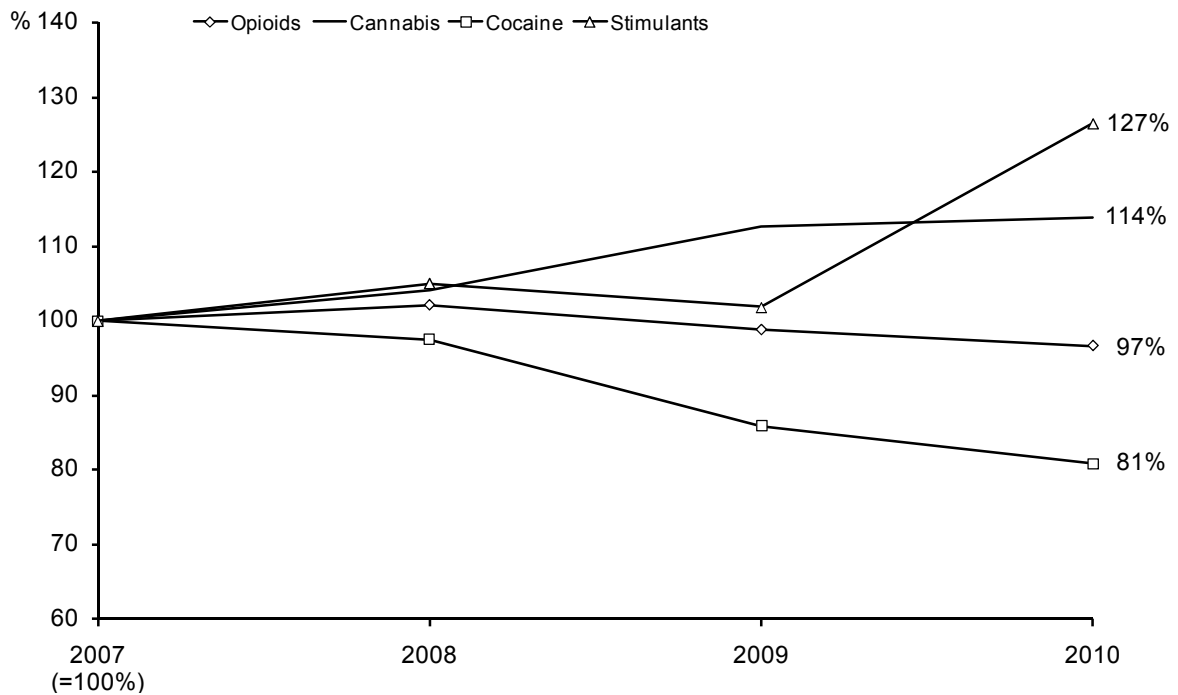
Figure 5.1 Duration of inpatient treatment broken down by substance use disorders (DSHS inpatient data, 2010)

5.5 Trends of clients in treatment

5.5.1 Developments in the outpatient and inpatient setting

All in all, disorders caused by the use of heroin continue to play a predominant role among the illicit drugs in outpatient and inpatient facilities. However, cannabis is in the first place of the treatment requests made by persons seeking outpatient therapy for the first time (first patients), whereas opioids are the reason for making contact with a treatment facility only in less than five users. Six years ago, this portion was still at about a third of the first patients. Among all the admissions to outpatient therapy, clients with disorders caused by the use of opioids still represent the largest individual population among the clients of illicit drugs, but their portion has been shrinking continually for several years.

When calculating the changes in admissions of clients to the outpatient setting broken down by main diagnoses since the introduction of the new Core Data Set in the year 2007 (Index=100%), one finds a continual, in the last year though only slight upward trend in the share of patients with main diagnosis cannabis, a continual decline in patients with cocaine problems, hardly any changes in opiate users and a very strong increase in clients with the main diagnosis stimulants between 2009 und 2010 (Figure 5.2).

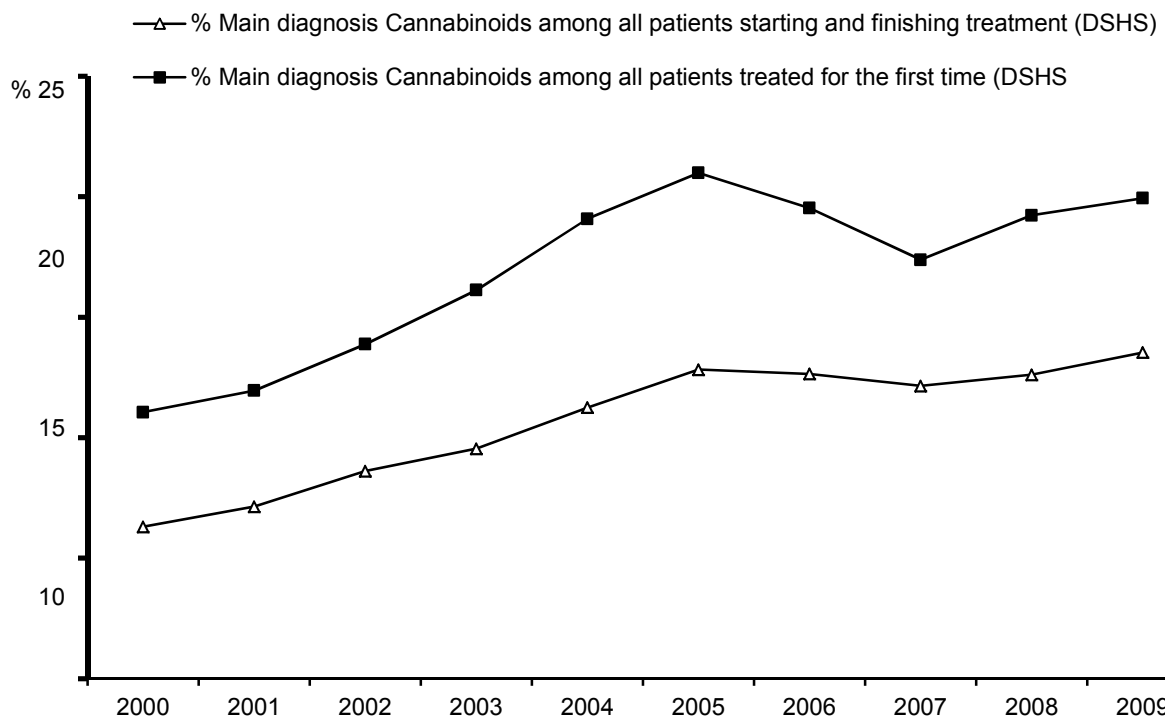


Pfeiffer-Gerschel et al. 2011b.

Figure 5.2 Changes in admissions to outpatient therapy broken down by main diagnoses (DSHS outpatient data)

In the inpatient setting, (rehabilitation statistics by the RV, DSHS), cannabis users form the second largest patient group after the opioid users. Inpatient treatment of cannabis disorders plays also an increasingly important role. This development is most clearly reflected by the DSHS data. Acute treatments for cannabis (statistical report on hospital diagnoses), by comparison, are still relatively seldom.

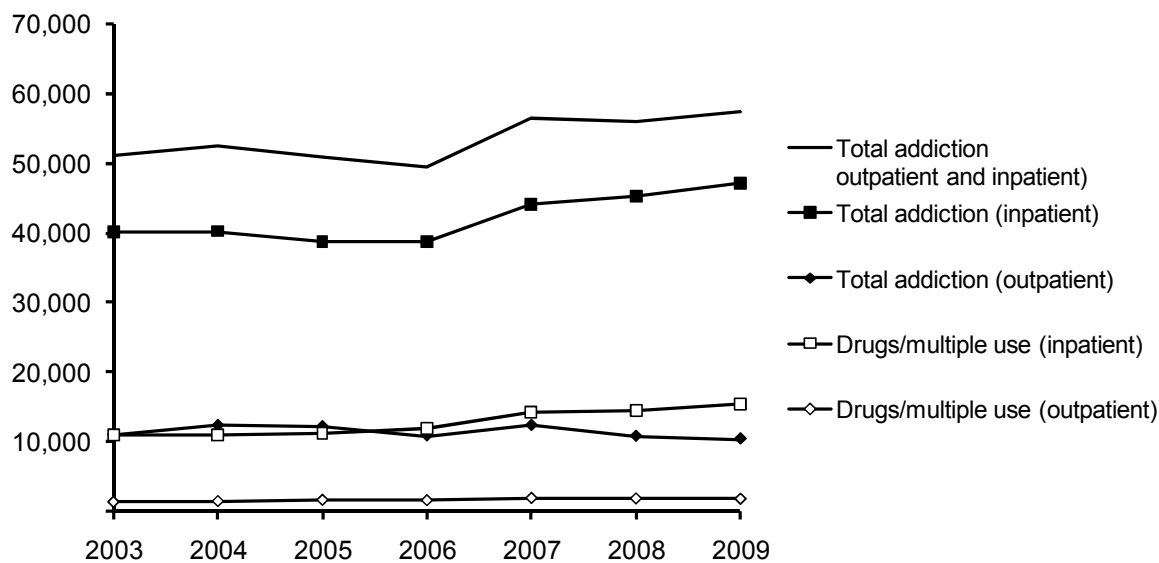
Kipke and colleagues (2011) described the profiles of clients with the main diagnosis cannabis based on the (outpatient) DSHS data from 2000 to 2009 and compared them to clients with other main diagnosis. It showed that the portion of clients with primary cannabis problems significantly increased from the year 2000 (6.3%) to the year 2009 (13.5%) (see Figure 5.3). The measured parameters indicate a negative development of the life situation of the cannabis patients: almost two thirds of the clients with the main diagnosis cannabis are single and the portion of precariously housed clients doubled from the year 2002 (0.5%) to the year 2003 (1.1%). Since then, the values have remained stable – apart from a few slight variations. Almost a sixth finished school without a school degree or with a degree from a special needs school. Unemployment increased extremely among clients with main diagnosis cannabis between 2000 (18.1%) and 2007 (42.0%) and has stagnated since then at a high level (2009: 43.6%).



Kipke et al. 2011.

Figure 5.3 Portion of clients with main diagnosis cannabis in all admissions/discharges or respectively all first patients (DSHS outpatient data)

The total number of rehabilitation services funded by the Pension Insurance in the addiction area increased from a total of 51,123 in 2003 by more than 10% to 57,456 (Figure 5.4). The largest part of the services (69.3%) is provided for alcohol-related disorders; disorders caused by the use of illicit drugs and multiple drug use account together for about 30% of the funded services (medical drugs: 0.6%). This share increased from 24.3% in 2003 by about 5%, this means that since 2004 the share of rehabilitation services funded by the Pension Insurance for the therapy of primary alcohol problems has continually been shrinking.



DRV 2010b.

Figure 5.4 Changes in out- and inpatient rehabilitation therapies

The ratio between inpatient and outpatient treatments is about 5:1 (across all services provided). This ratio shifted slightly between 2003 and 2008 (especially since 2005) in favour of the inpatient treatments (from 3.7:1 to 4.5:1). Looking only at the rehabilitation services funded for drugs and multiple use, one finds that the ratio between inpatient and outpatient treatment has, with 9:1, even more markedly shifted towards the inpatient treatments. However, the share of the rehabilitation services funded in the outpatient setting for drug-related problems (or multiple use) has been on the rise for several years. This is an indication that outpatient rehabilitation offers that are meanwhile firmly established for alcohol, are used and continually expanded also in the drug area (at a much smaller scale though).

The analysis of the case figures for rehabilitation therapies (Pension Insurance) gives a varied picture for the total of drug patients. The number of inpatient therapies carried out for patients with drug and multiple substance use continually increased since 2004 (Figure 5.4). The number of outpatient rehabilitation therapies provided for patients with drug or multiple substance use significantly increased between 2003 and 2007. Since then, it has remained stable for drugs and has declined for multiple use. The shift towards outpatient treatment that was observed over a few years, has been on the decline again since 2005. Outpatient therapies accounted for 10.7% of the patients treated for drug or multiple substance use in 2009. With this, their share lies slightly below the comparative value of the year 2003 (11.1%), after having climbed to around 13% in 2005 (Table 5.8).

Table 5.8 Rehabilitation treatments

Main diagnosis	Inpatient				Outpatient			
	2007	2008	2009	Δ '08/'09	2007	2008	2009	Δ '08/'09
Alcohol	29,492	30,328	31,299	3.2%	10,326	8,865	8,501	-4.1%
Illicit Drugs	9,746	9,664	10,307	6.7%	1,274	1,216	1,236	1.6%
Medicines	313	305	279	-8.5%	57	44	57	29.5%
Multiple use	4,518	4,894	5,188	6.0%	667	647	589	-9.0%
Total addiction	44,069	45,191	47,073	4.2%	12,324	10,772	10,383	-3.6%

DRV 2008, 2010a, 2010b.

So far, the available statistics do not show the treatments carried out in day hospital care in a discriminating manner. The attempt to take a differentiated look at the statistical data could contribute to going deeper in the analysis of changes in the reporting years to come.

The overall figure of the acute addiction or respectively drug treatments slightly increased between 2008 and 2009 (statistical report on the hospital diagnoses). Significant Increases were found for the number of treatments for intoxications with cannabinoids (+15.2%) and volatile solvents (+27.6%, at a comparatively low total figure). Significant declines were found for cocaine (-24.4%) and hallucinogens (+10.6%, at a comparatively low total figure). The other main diagnoses practically remained unchanged. So did the overall figure (Table 5.9).

Table 5.9 Inpatient treatment of drug problems in hospitals 2006-2009

Main diagnosis	Year				Changes
	2006	2007	2008	2009	2009 vs. 2008
Alcohol	298,955	316,119	333,804	339,092	1.6%
Opioids	29,472	31,638	30,776	31,496	2.3%
Cannabinoids	5,932	5,790	6,297	7,251	15.2%
Sedatives/Hypnotics	8,661	9,091	9,294	9,094	-2.2%
Cocaine	1,336	1,300	1,388	1,050	-24.4%
Stimulants	1,424	1,672	1,868	1,848	-1.1%
Hallucinogenics	471	532	482	431	-10.6%
Tobacco	234	236	281	258	-8.2%
Volatile substances	119	138	152	194	27.6%
Multiple/other substances	40,492	39,727	42,399	42,468	0.2%
Total addiction	387,096	406,243	426,741	433,182	1.5%
Total drugs	87,907	89,888	92,656	93,832	1.3%

Statistisches Bundesamt 2011a, 2009a, 2008b, 2008a.

It needs to be noted qualifyingly that the case figures for all illicit substances (with the exception of opioids, cannabinoids and sedatives/hypnotics) are significantly smaller in comparison with alcohol and multiple substance use, which can lead very quickly to sizeable changes in percentages.

5.5.2 Substitution treatment

The most recent census carried out within the framework of the substitution register permits to make inferences about the number of persons reached on a set day but not over the course of the year. The number of persons recorded on the census day of each calendar year (01.07.) increased continually since the inception of the register and significantly from 46,000 in the year 2002 to 77,400 in 2010 (BOPST 2011). As in 2009, approximately 190 double treatments could be detected in the year 2010 through the substitution register.

Access to substitution treatment is subject to strong regional divergences. Still only 3.0% (N=2,336; 2009: 2.9%; N=2,195) of the patients reported to the register (cut off date: 01.10.2009) and 5.2% (N=140; 2009: 4.8%, N=130) of the substituting doctors are from the eastern *Laender* (without Berlin) (BOPST 2011). Experts and people eligible for substitution treatment still rate the availability of substitution offers especially outside of larger cities as insufficient (Stoever 2010b, Stoever 2011). An alternative explanation of the low figures could be that the number of opiate users in rural regions is smaller than in city regions. Fischer and colleagues (2010), too, point to the problems of region-wide specialized care for the patient group eligible for substitution therapy. The authors furthermore thematize the fact that the increase in the patient figures over the last years does not correlate with the one in substituting doctors. According to the register of the Federal Institute for Drugs and Medical Devices 7,805 (2009: 7,233) doctors were registered for substitution treatment in 2010⁹⁶. Under care aspects, however, it is by far more relevant that only 2,710 (2009: 2,700) doctors reported to the substitution register in 2010 (BOPST 2011). The number of actually substituting doctors has been stagnating at a practically unchanged level since 2004. Looking at the relation between reported substitution patients and population figures in the individual *Laender*, the three city states Hamburg, Bremen and (at a considerable distance) Berlin are at the top of the list as in the previous years. The lowest numbers of substituted patients per inhabitant were reported by the three eastern *Laender* Brandenburg⁹⁷, Mecklenburg-Western Pomerania and Saxony as in the previous year. The number of registered patients per substitution doctor is also subject to considerable variations between the *Laender*. Whereas a substitution doctor in Hamburg treated on average 48.7 patients in 2010 (followed by the Saarland with an average of 39.8 and Berlin with 33.7), the average in Brandenburg was only 8.3 (Thuringia: 10.7; Mecklenburg-Western Pomerania: 13.2).

⁹⁶ The actual number of doctors with a corresponding additional qualification is presumably higher since some *Laender* automatically granted this qualification to all doctors specialized in psychiatry and psychotherapy (at least for a temporary period of time) without them being fully registered in the register.

⁹⁷ For the Land Brandenburg it can be assumed that numerous users change over to the metropolis Berlin to undergo substitution treatment.

The share of substances used in substitution treatment shifted significantly (in particular between 2002 and 2007) towards buprenorphine that was used in approximately every fifth opioid substitution treatment carried out in 2010. The share of opioid substitution treatments carried out with buprenorphine has been stagnating since 2007 (table 5.10).

Table 5.10 Type and portion of the substitution drugs reported to the substitution register (2006-2010)

Substitution drug	2006	2007	2008	2009	2010
Methadone	64.1%	61.4%	59.7%	58.9%	57.7%
Levomethadone	17.2%	19.0%	20.6%	21.8%	23.0%
Buprenorphine	18.0%	18.6%	18.9%	18.6%	18.6%
Dihydrocodeine	0.6%	0.5%	0.4%	0.3%	0.3%
Codeine	0.1%	0.1%	0.1%	0.1%	0.1%
Diamorphine		0.4%	0.3%	0.3%	0.3%

BOPST 2011.

Apart from the above-mentioned regional differences in the availability, misuse and unauthorized distribution of medical drugs also form part of the undesired side effects of substitution treatment. In summer 2011, Reimer (2011b) presented the final report of a study on the improper use of substitution substances that followed up on a study conducted in 2009. The results of the study were already presented in chapter 4.4.2.

The participants of the survey conducted in substitution practices (i.e. substituted patients) engaged by far less in the improper use of substitution drugs and likewise of illicit substances. This is taken as evidence that substitution treatment leads to a reduction in the use of unprescribed substitution drugs and other substances and can thus be regarded a protective factor. This is also reflected by the significantly less reported “overdoses/ life-threatening situations“. From the reported motives for using unprescribed substitution substances (one in six reports that he “cannot find a substituting doctor“) care shortfalls can be inferred that are already known from other surveys. In view of the fact that a fifth of the substituted patients stated that the dosage of their substitution drugs was too low, the question arises as to whether the dosages are adequately chosen.

The so far insufficiently known long-term effects of substitution treatment were the object of investigation of a three-year long research study (see chapter 5.6 of the REITOX Report 2009 for a detailed description of the study) commissioned by the Federal Ministry for Health.

First findings of the PREMOS Study⁹⁸ were presented in 2010⁹⁹. Characterizing, also in stable substitution patients, was the variability (disciplinary interruptions, attempts of lowering the dosage or cessation) of the treatments. Relatively low opiate (below 20%) and, without taking account of cannabis, relatively low by-use of other substances (20-30%) were found. The physical morbidity rate was still markedly (69.7%) and the psychological morbidity rate drastically raised (69%). The social integration of the patients was heterogeneous: 69% lived independently in their own flat, 23% had a job and 50% were jobless. The findings generally underline that the primary substitution goals (retention quota, securing survival, reduction of drug use and physical morbidity, societal participation) were reached in the vast majority of the patients. The therapy was found to be less successful in reaching a reduction of pronounced psychological morbidity. According to the authors, the findings suggest to reconsider the set goals and the administrative regulations for long-term substitution (Wittchen 2010) (cf. also chapter 6.3).

Despite the scarcity of available scientific literature with controversial findings, studies report again and again cognitive impairments of patients undergoing long-term substitution therapy with methadone. In their study¹⁰⁰, Soyka and colleagues (2010) could not find any group differences in terms of attention function, learning and memory, but they did find indications of slight performance improvements in for example executive functions. The authors point to the necessity of conducting longitudinal studies to investigate whether cognitive skills possibly improve under long-term methadone substitution treatment, taking into account the effects of different dosages and treatment durations.

As an alternative to the substances available for substitution therapy on the German market, oral retarded morphines have also been used for example in Austria since 1998. Baewert and colleagues (2010) consider these oral retarded morphines, that are only allowed for this indication in few countries, in combination with psychosocial counselling, a good alternative to the treatment with methadone or buprenorphine despite the risk of an increased injecting misuse potential and the lack of comprehensive multicenter studies. The authors emphasize

⁹⁸ Study PREMOS (Long-term substitution of opiate dependants: predictors, moderators and outcome); <http://www.premos-studie.de/index.html>.

⁹⁹ The concept of the study is to continue the country-wide clinical epidemiological study on substitution therapy that was started in 2003 in more depth. Under the acronym Cobra, (Cost-Benefit and Risk Appraisal of Substitution Treatment) this study pursued the goal of conducting a comprehensive empirical clinically differentiated evaluation of the substitution and the care situation of substitution patients treated from 2003 to 2006 (see also the Reitox Reports of last years). In order to investigate the long-term effects of substitution treatment, the COBRA survey and result platform was used to conduct two further studies with basically the same test methods. To summarize, it is a combination of a (1) clinical epidemiological study on central parameters of the care structure (doctor/institution/therapy features) on the basis of representatively selected substitution facilities, stratified by facility size, and (2) a prospective longitudinal study with representatively selected patients and up to four measuring points (baseline, 12-month status, 48-60 month status and 60-72 month status) including a retrospective follow-up between the measuring points. In a satisfying exhaustion (71.4%-91%) the course of 5-7 years respectively in a random subsample of N=289 patients the course of 6-8 years were evaluated. On a further N=470 patients at least follow-up and outcome data was collected.

¹⁰⁰ N=77 patients who were examined either 30 days after the start of the methadone substitution therapy (n=35) or at least after 6 months (n= 42) with a comprehensive neuropsychological test battery.

however that further corroborating research findings are necessary. As an argument for the expansion of the medications with an indication for substitution, Baewert and colleagues maintain that a broad spectrum of therapy offers is imperative to provide a specific therapy concept tailored to the needs of the individual patient in order to achieve a reduction in the relapse quotas.

Another intervention approach for substitution therapy presented by Haemmig (2010) consists of starting substitution therapy with buprenorphine with temporarily overlapping use of heroin ("Bern method"). On the example of a patient, the author illustrates the approach that consists of administering buprenorphine with still persisting heroin use and gradually increasing the dose of buprenorphine and cessating heroin use at an adequate dose of buprenorphine. In the described case, the considerations as regards the "Bern method" turned out to be right according to the authors. Qualifyingly, the author notes that this was the observation of a single case with a very reliable patient. According to the author, further explorative investigations are needed to delimit the possibilities of this method.

Piest and colleagues (2011) report on somatic and psychological reactions as well as changes in the by-use behaviour when changing from the replacement substance buprenorphine to the combination buprenorphine/naloxone. The authors report that, when changing from buprenorphine to the combination buprenorphine/naloxone at a ratio of 1:1, they observed considerable withdrawal symptoms, mental health issues and increased by-use. From these observations the authors infer the necessity of verifying the dose ratio and, if necessary, adjust it when switching to the combination therapy. The authors also consider the possibility of changing back to the original therapy plan and invite to conducting further studies to evaluate the adjustment of the dose ratios.

Despite the creation of the legal framework conditions for the administration of diamorphine to heavily dependent patients (see the REITOX Reports 2009 and 2010), the implementation and creation of new therapy offers turns out to be difficult in the practical world. Due to – among others – economic aspects, diamorphine-assisted therapy for heavily dependent users is not expected to be expanded nationwide. In Baden-Wuerttemberg for example, only three of the originally discussed nine locations, will be set up since it would not make sense to open ambulatories in smaller towns due to the too small number of people affected (Badische Zeitung 2011).

On 19 February 2010, the Board of the German Medical Association passed the "Guidelines on the substitution-assisted therapy of opiate dependents" in a revised version (see also chapter 1.2. of the REITOX Report 2010). The guidelines concretize among others the type and scope of psychosocial care noting that the provision and integration of measures suitable to eliminate psychosocial problems are mandatory for the treatment of opiate addiction. The guidelines furthermore underline the necessity of coordinating psychosocial care and medical care. In a current review on the role and importance of psychosocial care in the substitution therapy of opiate dependents, Stoever and Gerlach (2010) point again to the absence of a differentiated research study that could provide important planning parameters for the organization, timing and duration of psychosocial care.

Apelt (2010) reports on the results of a project started in 2007 to observe substitution therapy with dispensing machines¹⁰¹. The number of patients remained largely stable over the whole period of observation for all replacement substances apart from buprenorphine/naloxone. The number of patients treated with buprenorphine/naloxone and registered by the documentation software, considerably increased in the second quarter 2008 and levelled off at N=200 substitution patients on average per month. Although the number of patients registered by the documentation system slightly increased in the course of the study, the distribution of substitution substances remained largely stable. The average doses were at the lower limits of the dose ranges given in literature for all substitution drugs except levomethadone¹⁰². The authors conclude that an electronic documentation system like the one used within the framework of the study can reduce and simplify the high documentation expense while offering the possibility at the same time of conducting representative epidemiological analyses of replacement therapy of opioid dependent patients.

5.5.3 Other current developments

Care of older drug users

In 2010, Vogt and colleagues presented the final report of the study “Senior drug addicts in Germany“. The goal of the project was to show which resources are available and can possibly be used by drug care facilities or homes for the elderly, nursing homes or other relevant institutions for the care of older drug dependents in need of help. The cities Frankfurt/Main and Berlin were used as examples. Both cities have a very differentiated care network for elderly care and drug care.

In most of the care institutions for aged mentally disturbed people, alcohol and drug addicts do not form part of the target groups. Support institutions for the homeless are generally not addressed to older drug addicts either. Facilities catering for HIV/Aids patients usually accommodate persons with and without addictive diseases in different wards. Drug aid and addiction aid institutions provide a few offers that are directly geared to older drug users. The analysis of the data carried out within the framework of the study showed however that these offers are either addressed to severely dependent drug users or older alcohol dependents; indications of alcohol and drug dependents being jointly admitted and treated in one of these institutions were not found.

Experts point to the dynamics of the courses of disease in older drug users and the resulting differences to elderly people living in old people’s or nursing homes. With good care, it is

¹⁰¹ In this epidemiological study, data on the number of patients, the average age, the average dose and the drop out quota were collected from N=28 facilities over a period of 24 months and stratified by substitution substance and gender. In total, the data of N=2,320 patients in substitution therapy with methadone (76.6%), levomethadone (0.8%), buprenorphine (20.9%), buprenorphin/naloxone (0.4%) or respectively diamorphine (1.3%) (out of these 74.0% men) could be analyzed in the main study at t1 (January 2008).

¹⁰² It was not possible to calculate the 12- and 24-month retention quotas in this study. There was no patient-related information available due to the monthly aggregated data.

possible to improve the health condition of older drug users so that they can be transferred into other residential facilities like assisted living facilities or supervised residential groups.

The expert panel discussions led within in the framework of the study also showed that many experts are sceptical as regards the placement of older drug users in nursing homes for the elderly. Practical examples show however that interlocking between elderly care and drug care can prove to be beneficial with the appropriate conceptual planning. The authors underline that the interlinkage between the offers at the interfaces addiction help, support for the homeless, offers for people with mental illnesses and elderly care is expandable.

Within the framework of the study, semi-structured interviews with N=50 drug addicts were conducted. The majority of the interviewed drug addicts depend on professional help in case of sickness since only few can resort to a functioning social network. As regards old age, the majority of the interviewees stated that they wished to maintain an independent life in a familiar setting.

It is to be noted that both in the area of elderly care and drug care there is a need for further training. The authors therefore recommend to expand further and advanced training in elderly care to aspects of addiction medicine and psychosocial care of people with substance use disorders. In the area of addiction help, they recommend to expand further and advanced training to the topics of gerontology, geronto-psychosomatics and –psychiatry.

Also in 2010, Degkwitz und Zurhold (2010) presented the final report of an empirical study on the existing and expected health and social problems of the increasingly aging drug dependents in Hamburg. Within the framework of the study, the data of the regional drug help monitoring system in Hamburg (BADO) was surveyed according to age aspects¹⁰³. The results give a differentiated picture of the older drug dependents in comparison with the younger ones. Older opiate dependents live more often in their own living space and less often in a partnership than their younger counterparts. Older drug addicts in Hamburg are furthermore strongly affected by social isolation. In total, the older opiate dependents have more health issues than the younger ones. Most commonly found are HCV infections with 52% and liver damage with almost 40%. On the other hand, illegal activities and problems with police are significantly less often found among older opiate dependents than among younger ones. Intense, almost daily opiate use falls below 10% among the older users, which is attributable to the high portion of older opiate dependents undergoing long-term substitution treatment (two thirds of the older dependents). At the same time, problem alcohol use increases among the elderly. All in all, the housing situation of the elderly has improved, health problems have however increased. The interviews conducted within the framework of the study show that the majority of the interviewees do not have any problems

¹⁰³ This analysis is based on N=1,907 opiate addicts who were 45 years of age or older and who were at least once in ambulatory treatment between 2006 and 2008. N=5,890 opiate addicts under 45 years of age were in outpatient treatment in Hamburg in the same period of time. Furthermore, standardized and structured interviews with N=50 older drug users and guideline-based interviews with experts from different areas of addiction help and elderly care were conducted.

(yet) to look after themselves and structure their day independently. The interviewees need support especially in the form of food catering services and offers for recreational activities.

Violence in low-threshold addiction help facilities

A survey recently presented by Fais (2011) was devoted to the topic „Violence in low-threshold addiction help“¹⁰⁴. According to the results of the study, staff of low-threshold help facilities are confronted with aggression several times a day. It is mostly verbal aggression or refusal of clients to follow the instructions of staff, but also physical attacks among the clients but also against staff. Given these results, the author points out how important it is to train facility staff to be better able to respond to conflict and aggression situations adequately and to provide the financial resources for qualified and professional staff in low-threshold facilities.

Outcome of qualified inpatient withdrawal treatment

Mayer and colleagues (2010) investigated predictors for the outcome of qualified inpatient drug withdrawal treatment. Of particular interest to them was the question if and how changes made to the addiction help system and care of opiate patients are reflected by the outcome of inpatient qualified withdrawal treatment. To this purpose, data of N=1,010 opioid dependent patients treated in the period from January 2005 to March 2010, were analyzed. Significant factors turned out to be the duration of addiction, age, the perspective of being admitted to follow-up therapy after the withdrawal treatment and contact with a drug counselling facility. Whether the respective patient had undergone substitution therapy before, did not have any significant influence. However, among the group of patients who had been in substitution therapy before, the duration of substitution did have a positive influence on the outcome of the withdrawal treatment.

In another multicentre study, Specka and colleagues investigated in how far patient characteristics may explain divergences in the portions of opiate patients regularly discharged from detoxification treatment¹⁰⁵. After having controlled the variables of the “treatment facilities“, the authors observed that regular discharge from treatment was significantly associated with existing plans for follow-up therapy, earlier completed long-term therapies and detoxification treatments, less successful withdrawals, a higher age, a later onset of disorders and a longer duration of drug use. It needs to be noted qualifyingly that the variable “treatment facility“ had a significant effect in the survey (Specka et al. 2011).

¹⁰⁴ The survey was conducted in 21 low-threshold facilities by means of standardized questionnaires among staff (November 2009 – January 2010) and theme centred expert interviews with five heads of contact centres or emergency shelters in five German cities.

¹⁰⁵ To this purpose, N=1,017 opiate dependent patients treated in twelve detoxification facilities with comparable treatment programmes, staff, equipment and financial resources were surveyed. The patient data and results were collected by means of a standardized documentation system.

Regional divergences in drug care: report on the outpatient addiction help system in Saxony

In spring 2011, the Saxon Land Drug Agency presented a report on the outpatient addiction help system in Saxony (based on data of 2010). Based on the data collected from all 46 Saxon addiction counselling facilities, the report represents the offers, services and client characteristics within the outpatient addiction help system in Saxony. The report shows that the care situation in Saxony is subject to regional divergences. According to the report, the care situation needs to be urgently improved in some undersupplied regions of Saxony to meet the demand for addiction specific help and to provide early support for tackling addiction problems. Although about 60% of the clients make use of counselling services primarily because of alcohol problems, the authors regard problems in connection with illicit drugs as increasingly important. About 20% of all clients undergo therapy because of problems with illicit drugs. These are approximately 5,600 mainly young people using illicit drugs, in particular stimulants. The increasing demand for help in the area of illicit drugs is also reflected by an increase in therapy applications for drug rehabilitation therapy or respectively referrals to the youth help system (Saechsische Landesstelle gegen die Suchtgefahren e.V 2011).

Psychotherapy in addictive diseases

Based on a decision rendered by the Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA) on 14th April 2011 (Nessler 2011), cost coverage for psychotherapy will be permissible in the future for patients dependent on alcohol, drugs or medications even in the absence of abstinence from addictive drugs. However, abstinence needs to be reached by the tenth session at the latest, otherwise costs will not be born by the statutory health funds. Therapy in an inpatient or day care facility is also possible under certain provisions. With this decision, the Federal Joint Committee takes account of the fact that addictive diseases belong among the most common psychological disorders that often go along with chronic developments and low usage of therapy offers.

Bischof recently presented a review on the effectiveness of psychotherapy (Bischof 2010). According to the review, there is convincing evidence for the effectiveness of various behavioural, family and couple therapy approaches as well as for motivational interviewing. Effective therapy forms are characterized by a structured approach, strengthening of behavioural skills of the patients and – where possible – by the integration of family members. Bischof stresses that there is urgent need for research on non-pharmacological interventions in illicit substances as well as on insufficiently researched, but possibly effective treatment methods like for example structured depth psychological approaches. The author recommends intensifying the implementation of methods with proven effectiveness. Vogt (2010) notes in a recently published contribution on the topic that especially psychotherapeutic methods oriented by cognitive behavioural therapy have proven effective in the therapy of substance related problems. According to the author, these methods can be adapted to the specific addiction groups. Vogt suggests to profit from experience made in the

USA and to adapt successful training programmes to the German system and test their effectiveness in German settings and to expand in particular offers made for addicted pregnant women and mothers with small children. Vogt recommends to introduce psychodynamic therapy modules in Germany and to test their effectiveness.

Combination therapy for addictive diseases

The German Pension Insurance Funds Braunschweig-Hannover, Nord and Oldenburg-Bremen have been sharing a common understanding of the basic principles and organization of a combination therapy for alcohol and drug dependent people since 2009/2010. Ambulatory, daycare, inpatient and adaptive therapy forms can be combined over a total therapy period of 12 months depending on the individual therapy course. A time budget is allocated to each intervention form. Essential therapy elements used are handovers between care professionals, fitness assessment for ambulatory therapy, quality circles and process control. Important goals are among others the coordination, discussion and removal of interface problems between the institutions involved, a close cooperation between the service providers, the active participation of the patients in the further therapy planning and the support of a smooth transfer from inpatient to outpatient treatment. The therapy course is continually documented in a standard discharge report that is sent to the insurance service provider at the end of the therapy by the last treating facility. (Die Drogenbeauftragte der Bundesregierung 2011).

Results of the subgroup analyses of the demonstration project on diamorphine-assisted substitution treatment

Gender differences

Eiroa-Orosa and colleagues presented a gender specific analysis of the data of the German demonstration project on heroin assisted therapy (Eiroa-Orosa et al. 2010b). They found significant gender differences that found their expression in a larger extent of psychological disorders in women. The female participants showed complicated clinical syndromes at the beginning of the study. Higher severity grades of the existing addiction in four of nine ASI items are associated with higher rates of prostitution. Moreover, in comparison to the males, a higher portion of women had own children.

The most important partial result of the study was that the female participants in both study groups (heroin vs. methadone) did not show any differences in the primary outcome parameters for health improvement and use reduction of illicit drugs. Partial analyses showed that the therapy outcome is mediated by the factor "risk behaviour prostitution". The authors derive from the results of the study the necessity of looking at other outcome parameters for men than for women. It showed for example that in the surveyed sample prostitution decreased to a larger extent in the patient group that had received heroin than in the methadone group, which in turn had a significant influence on the reduction of the use of illicit drugs. It showed furthermore that women in therapy are not capable of reducing their

problems with their family and social relationships. The last two aspects however are only insufficiently reflected by the primary outcome parameters of the study.

Health related quality of life and health condition

In another study based on the data of the German demonstration project on diamorphine-assisted therapy, Karow and colleagues investigated the connection between health related quality of life and physical health condition in N=938 participants under different study conditions (Karow et al. 2010). To this purpose, the baseline data and the data of the 12-month follow-up were used. In the groups that had received substitution with heroin or methadone and psychosocial therapy, the health related quality of life improved significantly in the period of inquiry, whereby the improvement in the group that had received heroin turned out to be more pronounced than under methadone replacement. According to the authors, the improvement of the health-related quality of life was associated with an improved physical health condition. Further analyses lead to the finding that the patient group that had received psychoeducation showed a significantly higher increase in the health related quality of life than the group that had only received case management. The authors note that the improvement of the health related quality of life in the patient group that had received heroin-assisted therapy was partially attributable to a more pronounced improvement of the physical health condition. Taken altogether, the findings of the study underline, according to the authors, the importance of a comprehensive health care model for patients with severe opiate-related disorders. According to Karow and colleagues, the experience made with psychoeducation in this patient group requires further investigation.

Change from methadone to diamorphine

In another study that is based on the data of the German demonstration project on heroin-assisted therapy, Verthein and colleagues (2011) investigated the health status, drug use and social situation of a subgroup of patients who were changed from an initial methadone therapy to substitution with diamorphine in the course of the demonstration project¹⁰⁶. The patients who were changed to diamorphine only in the second year were able to catch up in the course of the second study year with the patients who were continuously treated with diamorphine with regard to their health condition and by-use of heroin and cocaine. The authors regard the findings as further evidence for the positive effects of diamorphine-assisted therapy for this specific group of opiate patients who are difficult to treat.

The role of earlier experience with substitution therapy

Haasen and colleagues took a closer look at a sub-sample of participants in the German heroin study who did not have any earlier experience with substitution therapies (but only abstinence oriented therapy attempts) in comparison with the rest of the participants in the heroin study. Despite significant differences between the study groups in terms of drug use at the beginning of the heroin study, the authors could not find any differences as regards the

¹⁰⁶ Among the N=434 patients who had started the second year of treatment, were 90 patients who had been switched from methadone to diamorphine (n=344 patients were treated with diamorphine for two years).

therapy outcome and the retention quota. As for the use of illicit drugs however, significantly better results in the sense of use reduction were found for the group treated with diamorphine, whereas no differences were detected in comparison with the population treated with methadone as regards the achieved health parameters. Given these findings, the authors consider it useful to take a closer look at the administration of diamorphine as a therapy option for heavily dependent patients irrespective of their experience made with substitution treatments earlier on (Haasen et al. 2010).

New instruments

Using the instrument “Measurements in the Addictions for Triage and Evaluations – ICF-Core-Set and Needs for Care (MATE-ICN)” as an example, Buchholz and colleagues (2011) published a paper presenting a possibility of integrating the international classification of functioning, disability and health (ICF) into the standard diagnostics of addiction therapy¹⁰⁷. Summarizing, it can be said that, according to the authors, the psychometric quality of the instrument is satisfying and the MATE-ICN was very positively rated by the interviewers conducting the surveys. At present, the MATE-ICN is used at the Psychiatric University Clinic Freiburg as part of a pilot study. Functional health is measured directly after the physical detoxification in a personal interview and in a 6-month follow up telephone interview. Data is also collected on follow-up therapies that patients are undergoing after the completion of their withdrawal treatment. All in all, the development of the implementation represents, according to the authors, a positive example of an implementation of the ICF in addiction help. Schuntermann (2011) sees the relevance of the ICF for the German health and social system in the provision of an internationally acknowledged and uniform language for functional problems that is understood by all professional groups in the health and social systems alike. According to the author, clear communication in respect of diseases is made possible within and between professional institutions only thanks to this.

Gardini and colleagues (2010) recently presented a German version of the ODAS/EODA questionnaire – an instrument used to determine the adequacy of the daily dose of methadone as part of the maintenance programme for the treatment of opiate dependence. The EADO scale, originally developed in Spain and then translated into English and published under the title “Opiate Dosage Adequacy Scale (ODAS)”, was translated for the German speaking territory and validated. The authors arrive at the conclusion that the ODAS questionnaire is an excellent tool for clinical practice and research. The point system of the instrument allows a standardized validation of the “adequacy” of a methadone dose, a detailed analysis both of the actual adequacy (qualitative validation) and of the adequacy grade (quantitative validation).

¹⁰⁷ The MATE-ICN has been integrated into electronic patient administration and treatment allocation in the Netherlands and is used almost countrywide in Dutch addiction help institutions. In Germany, the MATE-ICN was used as part of a pilot study on the psychometric evaluation of the German version of the MATE in various addiction help facilities. The results of this study were presented in detail two years ago in a special edition of the magazine “Sucht” (Sucht 55 (4), 2009).

6 Health correlates and consequences

6.1 Introduction

Drug use has an influence on morbidity and mortality of the users. Data on drug-related fatalities are collected by two countrywide systems: The Drugs Data File (Falldatei Rauschgift, FDR) kept by the Federal Criminal Police Office (Bundeskriminalamt, BKA) and the General Mortality Registry of the Federal Statistics Office (Statistisches Bundesamt). There are hardly any data available on the morbidity of untreated drug addicts which could be used for epidemiological purposes. That is why, alternatively, the descriptions of the health condition of the clients at the beginning of therapy are often used as an approximation. However, as these often represent a positive selection of the total of drug users, health aspects probably tend to get underestimated.

6.1.1 Infectious diseases

According to the Infectious Diseases Control Law, effective as of 1 January 2001, data on infectious diseases, including HIV and viral hepatitis, are to be reported to the Robert Koch Institute (RKI). These data are published in regular intervals¹⁰⁸. According to the German Regulation on Laboratory Reports and the Infectious Diseases Control Law (Infektionsschutzgesetz, IfSG) introduced in 2001, all laboratories in Germany are obliged to report confirmed HIV-antibody tests anonymously and directly to the AIDS-Centre of the Robert-Koch-Institute. These laboratory reports contain information on age, gender, place of residence of the infected individuals and routes of transmission. These data are complemented by supplementary anonymous reports of the doctors in charge, by limited clinical data and HIV-related laboratory parameters.

In addition, the AIDS-Case-Register anonymously collects epidemiological data on diagnosed AIDS-cases which are voluntarily reported by doctors in charge of the treatments. Thanks to a change in the collection of data on new HIV-diagnoses, it is now easier to avoid (formerly unrecognized) multiple data entries.

With the introduction of the Infectious Diseases Control Law in 2001, data on possible routes of transmission of hepatitis B and C (HBV and HCV) are also collected. This is done by the health authorities which investigate the case persons themselves or by the laboratories and general practitioners who pass on the information.

The updated data are published yearly by the Robert Koch Institute in Berlin in the "Yearbook – Infection epidemiology of notifiable infectious diseases" (Infektionsepidemiologisches Jahrbuch meldepflichtiger Krankheiten) (RKI 2010) or respectively in the Epidemiological Bulletin of the RKI (RKI 2011a).

Since 2007, the German statistical report on treatment centres for substance use disorders

¹⁰⁸ www.rki.de

records also data on the HBV- and HCV-status of patients in addition to the HIV-status. Since the number of facilities which report these data is very small and only patients with test results are recorded, these data require cautious interpretation.

6.1.2 Drug-induced deaths

Drugs Data File

In general, drug-induced fatalities are recorded by the Land Criminal Police Offices in the individual *Laender*. The BKA has access to the database and is responsible for data quality management and data collection. Data collection modalities and the bases for the assessment of drug-induced fatalities differ between the individual *Laender*. The portion of autopsied drug-induced deaths as a measurement for the quality of the assignment of drug-related fatalities varies (in some cases considerably) between the *Laender*. Toxicological reports on body fluids and tissue play an important role in determining the cause of death providing clarifying information on the drug status at the time of death. Reports on autopsies and toxicological reports are generally written by different institutions. Since especially toxicological reports are often made available with considerable delay, they are taken into account in the classification of drug-related fatalities only to a limited extent.

In order to facilitate the recording of drug-induced deaths and reduce mistakes, the following categories for drug-related fatalities were defined in a leaflet by the Federal Criminal Police Office (BKA 1999):

- drug-induced deaths caused by unintended overdose,
- death as a result of health damage (physical decline, HIV or hepatitis C, weakness of organs) caused by long-term drug abuse (= long-term health damage),
- suicide out of despair over living conditions or under the influence of withdrawal symptoms (e.g. delusions, strong physical pain, depressive mood),
- fatal accidents under the influence of drugs.

General Mortality Registry¹⁰⁹

In Germany, a death certificate is written out for every case of death, complete with personal data and information on the cause of death. The death certificate is passed on to the health office and then to the Land Statistics Office. Aggregation and evaluation at national level is done by the Federal Statistics Office. Often, this data source doesn't take account of the results of delayed toxicological reports in the classification of the drug-related deaths either.

Only cases that correspond to the definition of "direct causality" are selected from the General Mortality Registry to be reported to the EMCDDA. The goal is here to record death

¹⁰⁹ The usage of the term "General Mortality Registry" is oriented to the terminology of the EMCDDA. The data reported hereinafter is from the "Statistical report on the causes of death" ("Todesursachenstatistik") of the Federal Statistics Office (special series 12, part 4).

cases within the framework of a sensitive data collection as shortly as possible after the use of opioids, cocaine, amphetamine (derivates), hallucinogens and cannabinoids, i.e. in particular after fatal intoxications. The selection is based on the specifications of EMCDDA (the so-called ICD-10 Code Selection B). As a basis for the assignment to the group of drug-induced fatalities, the assumed underlying disorder (ICD10-Codes F11-F19) or the assumed cause of death (ICD10-Codes X, T, and Y) in the case of accidents and suicides is used respectively. This means that long-term secondary diseases, accidents not directly caused by intoxications and suicides are not comprised by this definition although individual cases of this type may be included due to faulty death certificates or coding errors. In 2006, new coding rules of the World Health Organization (WHO) entered into force. According to the new rules, the acute causes of death are to be generally coded, if possible, in form of the substance underlying the intoxication in lieu of the F1x.x-codes. In Germany, the new coding has however not led to the desired increase in the specificity.

The data collected by the Federal Criminal Police Office, by contrast, explicitly set out long-term secondary diseases, suicides and accidents that have come to the knowledge of police. It is however not possible to completely isolate the registered cases of intoxication to achieve data comparability with the General Mortality Registry on the basis of the aggregated data recorded by the BKA due to the usage of not completely disjunct categories.

Comparisons with other European countries should only be made on the basis of the General Mortality Registry, as this registry largely follows common standards. Due to the broader definition of the term 'drug-induced death', the data of the police register lead to higher estimates. The police register is of great importance for long-term comparisons of national trends but is less suitable for European-wide comparisons due to differences in the selection criteria and recorded age groups.

Neither of the two registers records the totality of drug-related fatalities. A certain number of relevant cases is not recognized, not reported or wrongly assigned – by either register. However, a long-term comparison of the two registers shows very similar developments and trends that can be seen as a kind of cross-validation of the two estimation procedures. An empirical analysis of the question as to whether the two systems record the same cases and in how far target groups overlap remains to be undertaken.

6.2 Drug-related infectious diseases

6.2.1 HIV/AIDS and viral hepatitis

The figures presented hereunder stem from the data on new HIV and hepatitis C diagnoses, acute hepatitis B and Aids infections reported to the Robert Koch Institute in the year 2010. Furthermore, results of the national HIV-incidence study are presented. Data from other sources give additional insight into the problems of specific, often regional populations of drug users (e.g. consumption room users, clients of outpatient addiction aid facilities) affected by HIV and hepatitis.

Comprehensive epidemiological studies on the prevalence of hepatitis B, C and HIV among injecting drug users are not available in Germany.

Data on the prevalence of hepatitis B and C and of HIV in injecting drug users are also contained in standard table 9.

HIV (data reported to the RKI)

A total of 2,918 newly diagnosed HIV infections were reported to the RKI for the year 2010. This means that there was no significant change in the total number of new HIV diagnoses in comparison with the year 2009 (N=2,885). Since 2007, the increase in new HIV diagnoses has significantly slowed down.

Data on the route of transmission was available for 85% (n=2,482) of the newly diagnosed HIV infections in the year 2010. The share of persons who probably contracted an HIV infection through injecting drug use was at 3.7%.

The number of new HIV diagnoses in IDUs dropped with 93 reported cases in 2010 (2009: 101) to the lowest level ever recorded since the start of differentiated data collection in the year 1993. Moreover, the decline of new HIV diagnoses is connected with a change in the age structure: the portion of the below 30-year olds decreased from von 35% in the year 2006 to little less than 23% in the year 2010.

The portion of the new HIV diagnoses in IDUs reported from North Rhine-Westphalia used to be overproportionally high (45%) in relation to the number of inhabitants in the past, in 2010 however, it declined to 31%.

The majority of the newly diagnosed HIV infections in IDUs were contracted in Germany. 10% of the infections were contracted in Eastern Europe. Central Europe was mentioned for the first time in 2010 more often as an infection region than Western Europe (4% vs. 1%). In view of the small case figures, it would however be too early to speak of an increasing HIV epidemic in IDUs in Central Europe (RKI 2011a).

AIDS (AIDS case register of the RKI)

Between 1.1.2008 and 31.12.2010, a total of 1,337 cases of new AIDS infections were reported to the RKI (notifications until 1.3.2011). With this, the total number of persons with full blown AIDS has increased to 28,027 since the start of the epidemic. There are however considerable divergences between regions to be found with regard to completeness of the reported AIDS-cases.

Among the new AIDS cases registered between 1.1.2008 and 31.12.2010, 82% were men and 18% women. With 7% of the infected men and 14% of the infected women, injecting drug use was for both genders in third place on the list of known infection risks. For 22% of the reported AIDS cases among men and 18% of the AIDS cases among women, there was no information given on the infection risk (RKI 2011a).

Results of the HIV incidence study 2008-2010

From March 2008 until March 2010, socio-demographic, clinical and laboratory data were collected from a representative sample of patients with a newly diagnosed HIV infection and blood samples tested to find out whether the infection was recently contracted (< 5 months). In the overall sample of N = 3,082, 137 (4.5%) were samples from injecting drug users. Among these, the portion of recently contracted HIV infections was with 35% the highest in comparison with all other transmission groups. Among male IDUs (n=98; 71.5%), the portion of recently contracted infections was at 30,6%, among females (n=39; 28.5%) at 46.2%. Furthermore, the portion of recently contracted infections was the highest among the youngest age group (18-29 years) (46%), in the group of the above 30-year olds it amounted to 32%. Most of the examined IDUs were Germans (n=94; 6.6%). Among the other countries of origin, the most frequently mentioned was Russia (n=11), followed by other East European countries (n=10). A significant difference was found in the portion of recently contracted HIV infections from Germany (39.4% of the recently contracted infections) and from Russia (no recently contracted infection; p=0.01; OR = 1.7; 95% CI[1.4; 1.8]). The authors take this as an indication that the group of the IDUs from Russian origin either has little access to HIV testings in Germany or that they contracted the virus before their migration. The German IDUs who are in contact with the medical system, in contrast, seem to be regularly tested and therefore often get diagnosed at an early stage of infection (Zimmermann et al. 2011).

HIV data from other sources

From Hamburg, data is available on the HIV prevalence among clients of the outpatient addiction help institutions. The HIV prevalence among the opioid clients in outpatient therapy amounted to 5.2% in 2009, whereby women (6.2%) were more frequently HIV positive than men (4.8%). The prevalence remained stable in comparison to the previous years (Oechsler et al. 2010).

In the Frankfurt documentation on consumption rooms (Simmedinger & Vogt 2010) 4.4% of the consumption room users reported in 2009 that they were infected with the HIV virus (males 3.7%, females 7.7%). With 1.7%, the HIV infection quota among the new clients was significantly lower than among the medium- or long-term clients who displayed an overproportionally high infection rate with 9.7%.

In the scene survey MoSyD (Mueller et al. 2011) also conducted in Frankfurt among 150 drug users (recruited at equal parts from the open drug scene round the central station and from low-threshold facilities), 6% reported HIV infection.

The DSHS, too, records data on the HIV-infection status of the treated patients (Pfeiffer-Gerschel et al. 2011b). The prevalence among the tested opioid clients in outpatient facilities was 7% (N=433), among the tested patients with illicit substance use 7% (N=511).

Hepatitis B (data reported to the RKI)

In the year 2010, a total of 1,843 hepatitis B cases were reported to the RKI (data status: 1.3.2011). Out of these, 767 cases (41.6%) corresponded to the reference definition - 1.7%

more than in the previous year (754). Among these, six people had died of hepatitis B or of secondary diseases. The incidence in Germany was at 0.9 infections per 100,000 inhabitants. No seasonal variations were found in the temporal course. The last ten years showed a downward trend in the reported hepatitis B infections, in the year 2010 however, figures practically did not change in comparison with 2009. (RKI 2011b).

For 651 (85%) of the reported infections in line with the reference definition, data (defined as at least one »yes«- or »no«-answer) was available on possible expositions in the last 6 months before the diagnosis was made. Multiple entries were possible. With 268 infections (41% of the infections with reported infection risk), sexual contacts were the most frequently reported exposition. Injecting drug use was only mentioned in 18 hepatitis B infections (3%) (RKI 2011, personal communication).

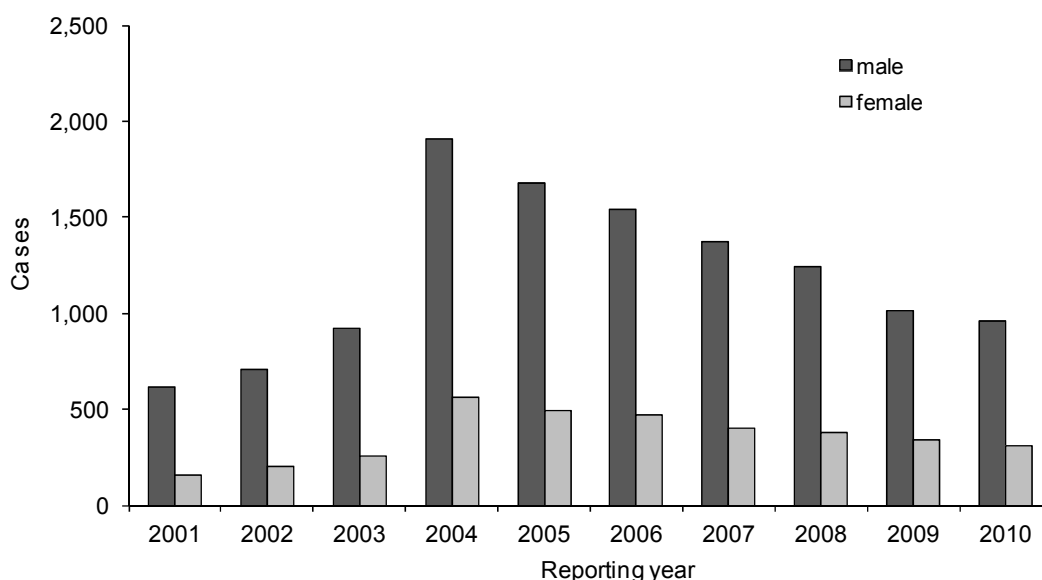
Hepatitis C (data reported to the RKI)

For the year 2010, a total of 5,283 cases of newly diagnosed hepatitis C were reported¹¹⁰. At national level, this corresponds to 6.5 first diagnoses per 100,000 inhabitants (data status: 1.3.2011). With this, the quota of reported first diagnoses was lower than in 2009 (6.7) or respectively below the median of the years 2005 to 2009 (8.3). Among the new hepatitis C cases, 3,568 (67%) were without clinical symptoms. 10 died of hepatitis C or of secondary diseases in 2010. No seasonal variations were found in the temporal course. The national incidence of newly diagnosed hepatitis C cases has been on the decline since 2005.

For 3,883 cases (73.5%) data on previous expositions (at least one »yes«- or »no« answer) was available. Several entries were possible. Intravenous drug use, which is, in all probability, in causal connection with hepatitis C, was the most frequently reported exposition with 1,267 cases (32.6%). Among the 20- to 29-year old men, injecting drug use was mentioned 332 times (67.5% of the men of this age group with recorded exposition). Over the last ten years, men have been overrepresented among the IDUs (see RKI 2011b).

Figure 6.1) (RKI 2011b).

¹¹⁰ According to the Law on the Prevention and Control of Infectious Diseases in Humans (IfSG), all hepatitis C infections for which a chronic infection is not yet known, are notifiable. The presently available laboratory tests do not allow differentiation between acute or chronic HCV infection diagnosed for the first time. In addition, the majority of the new infections of hepatitis C (approx. 75%) take an asymptomatic course. In this way, all newly diagnosed cases are entered into the statistical report, but cases with an indicated earlier HCV laboratory record, are excluded. The reports on hepatitis C first diagnoses thus comprise acute infections but also chronic infections with varying infection durations diagnosed for the first time. The reported hepatitis C first diagnoses may not be equated with the hepatitis C incidence nor with the hepatitis C prevalence. Other factors that can influence the reported data, are the offer of test possibilities, the usage of such test offers and the reporting behaviour of the doctors. Especially changes of these parameters in the temporal course may render the interpretation of the data difficult. Nevertheless, the reported hepatitis C first diagnoses, for want of other data sources, offer the currently best possible evaluation of the present infection situation.



RKI 2011b.

Figure 6.1 Hepatitis C cases reported to the RKI with indication of injecting drug use broken down by reporting year and gender, Germany, 2001-2010

Hepatitis B and C – data from other sources

In 2010 too, data were collected on the hepatitis B and hepatitis C infection status of outpatient addiction patients within the framework of the German Statistical Report on Treatment Centres for Substance Use Disorders (Deutsche Suchthilfestatistik, DSHS) (Pfeiffer-Gerschel et al. 2011b). According to the DSHS, the prevalence for hepatitis B among the tested opiate clients is at 10.1% (n=753), among the tested clients with illicit drug problems at 7.7% (n=845). The prevalence of hepatitis C among the tested opiate clients is at 54.2% (n=5,565, out of these acute in 460, chronic in 5.105), among the tested clients with any illicit drug problem at 40.0% (n=6.081).

According to the Hamburg base documentation system of the outpatient addiction help system (BADO) almost every second opiate user was infected with hepatitis C (48%) in 2009. The infection rate could however be significantly decreased since 2005 (57%) (Oechsler et al. 2010).

In the Frankfurt drug consumption room documentation (Simmedinger & Vogt 2010), 52% of the users who have been tested for hepatitis, have a hepatitis infection. The most commonly stated infection (47%) is infection with hepatitis C, a further 3% are infected with hepatitis B and C. Only 2% report a hepatitis B- infection. Gender differences are minimal. Differentiating the data by age groups, one finds, like in the last years, that the younger users (till 33 years) display markedly lower hepatitis infection quotas than the older ones (above 33

years). 45% of the younger, but 58% of the older consumption room user have a hepatitis infection.

In the scene survey MoSyD that was also conducted in Frankfurt (Mueller et al. 2011), 65% stated that they were infected with hepatitis C. Respectively 1% and 2% stated that they were infected with hepatitis A and B.

6.2.2 Sexually transmissible diseases, tuberculosis and other infectious diseases

There is no current data available on other infectious diseases affecting drug users.

6.2.3 Behavioural data

A survey conducted among approximately 150 drug users in Frankfurt (Mueller et al. 2011) is the only source for behavioural data in the reporting period. 70% of this random sample engaged in injecting drug use when the survey was conducted and they were therefore also interviewed about risk behaviours as regards the use of injection utensils: 85% of the interviewees use an injection needle on principle only once. The other interviewees use needles several times at least occasionally, 4% even more than three times. Nearly a third of the interviewees shared utensils for injecting drug use at least occasionally with other users. About one in ten engaged in this practice almost daily. Sharing drugs from one and the same syringe is common in about a quarter of the interviewees and 10% out of these do this daily. The extent of risky behaviour has hardly changed in comparison with 2008. This means that risky use patterns are still prevalent among a certain group of users.

“Druck” Study – Drugs and chronic infectious diseases

Since June 2011, the Robert Koch Institute has been conducting a pilot study among injecting drug users in cooperation with the Berlin drug help facility Fixpunkt e.V. Goals of the study are to gain information on infectious risks and behaviours of people who engage in injecting drug use and to test the feasibility of such a study. Furthermore, an examination of the blood samples of the participants is to give insight into the prevalence of infectious diseases that can be sexually transmitted or transmitted through drug use. The infectious diseases under enquiry are hepatitis B, hepatitis C, HIV and anthrax.

The study is funded by research funds of the Robert Koch Institute for the year 2011. An expansion of the study to other German cities with funds by the Federal Ministry of Health is planned.

The participants are interviewed by trained interviewers by means of a structured questionnaire and asked to give a few blood drops on a special filter paper that is examined in the laboratory. The interviewing and testing is done anonymously, each participant receives a participant number.

The study is to survey persons who have used drugs intravenously in the last 12 months and who live in Berlin. Participation is irrespective of the infection status and knowledge thereof. In order to maximize the representativeness of the sample drawn among this group of

persons, participants are recruited through a modified respondent driven sampling that makes use of the social networks existing within the group of drug users: starting from a group of approximately 10-12 persons selected and approached by study personnel, the participants are asked to address two to three persons respectively from their circle of friends and acquaintances and get them on board to participate in the study. The RDS is continued until the planned number of participants (approximately 400 persons in Berlin) is reached or the project period comes to an end.

The RDS method has already proven successful in other European countries and countries outside Europe in recruiting groups like drug users that are difficult to reach. It is tested for the first time in Germany within the framework of this study.

The participants receive an expense allowance to the amount of 10 Euro for filling in the questionnaire and giving the blood sample. The expense allowance also serves to cover possible travel costs. The participants receive a little reward to the amount of 5 Euro for successfully recruiting further (up to three) participants. The reward may be collected approximately two weeks later during the consultation hours provided that the recruited persons also showed up. Persons recruited in the last recruiting wave do not have the possibility to recruit participants themselves, therefore they do not receive a recruitment reward.

Fixpunkt additionally offers separate consultation hours during which the participants are informed about their individual risks, possibilities of protecting themselves and about the result of their blood test. In the case of a positive HIV, hepatitis B or hepatitis C testing, it is urgently recommended to the participant to seek medical treatment or respectively to give a second blood sample for verification.

Similar studies are planned in Essen for this year and in another six cities for the year 2012.

It also planned to use this pilot study to assess the overall size of the group of the injecting drug users in Berlin. To this purpose, a so-called capture-recapture-method is used: before the start of the study, approximately 600 little give-away articles (lighters with a printed message on the current HIV and hepatitis C testing project) were distributed to IDUs by low-threshold contact and counselling centres for injecting drug users. The recruited participants are asked if they have received such a give-away article in the previous weeks. Based on the total number of the distributed give-away articles that make their reappearance in the study, it is possible to forward an estimate on the total number of injecting drug users in Berlin (RKI, personal communication).

6.3 Other drug-related health correlates and consequences

6.3.1 Non-fatal overdoses and drug-related emergencies

The only recent data on non-fatal overdoses stem from the Frankfurt scene study MoSyD (Mueller et al. 2011). 64% of the drug users interviewed within the framework of this study report that they have survived an overdose once in their lives. The median of the number of overdoses is at 2.5. The last overdose dates back three years (36 months) on average. Both

as regards the time of the last overdose and the number of overdoses, answers diverge considerably. The most frequently used drug in the last overdose was heroin (94%), followed by crack (40%), medications (34%) and alcohol (26%; several answers were possible). When asked about the substance that was primarily responsible for the overdose, interviewees put heroin (47%) in the first place and simultaneous use of several substances (26%) in the second (26%). The main reason given for the overdose was mainly the unknown quality of drugs (47%) followed by poly-drug use among approximately a quarter of the interviewees. Only an eighth of those with overdose experience report too high a use after previous abstinence. Reasons like bad general condition on that day or intention to commit suicide only play a minor role. The consumption room is the most frequently mentioned setting for overdose (57%), followed by overdoses on the street (21%), at home or in other private settings (19%). 60% reported that they had received help from drug help facilities, 36% from emergency doctors, 13% from other users, 6% from acquaintances (non-users) and a further 6% stated that they had not received any help at all.

There is no other recent data on non-fatal overdoses and drug-related emergencies available.

6.3.2 Other topics of interest

Somatic and psychiatric comorbidity in drug users

Apart from the infectious diseases described above, drug users are affected to a considerable extent by a series of somatic and psychiatric comorbidities. Comprehensive national or representative surveys do not exist on this topic, a few regional studies do however give an impression of the range of health problems in samples drawn among drug users of the open drug scene and clients of various drug help facilities.

The Frankfurt scene survey MoSyD (Mueller et al. 2011) has been collecting data since 1995 on the health status of drug users of the open drug scene and clients of low-threshold drug facilities. Over all the years of enquiry, depressions are the most commonly reported complaints. In the year 2010, 38% of the interviewees were affected by depressions. 31% reported problems with their lungs/bronchi, 24% cardiovascular problems, 19% gastrointestinal problems, 17% cold and flu, 15% respectively toothache and abscesses. 38% of the HIV infected persons reported AIDS-related diseases. About a quarter to about half of those who reported complaints, also made use of medical treatment.

The basic documentation kept by the outpatient drug help system in Hamburg also provides information on the physical and mental health of the treated clients for the year 2009 (Oechsler et al. 2010):

According to the Hamburg basic documentation, 10% of the opioid clients, 8% of the cannabis clients and 7% of the cocaine clients display impairments of their nervous system. Liver damage occurs in a quarter of the opioid clients and in about one in ten in the two other substance groups (9%; cannabis-only users: 0.8%). 7% of the opioid clients and respectively 3% of the cannabis and cocaine clients are (cannabis-only users: 0.6%) affected by epileptic

fits. The portion of pulmonary diseases increased in almost all groups over the last five years: from 16% to 20% in the opioid group and from 9% to 13% in the cocaine group. In the cannabis clients however, it remained stable at also 13%. Cardiovascular problems occur in 17% of the opioid clients, in 10% of the cannabis and in 9% of the cocaine clients (cannabis-only users: 6%). More than half of the clients complain about sleeping disorders. The dental status showed a slight improvement, the portion of clients with normal or respectively repaired dentures is at currently 81% in cannabis clients and at 77% in the cocaine clients (cannabis-only users: 89%), in the opioid clients however only at 58%. If there were any appreciable gender differences found, they generally affected women more than man.

Clients of drug help facilities are also affected by psychological problems. 15% of the opioid clients, 11% of the cannabis and 13% of the cocaine clients suffer from significant anxiety and phobia. The portion of clients suffering from extremely depressive moods declined in the last five years in all substance groups by three to five percentage points, but it still accounts for 21% of the opioid clients, 16% of the cannabis and 17% of the cocaine clients. Nearly one in three opioid clients and almost one in four cocaine clients has committed at least one suicide attempt. These portions increased by eight (opioids) or respectively four percentage points (cocaine) in comparison with the year 2005.

A survey conducted by Langenbach and colleagues (2010) among 151 patients aged between 13-22 years who had been admitted to one of two psychiatric clinics in North Rhine-Westphalia for the treatment of substance disorders also revealed a significant psychiatric comorbidity in this young group of clients: 40.5% had at least one axis-I-disorder in respect of DSM IV (22.5% anxiety disorders; 19.2% affective disorders; 9.3% somatoform disorders) at the time. In a subgroup of 65 patients below 18 years of age who were surveyed with an additional screening instrument, 9.2% fulfilled at the time the criteria of ADHD, 41.1% displayed behavioural disorders.

Within the framework of the European TREAT Project (Treatment systems Research on European Addiction Treatment) that also served to examine differences and communalities among others with regard to the psychiatric comorbidity in six European regions, a sample of 100 opioid users from the region of Essen was surveyed. The results show that 17% of the interviewed participants additionally displayed alcohol dependence, 9% suffered from a generalized anxiety disorder and 46% from a major depression (Reissner et al. 2011).

In a review on German and international studies, Koerkel (2011) deals in depth with the topic of alcohol use among drug users. He arrives at the conclusion that a high portion of drug addicts uses alcohol and this in high quantities that pose already a significant health risk to healthy people who do not use drugs. Furthermore, a high percentage of alcohol using drug addicts is to be classified as alcohol dependent. In very different settings and samples (drug addicts in inpatient withdrawal or rehabilitation therapy, drug addicts in low-threshold facilities, substituted and non-substituted drug addicts) German studies found portions of addictive alcohol use ranging between 28% and 52%. In this connection, it showed that many drug users are aware of the problems and motivated to change their behaviour. The current non-alcohol-related therapy offers (substitution, rehabilitation) made for drug users

only show little or no effect at all on the alcohol use of the persons treated. Therefore, the author recommends to address alcohol use standardly in an open, non-sanctioning approach and to offer specific interventions.

Backmund and colleagues (2010) conducted a study on benzodiazepine dependence among opiate addicts. They note that in connection with opioid dependent patients, it is seldom talked about an additional addictive disease but rather about by-use, leaving out of account that benzodiazepine dependence per se represents a severe disease. In the survey conducted among 115 patients who participated in a substitution programme of a practice for addiction medicine, 22.6% fulfilled the ICD-10-criteria for benzodiazepine addiction. The patients were additionally asked about further psychological disorders. 34% reported that they suffered from anxiety, 11.5% from a psychosis, 42.5% from depression and 5% from an obsessive-compulsive disorder. There was a significant connection between another reported psychological disorder and a diagnosed benzodiazepine dependence. According to the authors, this finding can be interpreted as a corroboration of the self-medication hypothesis. This would mean that the psychological symptoms need to be treated successfully in order to achieve abstinence from benzodiazepines. So far however, no larger studies have been conducted on the effectiveness of the therapy of psychiatric comorbidity in opiate dependents.

Cannabis abuse and risk of psychosis

Cannabis use has repeatedly been associated with the incidence of psychotic disorders. It remains a matter of debate whether there is a causal connection in this order or whether rather the early experience of psychotic symptoms prompts cannabis use as a means of self-medication. This question is the central topic of a German prospective cohort study (Early Developmental Stages of Psychopathology; EDSP) conducted among 1,923 interviewees from the general population who were between 14 and 24 years of age at the beginning of the study. Investigated were the incidence and the persistence of the psychotic symptoms after cannabis use in adolescence. Data were collected three times over a period of 10 years (baseline, T2: after 3.5 years on average, T3: after 8.4 years on average). The analyses showed that cannabis use significantly increases the risk for psychotic outcomes (the incidence rate of psychotic symptoms over the period from baseline to T2 was 31% in individuals who had used cannabis versus 20% in individuals that had not used cannabis; over the period from T2 to T3, these rates were 14% and 8% respectively). No indication was however found for the self-medication effect: incident psychotic symptoms were no predictor for later cannabis use. Additionally, continued cannabis use was confirmed as a risk factor for the persistence of psychotic symptoms. As for the methodology used, the authors note that the study investigated the incidence of (individual) psychotic symptoms and subclinical psychoses. It is assumed that such experiences with psychotic symptoms are a common but generally transitory phenomenon in the general population that however may progress, in combination with other risk factors, to persistent symptoms and clinical psychotic disorders (Kuepper et al. 2011).

6.4 Drug-related deaths and mortality in drug users

6.4.1 Drug-induced deaths (overdose/intoxication)

Data from the special police register on drug-induced deaths

The reliability of information on drug-induced deaths strongly depends on the question as to whether autopsies and toxicological examinations have been used to validate the initial classification as drug-induced death or not (cf. chapter 6.1). The autopsy rate of all drug-induced deaths in the reporting year 2010 was on average at 66% (2009: 66%; 2008: 62%), whereby individual *Laender* considerably diverged from this value.

In the year 2010, a total of 1,237 people died because of the use of illicit drugs which corresponds to a decline of seven percent in comparison with the previous year (1,331). Overdose of heroin (including use of heroin in connection with other drugs) remains with 855 cases the most common cause of death (69%; 2009: 70%; 2008: 66%). The portion of drug-related deaths in which substitution substances alone or in combination with other drugs were detected, was at 14% (2009: 13%; 2008: 12%); in 2002, this portion was still at 40%. Since 2006, the statistics of the federal criminal police office discriminate in the detected substitution substances between methadone/polamidone and subutex® (buprenorphine). According to the BKA data, the majority of death cases that were attributable to one substitution substance alone happened in connection with methadone/polamidone (N=45; 88%). Among the 116 death cases, in which substitution drugs in combination with other drugs were found, there were also two cases in which buprenorphine was detected¹¹¹ (see also Table 6.1) (BKA 2011b).

The number of death cases in which substitution substances played a role is still low, which can be attributed to the good qualification of treating staff and the reliability of quality assurance measures taken. Generally, it is however to be assumed that in the presentation of the involvement of substances in the recorded deaths, the number of mixed intoxications (combination categories) but also the involvement of substitution substances is underestimated due to frequently missing exact toxicological data on a death case.

¹¹¹ Since the data collected by the Land Criminal Police Offices for the national statistical report may contain multiple entries of the same case, it could for example be that a death case is coded both as a suicide and cocaine overdose. The sum of all overdose cases entered is already higher than the overall figure of death cases. This means that double entries are also contained in this category. Therefore, it is only possible to add up categories that do not contain any overlapping data. This is for example the case for the categories "overdose of heroin (alone)" and "overdose of heroin and other drugs". The figure of death cases caused by overdose can therefore not be calculated, but only estimated as an approximate value (see Table 6.1).

Table 6.1 Drug-related deaths 2005-2010 broken down by substances

Death causes	Percentage out of total N ¹⁾						Figure ¹⁾
	2005	2006	2007	2008	2009	2010	2010
1. Overdose of ¹⁾ :							
Heroin	40	38	39	42	43	43	529
Heroin + other drugs	23	27	26	24	27	26	326
Cocaine	2	2	1	1	1	2	27
Cocaine + other drugs	9	9	10	7	8	7	90
Amphetamines	1	<1	<1	1	1	2	20
Amphetamines + other drugs	2	3	2	3	2	4	54
Ecstasy	0	<1	<1	<1	<1	0	2
Ecstasy + other drugs	0	1	1	1	<1	0	6
Pharmaceutics/substitution druas ²⁾	6	5	4	3	3	4	51
- thereof: Methadone/Polamidone			3	3	3	4	45
- thereof: Subutex (Buprenorphine)			--	<1	<1	0	4
Substitution drugs + other drugs ³⁾		12	9	9	10	9	116
- thereof: Methadone/Polamidone			8	8	9	9	110
- thereof: Subutex (Buprenorphine)			<1	<1	<1	0	2
Other drugs + alcohol + substitution drugs ⁴⁾	19						
Other narcotic drugs/unknown	10	8	10	10	13	12	148
2. Suicide ¹⁾	8	6	6	6	4	5	61
3. Long term damage	12	11	12	17	20	17	214
4. Accident/other	2	13	12	11	8	1	17
5. Total (N) ¹⁾	1,326	1,296	1,394	1,449	1,331		1,237

1) Due to multiple entries in the categories "overdose" (different types of drugs) and "suicide", the sum of the recorded causes of death is higher than the overall number of drug-induced deaths.

2) Since 2006: substitution substance.

3) Since 2006.

4) Does not exist anymore since 2006.

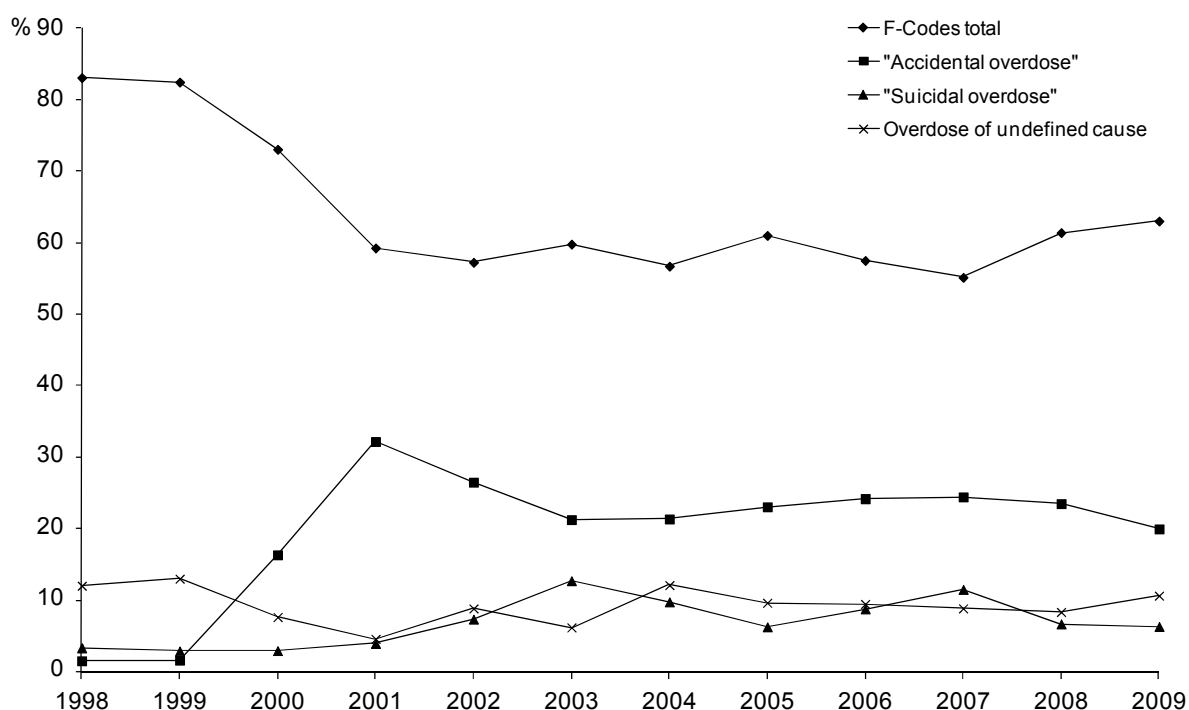
BKA 2011a.

Data from the general mortality register

The most recent data on drug-related deaths recorded by the general mortality register are from the year 2009. In that year, data on 1,276 persons were collected – this corresponds to a decline of 3.8% in respect of 2008 (n=1,326). Among these were 245 females and 1,031 males (portion of 80.1%) who died in connection with illicit drug use. With this, the number of death cases recorded by the general mortality registry in respect of the definition of the

EMCDDA developed in parallel to the declining number of deaths recorded by the BKA (-8.1%). As for the previous years, the BKA register gives somewhat higher case figures also for 2009, which may be explained by the fact that it includes also indirectly related fatalities that are difficult to separate since the category "suicides" and, as the case may be, also the category "accidents/other" does not clearly differentiate between direct and indirect cases. But even without including the clearly defined category "long-term secondary diseases" of the BKA register, the case figure for 2009 was with $n=1,066$ markedly below the case figure of direct death cases recorded by the general mortality register. This means that the general mortality register includes more cases than the BKA register.

In 2009, the underlying disease (addiction, harmful drug use, other of the ICD-group F1x.x) was coded as the cause of death in 63.0% of the death cases (2008: 61.4%). As in the previous year, it showed again that the revision of the WHO coding rules of the year 2006 that aimed at coding acute causes of deaths in form of an intoxication with underlying substances has so far not produced any effect in Germany (see Figure 6.2). A strong point of the special register kept by the BKA is that it is able to break down available substance-related information in drug-induced deaths more reliably than the general mortality register of the Federal Statistical Office. On the other hand, the death-inducing substances are in the majority of the cases not identified at all due to lack of autopsies or toxicological analyses.

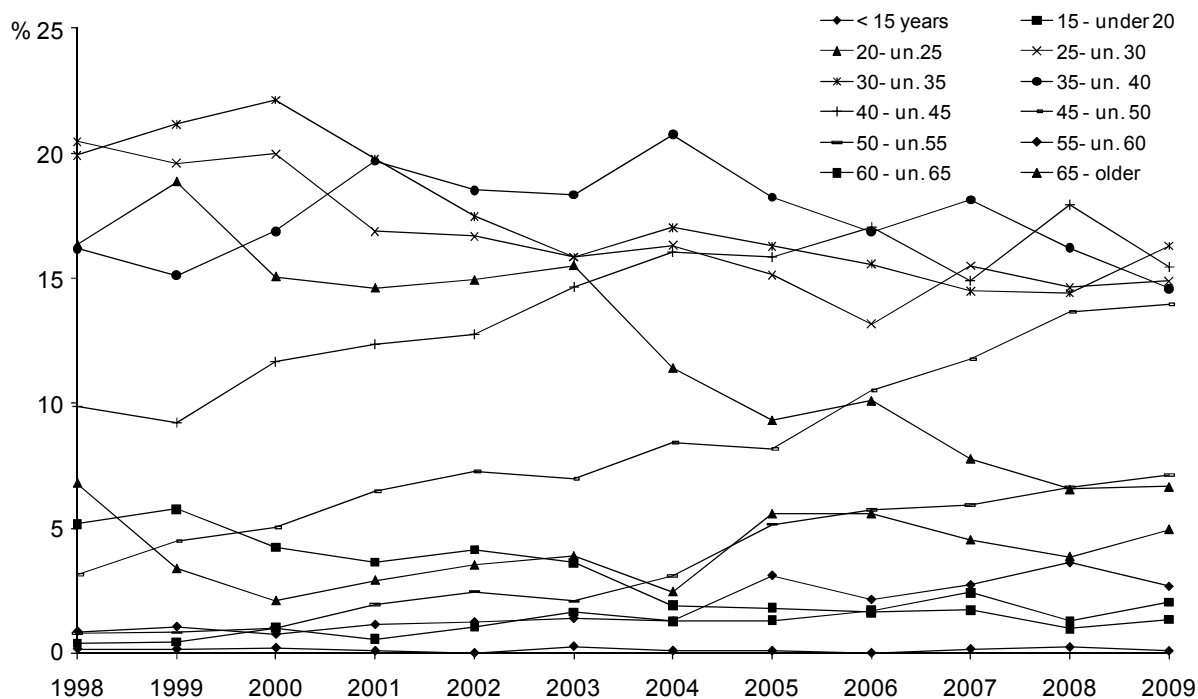


Statistisches Bundesamt; special calculations.

Figure 6.2 Coding of the causes of death in the general mortality register (1998-2009)

Looking at the age distribution of the drug-related deaths over the last ten years, one notices an increase in the portion of older drug users over the last few years. In 2009, the age groups between 45 and 55 years reached their highest shares since the start of data

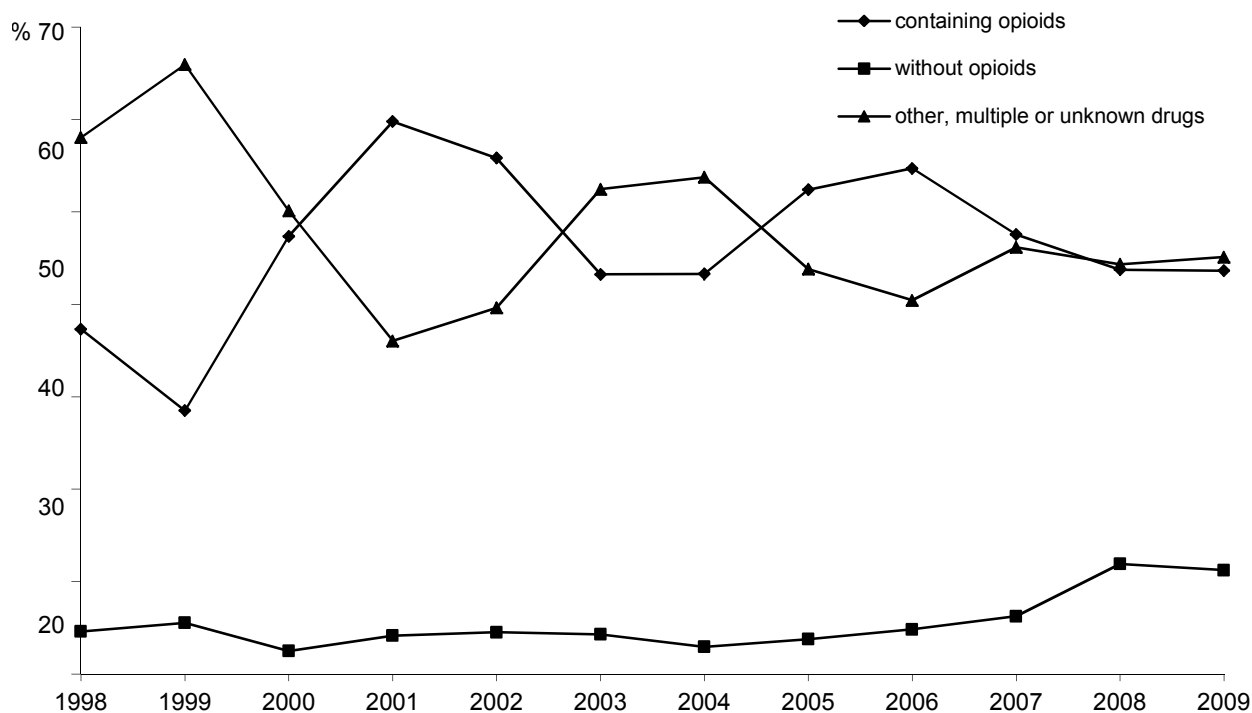
collection in the year 1998. At the same time, the shares of younger age groups have been on the decline for several years, whereby the effect was not stronger in 2009 in comparison with the previous year. The development of the drug-induced deaths still does not allow to make any inferences on a new trend in young users of hard drugs (Figure 6.3).



Statistisches Bundesamt; special calculations.

Figure 6.3 Drug-induced deaths broken down by age groups, 1998-2009

Only the coding of drug-induced deaths with the additional X and Y codes for external causes that are combined with the T codes for substances in the ICD-10 classification allow to make inferences on the substance spectrum involved in intoxications. This applied however to only 37% of the registered cases in 2009. Monovalent opiate intoxications accounted for approximately 43.6% of the death cases in this subgroup in 2009. In 11.2%, other substance groups were recorded, in 45.1%, intoxications were not specified. This applied especially to cases with polydrug use involving several substance groups. It may of course be assumed however that opiates played a primordial role again leading the field of substances. There were hardly any changes observed in comparison with the previous year. Qualifications need however to be attached to the validity of the data since it is not exactly known how many of these classifications are actually based on the findings of chemical toxicological analyses on the spectrum of substances that caused the deaths (Figure 6.4).



Statistisches Bundesamt; special calculations.

Figure 6.4 Opiate induced intoxications in fatal drug overdoses 1998-2009 with ICD X/Y-coding

6.4.2 Mortality and causes of death among drug users (mortality cohort studies)

There is no survey available on the mortality of the overall population of drug users nor have there been any regional cohort studies carried out recently. It is however possible to get at least closer to the question by resorting to the data that exist on drug addicts in therapy.

According to the German Statistical Report on Treatment Centres for Substance Use Disorders (Pfeiffer-Gerschel et al. 2011b) for the year 2010, therapy in outpatient counselling facilities ended in 1.5% (2009: 1.5%) of the opioid clients with death (opioid clients accounted for 89.7% of the clients registered by the DSHS and deceased while in outpatient treatment in 2010). In order to eliminate the effect of treatment duration, which has increased on average by more than 10 weeks since 2000, a treatment duration of 12 months was mathematically assumed. The resulting mortality per year was also in 2010 at the levels of previous years (Table 6.2).

However, when looking at these data, it needs to be taken into account that the treating facilities are not always informed about the death of a client so that the actual mortality – in particular of treatment dropouts - is presumably higher than the value given here. Proceeding on the assumption that knowledge of the facilities about clients' deaths has not changed systematically over the years, it is nevertheless possible to interpret trends in the way presented.

Table 6.2 Mortality of opioid users in outpatient treatment – trend

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Death proportion among treatment outtake	1.2%	1.2%	1.2%	1.4%	1.3%	1.4%	1.2%	1.5%	1.5%
Treatment duration (days)	280.7	282.1	297.5	305.2	301.7	314.3	321.2	336.4	343.3
Mortality p.a.	1.6%	1.5%	1.5%	1.7%	1.6%	1.6%	1.4%	1.6%	1.6%

Pfeiffer-Gerschel et al. 2011b and own calculations.

Data on the mortality among drug users are contained in standard table 18.

6.4.3 Specific causes of mortality indirectly related to drug use

Data on road accidents in connection with drug use are presented in chapter 9. Other data is currently not available.

7 Responses to health correlates and consequences

7.1 Introduction

Health aspects of drug use are addressed by specific offers provided for drug users as well as within the framework of general health care. Information on the scope and type of measures is generally only available for a part of the specific measures, as these are carried out by specialized facilities or as part of a specific program.

General health care

Data on general health care do not provide any information that could be specifically referred to the group of drug addicts. Except for a few individual cases, there are no data available on the overall number of emergency cases due to overdose or other life-threatening conditions caused by drug use. Nor are there any data on the treatment of secondary diseases carried out in office-based practices or clinics.

Special offers

Outpatient services facilitate access to basic medical care that is generally provided by office-based doctors in their function as medical consultants. Dental treatments that have been put off for a long time and other medical treatments are commonly carried out during inpatient addiction therapy. Basic data hereto are available from the German Annual Statistical Report on Addiction Therapy. In a few *Laender*, specific projects on dental hygiene and infection prophylaxis are offered as part of low-threshold drug aid.

7.2 Prevention of drug-related emergencies and reduction of drug-related deaths

Various targeted approaches are used to prevent drug-related deaths: they range from programmes for drug emergency prophylaxis that comprise training in the use of naloxone over offers providing immediate help (“therapy now”), the provision of drug consumption shelters to the expansion of substitution therapy as the most important measure. Apart from data on substitution treatment (see chapter 5) there is also updated information available on some consumption rooms.

Drug consumption rooms

In view of the still highly risky use pattern linked with heroin, drug consumption rooms and low-threshold facilities play an important role in offering help for addicted people at an early stage. Drugs are brought along to drug consumption rooms by the drug users themselves. Infection prophylaxis forms systematically part of the service provided. Paraphernalia brought along to the consumption rooms may not be used. The goal of this initiative is to secure the survival and stabilization of the health conditions of the drug users as well as to attract drug users who can otherwise not be reached by the system in order to provide them with motivational offers to quit drug use. Based on §10a of the Narcotics Act, which defines

minimum requirements for the operation of these facilities, the governments of the *Laender* may pass regulations specifying the authorization criteria to be fulfilled for setting up and running drug consumption rooms.

In 6 out of 16 *Laender*, corresponding regulations have been passed. According to a survey carried out among the *Laender*, there are currently 28 drug consumption rooms with 251 consumption places (Floeter & Pfeiffer-Gerschel 2011).

More detailed data on the use and the clients of the consumption rooms are only available for individual facilities at regional level.

The Frankfurt consumption room documentation (Simmedinger & Vogt 2010) of the four Frankfurt consumption rooms reports in its annual evaluation for 2009 205,380 (2008: 196,221) drug use activities of 4,658 consumption room users (2008: 4,681), out of whom 1,510 (2008: 1,753) were new clients. In comparison with the year 2008, the number of consumption activities increased by 5% (increase in the previous year: +15%). This means that for each user 44 consumption activities were documented on average in 2009. Among the intravenously injected drugs, heroin and crack played a predominant role in the consumption rooms. Heroin was used alone or in combination with other drugs in 82% (2008: 78%) of all drug use activities and crack in 36% (2008: 38%) (multiple responses). As in the previous year, 16% of the consumption room users injected benzodiazepines intravenously, mostly in combination with other psychotropic substances. Intravenous use of cocaine was only reported for 2% of all users. In about 2% of the drug use activities (2008: 4%), the drugs were not intravenously applied. When analysing the use patterns in a discriminating manner, one finds that heroin was the drug that was most frequently used alone (not in combination with other drugs) accounting for 49% of the records. Second came heroin in combination with crack with 21% and in third place was crack alone with 12%. Only slight changes were found in the comparison with the previous year. Use patterns diverge significantly between men and women as in the previous years: there are relatively more users of heroin alone among men (51%) than among women (35%). More women (30%) than men (20%) prefer the combination between heroin and crack (27%). The same applies to injecting use of crack alone (women 14%, men 11%). Similar gender differences in the use patterns of the users of the drug consumption rooms were already found in the previous years. The overall group of consumption room users is made up of 84% (n= 3,915) men and 16% (n= 743) women. The average age of the users of the consumption rooms is 34.5 years (2008: 34.2). Comparing the average age of all users of the consumption rooms of the year 2009 (34.5 years) with the one of the year 2003 (33.3 years), one finds that the average age of the users of the consumption rooms only increased by 1.2 years within seven years. This finding is an indication that relatively many new and comparatively young persons use the consumption rooms each year. 25% of the consumption room users only used one of the four Frankfurt consumption rooms once. This figure corresponds to the findings of the six previous years. The portion of those who used the consumption rooms more than 20 times remained at 28% as in the previous year. The most frequent users (>20 times) of the consumption rooms are – as in the previous years – rather persons who are socially disintegrated. These are mainly

drug users from Frankfurt on the Main who are somewhat older (over 33 years), live in precarious housing conditions and are jobless. The persons who frequently use the consumption rooms display overproportionally high hepatitis C infection rates.

Up to the present, there have only been few studies devoted to the analysis of the effectiveness of the provision of drug consumption rooms as regards changes among the clients and the achievement of institutional goals. Therefore, Scherbaum and colleagues (2010) conducted a prospective longitudinal study in the drug consumption room in Essen among 129 consumption rooms users newly registered during the period of enquiry, to investigate whether the use of the consumption rooms correlates with less risky use behaviour and an increase in the referrals to further treatment. The typical consumption room user surveyed in the study was 31 years old, single, without vocational training and had a long history of injecting opiate use in the context of multiple substance use. On average, the facility was regularly visited for a duration of five weeks. A regular continued visit of the facility over the whole period of enquiry of six months after the baseline interview was only found in nine clients (7%). 29 clients (22%) visited the consumption rooms for more than three months, 26 clients (20%) for one month, a further 29 clients (22%) used the facility less than a week, out of these 20 only one time. The number of visiting days per client ranged in the period of enquiry of six months between 1 and 122 days with a median of 9 days (median value: 19 ± 24 days). The most frequently mentioned reasons for not using the consumption room anymore was the referral to further treatment (37%), among which mainly the start of substitution therapy, or imprisonment (17%). For 27 clients (21%), the reasons remained unclear and two patients died (one committed suicide, for the other one the reasons of death were unknown). The analysis of the drug-related risk behaviour showed that the share of clients who had used drugs outside of the consumption room and/or had used non-sterile drug use paraphernalia nearly remained unchanged at 50%. Needle sharing also remained stable at a portion of 20%. Summarizing, it can be noted that the use of a drug consumption room does not correlate with a reduction in the risk behaviour. According to the authors, the referral of 37% of the surveyed clients to further treatment may be cautiously rated as a success. All in all, the findings require cautious interpretation because the sample drawn was small and not representative and no control group was used for comparison. The study is nevertheless one of the few of its kind that demonstrates that it is possible to conduct effectiveness studies in the low-threshold area.

The German aids help organization Deutsche AIDS-Hilfe conducted a national survey on drug emergencies that occurred in 2009 in drug consumption rooms in order to be better able to assess what contribution consumption rooms can make to avoiding drug-related deaths. With 13 facilities from eleven cities, half of all consumption rooms in Germany took part. During the six-month period of enquiry, a total of 266 drug-related emergencies were documented, out of which 263 could be evaluated. 139 cases (53%) were classified as "light" or "moderately severe", 124 (47%) as "severe" or "life threatening". According to the author, it can be assumed that 47% of the people affected would in all probability not have survived the emergency in a different setting (e.g. in their own flat or in public space) and thank their

lives to the competent intervention of the consumption room staff (Schaeffer & Stoever 2011).

7.3 Prevention and treatment of drug-related infectious diseases

Safer use initiatives

Prevention of drug-related infectious diseases by low-threshold drug help facilities consists mainly of providing information on infectious diseases and risks as well as distributing safer use articles. Distribution of needles and needle exchange is explicitly permitted by the Narcotics Act and is also practiced by many facilities.

In the period of enquiry, several projects attempted to fill the information gaps with regard to the offer of needle exchange programmes and other safer use measures undertaken in Germany.

The project "Prevention of infectious diseases in injecting drug users in Germany. Syringe exchange programmes and other measures – a review" carried out by the Institute for Therapy Research (IFT) and funded by the Federal Ministry for Health in 2010, had the goal to perform a systematic compilation of information available on measures and approaches used in the area safer use and safer sex for drug users at national and Land level as well as in selected cities. However, it was not possible to give a review at national nor at *Laender* level. Regular and systematic collection of data on safer use offers made at Land level or summary statistics were only performed in exceptional cases (e.g. for the documentation of the distribution of needles in North Rhine-Westphalia by the AIDS-Hilfe). There are considerable regional, community and institution-related differences in the approaches used and in the implementation of the offers. Therefore, it was not possible to conclusively quantify the offers made as regards safer use and safer sex for drug users on the basis of the information collected within the framework of the survey. Figure 7.1 shows the availability of syringe exchange offers made at district level that have been confirmed by interviewed experts or that have been identified within the framework of a complementary Internet search. There is at least one syringe distribution offer made (including dispensing machines) in 114 out of a total of 429 rural and urban districts (26.6%).

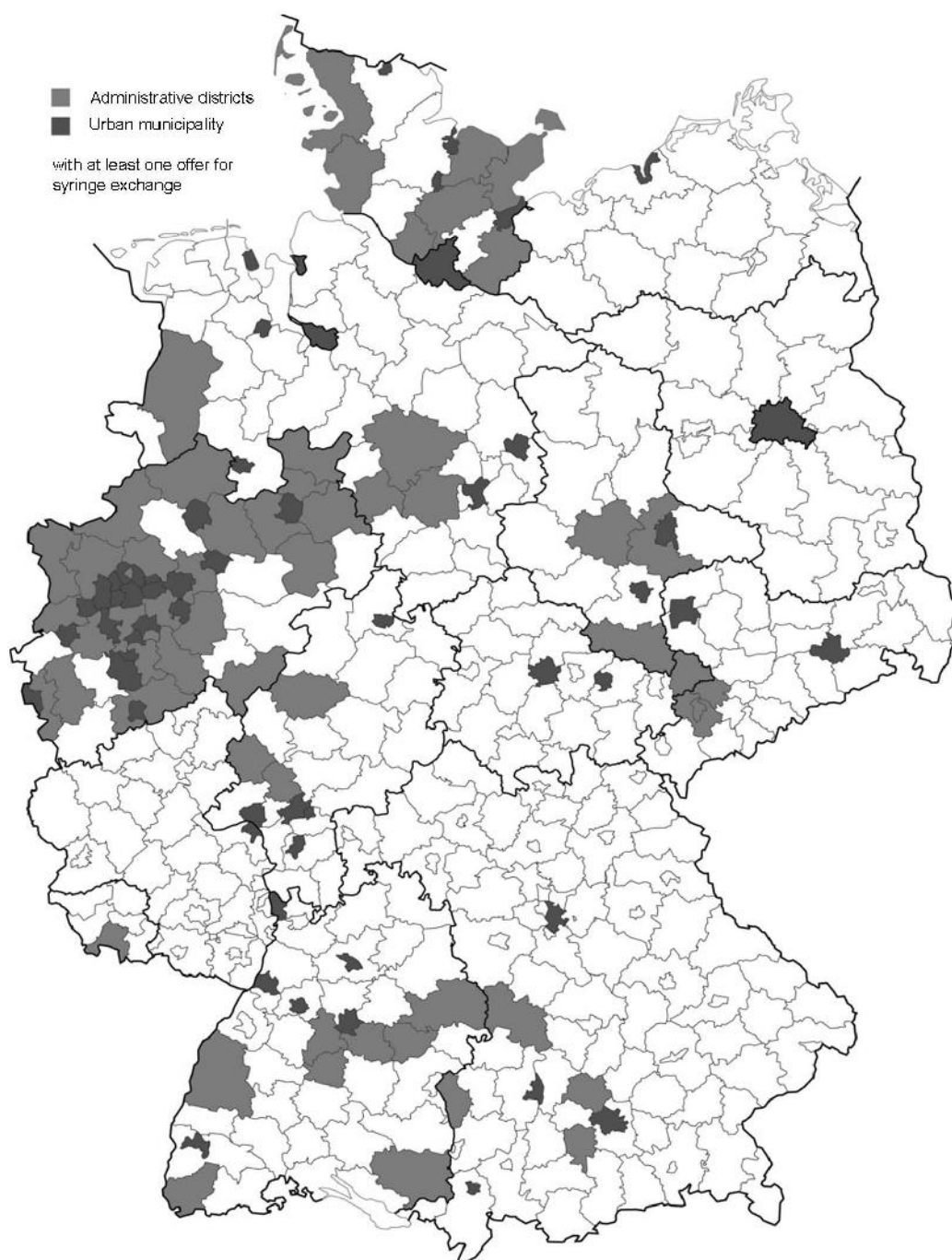


Figure 7.1 Availability of syringe distribution offers (including distribution machines) at district level based on the data provided by the *Laender* experts and a complementary Internet search

Floeter et al. 2011.

At institutional level however, the data situation as regards the quantity of distributed safer use utensils is relatively good (numerous annual reports, facility statistics). However, there is no systematic data available on the usage of the measure by the target group. There is no data either on the existing demand that could be used for the assessment of the offers made. No common standards for carrying out safer use or safer sex measures could be identified.

Based on the assessments made by the interviewed experts from the federal states, the overall offer of safer use measures is largely rated as insufficient. It needs to be added qualifyingly that the knowledge of the drug aid experts about the availability of corresponding offers at Land level is extremely heterogenic. As regards the availability of safer use offers, there are significant differences to be found between rural and urban areas, whereby it needs to be taken into account that the majority of injecting drug users presumably live in larger urban districts. Experts nevertheless report considerable supply deficits especially in rural areas. Only the availability of information material is generally rated positively. Offers on trainings on safer use are an absolute exception. According to the experts, there is in particular a supply deficit in prisons. Apart from the addiction help system, there are important other institutions that make safer use and safer sex offers (especially the branches of the AIDS-help organization AIDS-Hilfe, but also the health offices, youth help agencies, doctors and sporadically penal institutions). There are however indications that there is no systematic information exchange at Land level between the addiction help system and other providers.

Doctor's practices and pharmacies are (often) in (regular) contact with the target group of IDUs. It remains unclear to what extent pharmacies and doctors make active offers in the area of safer use (apart from the ad hoc information in the practice and the sale of syringes by pharmacies). A survey conducted among experts and a non-representative survey among pharmacists showed that such offers – in so far as they exist at all – represent individual initiatives.

Systematic evaluations of safer use offers have not been found. Founded process and result evaluations were not reported within the framework of the project (Floeter et al. 2011).

Further information and derived recommendations can be gathered from the final report posted at www.dbdd.de. Standard table 10 also contains information on this.

The association Fixpunkt e.V. carried out a project in 2009 for the region of Berlin to evaluate the dispensing of syringes. The project showed that only a small part of the demand of IDUs for syringes is covered by drug help facilities or syringe dispensing machines (approximately 20%). Contact centres/Mobile and one drug counselling facility play the most active part in dispensing syringes. There is no distribution offer made for drug use equipment in several districts of Berlin. The existing dispensing places are accessible 25 hours per week on average. Part of the standard or basic offer are syringes, tubes, alcohol pads and nearly always ascorbic acid. Half of the responding facilities also offer a larger package with filters and stericups that can be bought or exchanged against used ones. Some facilities also sell other use equipment like lighters or earplugs. Large syringes, as used for injecting

methadone, are, if at all, only available in exchange for used ones. All facilities complement the syringe distribution service with oral and written information on a comprehensive spectrum of topics focusing on infectious diseases, safer use, drugs and drug dependence. Nearly all facilities can refer to other facilities that dispense utensils for injecting use. The internal organisation of the dispensing service is defined in principle, but not in detail. Safety provisions are based on a good foundation, but there is potential for improvements as regards for example occupational medical check-ups and vaccination offers for facility staff (Fixpunkt e.V. 2011, personal communication).

Especially syringe dispensing machines can provide 24h supply for sterile drug use equipment for drug users. With approximately 160 syringe dispensing machines, Germany has the largest number of syringe dispensing machines worldwide. In the year 2009, approximately 380,000 boxes with syringes, needles and accessories were dispensed in this way. Nevertheless, the syringe exchange programme is far from covering the whole of Germany – there are still no locations in six *Laender*. Only North Rhine-Westphalia (with about 100 dispensing machines) and Berlin (17 dispensing machines) have a well developed network. The project “Syringe dispensing machines now“ carried out by the Deutsche AIDS-Hilfe and funded by the Federal Ministry for Health, staff of drug and aids help organisations and agencies are to be informed since 2009 about the potentials of this initiative and motivated to expand the offer. The core of the project is formed by the Internet website www.spritzenautomaten.de. From 2011 onwards it is additionally planned to test the acceptance and usage of the offer of safer use information via syringe dispensing machines (in the form of package leaflets) in a pilot project in Berlin (Deutsche AIDS-Hilfe, personal communication).

On the whole, there are only few studies that investigated the effectiveness of the provision of safer use information. Within the framework of a small study conducted in a consumption room run by the association INDRO e.V. in Muenster on the occasion of the expansion of the offer by two-part tuberculin syringes (as an alternative to the one-part insulin syringes dispensed so far, that are actually designed for subcutaneous injections and that pose various health risks for injecting drug use) and sterile disposable filters coming along with the tuberculin syringes (as an alternative to cigarette filters), 39 clients were interviewed before and after the introduction of these utensils and the accompanying safer-use counselling. At the beginning of the study, 77% of the interviewed persons used the insulin syringe always or often for intravenous injection, four weeks later it was only 46%. 36%, by way of contrast, seldom or never used the insulin syringe at that point of time, but mostly used the tuberculin syringe instead. The specific health risks linked to the use of the insulin syringe were known to 29 users (74%) at the end of the survey, whereas at the beginning of the survey only 16 persons (41%) were aware of the health risks. The sterile disposable filter, in turn, was already known to most (87%) of the interviewees at the beginning of the survey, but since its use is not possible in combination with the insulin syringe, most of the users had only used cigarette filters. After the targeted provision of safer use information, a second survey showed an increase in the awareness to 97%. 85% knew about the advantages offered by

the disposable filter. A total of 92% of the interviewees stated in the second questionnaire that the safer use messages conveyed within the framework of the study had brought about changes in them. The authors conclude that safer use counselling is an effective method to demonstrate risk reducing variations of injecting drug use to many users and invoke behavioural changes (Manthe & Vogt 2011).

Prevention and treatment of HIV and hepatitis in drug users

The demonstration project "Test it" funded by the Federal Ministry for Health, provided low-threshold access to HIV testing for drug users in Dortmund. The test offer was integrated into HIV counselling complete with a risk check. For the actual testing, a so-called "quick test" was used that delivers a result within approximately 20 minutes. The project was carried out in the year 2010 by the Deutsche AIDS-Hilfe in cooperation with the AIDS-Hilfe Dortmund and the Dortmund drug help organization "KICK". All in all, 185 test counselling sessions and 179 tests were carried out twice a week over a test period of 8 months. Out of these, 17 were carried out as repeat tests half a year after the first test. Out of the 162 persons tested in the beginning, 6 were HIV positive (3.7%). It became apparent that a relatively large number of people engaged in risky behaviours both as regards drug use and sex. The most frequently mentioned risk situation was unprotected intercourse with unknown partners or casual partners – often in connection with alcohol consumption. Most interviewees did not know the HIV status of their sexual partner. The conclusions that can be drawn from the project are that the offer of quick tests in a low-threshold drug aid facility appears to increase the probability that IDUs make use of it. The readiness of the people affected to make use of counselling and re-use the counselling service a second time on their own account, is an indication that the possibilities of low-threshold offers are not yet systematically exploited. Due to the fact that a familiar environment is regarded as an important factor for making use of the offer by the people affected, the project did not succeed in motivating drug dependents from other Dortmund facilities to participate in the project. Therefore, cooperation models are tested with other facilities in a follow-up phase. (Deutsche AIDS-Hilfe, personal communication and Schaeffer & Stoever 2011).

Following the experience made in Dortmund in 2011, a „Test It“ project was funded by the Deutsche AIDS-Hilfe and carried out by the Berlin addiction help organisation Fixpunkt to offer drug users a low-threshold and anonymous test for HIV and hepatitis C complete with a corresponding counselling offer. Results are not available yet (Fixpunkt e.V., personal communication).

In an anonymous survey conducted among more than 2,300 doctors actively working in substitution therapy, Reimer and colleagues investigated among others the frequency of infectiological treatments and the reasons for corresponding offers made. The response quota was 30% resulting in 700 filled in questionnaires. 37% of the participants conduct HIV/HCV test according to the standard schedule, 10% test every 6 months, 30% every 12 months and 40% only on clinical suspicion. Prevention and after care measures in drug-associated infectious diseases are medical consultation and information (83%), treatability

testing (77%) and information on the transmission routes (63%). In approximately 25% of the facilities, antiretroviral HIV therapy and in approximately 50% antiviral HCV therapy is offered. The HIV treatment rate amounts to 78.5%, the HCV-treatment rate to 12.7%. Common patient-related reasons for exclusion from infectiological therapy are insufficient therapy adherence (46%), psychiatric comorbidity (36%) and expected side effects (21%). Structural reasons for not offering infection therapy are insufficient specialist experience (HIV 51%; HCV 27%), high therapy costs (HIV 24%; HCV 18%) and incalculable treatment risks (HIV 20%; HCV 13%). Factors facilitating the initiation of infectiological treatment are secured funding (HIV 28%; HCV 32%), specific further training measures (HIV 26%; HCV 27%) and an improvement of the linkage between competence partners (HIV 22%; HCV 24%). With 12.7%, the quota of the annual HCV treatments was slightly above the level of others studies conducted in this area. However, this study did not allow either to identify a HCV treatment quota that would be sufficient to significantly reduce the HCV infection quota among drug users through the reduction of other transmissions (Reimer et al. 2010a).

The countrywide multicenter observational study SUPPORT, in which 242 data sets of opioid dependent patients undergoing replacement therapy could be evaluated, analyzed factors that have an influence on the retention quota in HCV therapy. The findings show that specific parameters like the gender (more women than men complete the therapy), the HCV-genotype and psychiatric comorbidity can have an influence on the compliance of the patients undergoing substitution therapy. The findings suggest that patients with unfavourable starting conditions need to be looked after more intensely during HCV therapy. Stable replacement therapy and the setting alone don't seem to suffice in order to guide these patients successfully through therapy. Rather, psychiatric and somatic comorbidity need to be analyzed in detail and integrated into therapy planning (Apelt et al. 2010).

Die PERMIT study (Psychoeducation reaches methadone / buprenorphine substituted patients in antiviral treatment), whose final report was presented in 2010 by the Centre for Interdisciplinary Addiction Research (Zentrum fuer interdisziplinäre Suchtforschung, ZIS) in Hamburg, investigated the influence of accompanying psychoeducation on the retention quota of patients undergoing a combined hepatitis C treatment with interferon/ribavirin. To this purpose, two groups were compared in a naturalistic multicenter study. Both groups received a combined therapy of PEG-IFN- α (pegylated interferon- α) and RBV (Ribavirin), one group received additional psychoeducation of 12-20 hours, the other group did not receive any additional intervention at all. A total of 24 test centres with 26 test doctors took part in the study. Psychoeducation took place in seven addiction centres. The sample consisted of 189 participants who were 36.4 years of age on average and mostly male. On the whole, 72.5% of the participants could be retained over the whole duration of the study (24- or 48-week therapy plus 24-week after care phase). The study showed a difference in the retention quota between the participants who received psychoeducation (78%) and those who did not receive an additional intervention (68.2%). However, the difference was not significant. The superiority of the psychoeducation groups as regards the retention quote could not be confirmed (possibly due to small size of the sample). It was however observed that

psychoeducation tended to show some effectiveness after longer participation. The authors found that the longer the participants took part, the more they profited from the psychoeducational intervention. Being at a level comparable to other studies, the observed retention quota corroborates the finding of the stabilising effect of substitution therapy on antiviral hepatitis C therapy. The concept of psychoeducation was rated as beneficial by the participating practices and was continued by some practices after the end of the study (Reimer et al. 2010b,c).

7.4 Responses to other health correlates among drug users

On the occasion of its 22nd network conference held in October 2010, the Bavarian Academy for Addiction Issues in Research and Practice (Bayerische Akademie fuer Suchtfragen in Forschung und Praxis, BAS e.V.) discussed its recommendations passed in 2007 on the responses to be made to addicts affected by an adult attention deficit/hyperactivity disorder (ADHD) as regards practicability and complemented them correspondingly. The background for the revision is that, on the one hand, the prevalence of adult ADHD in addicted individuals is overproportionally high in comparison with the general population, but, on the other, there are hardly any controlled studies to be found on the treatment of this target group. The authors plead in their recommendations in particular for thorough and comprehensive diagnostics to be carried out that would for example comprise evidence for the occurrence of the disorder in two separate areas of life already in childhood and adolescence. The authors point out that the occurrence of characteristic ADHD symptoms can also be related to substance use or withdrawal and therefore they recommend having a diagnosis categorically secured by a specialist doctor (in particular by a psychiatrist). After the diagnosis has been made, the authors recommend assessing the actual need for therapy depending on the extent of the severity of the impairments. Targeted symptoms and severity are to be meticulously documented throughout the whole course of therapy. Pharmacotherapy should be integrated into a multi-modal treatment concept (cognitive behavioural therapy, psychoeducation, relaxation techniques). As regards the choice of medication, the authors advise to use non-stimulants for addicted patients. Since up to the present, no substantive evidence has been provided for the effectiveness of methylphenidate treatment in addicted patients affected by ADHD, stimulants should only be used in well documented exceptional cases (BAS 2010).

8 Social correlates and social reintegration

8.1 Introduction

Drug use is often linked to difficult family and personal life circumstances. While it may, on the one hand, be a consequence of these circumstances, it can also, on the other, aggravate the situation and worsen the drug users' future prospects. The social framework conditions under which drug use takes place illustrate the marginalization especially of individuals with intensive drug use.

Some indication of the aggravated general living conditions of drug users can be gleaned from socio-demographic data of treatment documentation. Opioid-addicted members of the open drug scene are affected the most. Insight into the situation can be gained from data provided by the German statistical report on treatment centres for substance use disorders, the short reports of the *Laender* and the regional monitoring systems used for example in Hannover, Frankfurt/M. and Hamburg

8.2 Social exclusion and drug use

8.2.1 Social exclusion of drug users

According to the DSHS data, 18.3% of the clients of outpatient therapy facilities with primary opioid problems, 16.8% of the clients with primary cocaine related problems and 25.8% of the cannabis clients do not (yet) have a school leaving qualification at the beginning of the therapy (11.5% of the cannabis clients are still at school at the start of therapy). Almost two thirds of the clients with primary opioid related problems (63.6%) are jobless at the start of the therapy and so are a little more than a third (37.6% and respectively 39.7%) of the clients with primary cannabis and cocaine related problems (Table 8.1). In general, this situation hardly changes until the end of therapy. While as for cannabis clients, this may be simply due to the relatively young age, the rest (in particular opioid addicts) are mostly early school leavers (Pfeiffer-Gerschel et al. 2011b).

According to the status report of the Hamburg basic documentation (Oechsler et al. 2010), a total of 5,023 opioid clients who made use of outpatient addiction help (2008: 5,089) were registered in 2009. Out of these, 78% (2008: 82%) lived in stable housing conditions, but 70% (2008: 69%) were out of job or respectively without gainful activity. A total of 89% (2008: 87%) had at least a lower secondary school leaving qualification, but only 65.9% also had completed vocational training.

In the Hessian Land evaluation of the computer-based basic documentation of the outpatient addiction help system (COMBASS) of the year 2009, the social situation of the opioid clients looks similar: 81% live in their own apartment or with relatives/parents, 85% have at least a lower secondary school leaving qualification or are still at school, 74% are jobless (Werse et al. 2010a).

Since 2007, there is also data available within the framework of the DSHS based on evaluations carried out by low-threshold facilities (2010: N=26) themselves. According to these evaluations, the socio-economic conditions of the clients who sought help from low-threshold facilities in 2010 are even worse than those found in other help areas. As can be seen from Table 8.1, the figures for missing school leaving qualifications, unemployment and homelessness are for all substances significantly higher than in clients in outpatient therapy. However, the figures can only be interpreted with limitations, since the total number (N=26) of the low-threshold facilities participating in the DSHS only give a small glimpse of all offers made in this area in Germany (cf. chapter 5.2) and no data is available on the representativeness of the sample (Pfeiffer-Gerschel et al. 2011d).

Table 8.1 Social situation of persons in outpatient therapy and low-threshold facilities broken down by main drug (2010)

Main diagnosis	Outpatient treatment			Low-threshold facilities		
	Without graduation ¹⁾	Unem- ployed ²⁾	Homeless ²⁾	Without graduation ¹⁾	Unem- ployed ²⁾	Homeless ²⁾
	%			%		
Alcohol	6.6	41.3	0.5	8.4	52.0	4.6
Opioids	18.3	63.6	2.5	23.4	73.2	12.8
Cannabinoids	25.8	37.6	0.8	45.8	44.1	4.1
Sedatives/Hypnotics	6.8	36.9	0.5	0.0	44.4	0.0
Cocaine	16.8	39.7	1.0	30.2	65.9	10.0
Stimulants	15.6	45.5	1.2	23.5	55.9	14.3
Hallucinogenics	26.1	39.8	1.1	100.0 ^{*)}	100.0 ^{*)}	0.0
Tobacco	17.9	17.9	0.3	36.0	30.8	0.0
Volatile substances	32.6	41.2	3.7	0.0	0.0	0.0
Mult./other substances	17.4	48.3	0.6	0.0	0.0	0.0

1) Or still in school.

2) On the day before the start of treatment.

*) n=1

Pfeiffer-Gerschel et al. 2011b, Pfeiffer-Gerschel et al. 2011d.

8.2.2 Drug use among socially excluded groups

There is no current data available on the drug use of socially excluded groups.

8.3 Social reintegration

Last years' revision of the German Social Security Codes has created a series of preconditions for an improvement of the social reintegration also of people with substance-related disorders. More details on this can be found in the REITOX-reports of the years 2005,

2007 and 2008.

The “Law on the further development of the basic social assistance for people in search of work“ effective as of August 2006, has laid down comprehensive regulations for the status of persons in inpatient facilities with regard to their right to basic social government care.

In connection with the health reform, which entered into effect on 1 April 2007, not only parent-child-cures and geriatric rehabilitation, but also medical rehabilitation for addicted individuals were included in the catalogue of standard insurance benefits.

According to a survey carried out by the *Laender* in the reference year 2010, there are 105 facilities (data from 14 *Laender*) with a total of 911 therapy slots (data from 13 *Laender*) offering day patient rehabilitation therapy for addicted individuals. Inpatient rehabilitation measures are offered by 327 facilities (data from all 16 *Laender*) with 13,256 treatment slots (data from 14 *Laender*). Information on social therapy day care facilities are available from 11 *Laender*. On the whole, there are 112 facilities of this type in these *Laender* with 1,206 treatment slots (data from 10 *Laender*). However, it is not possible to differentiate between clients with illicit drug problems and others in any of these offers (Floeter & Pfeiffer-Gerschel 2011).

8.3.1 Housing

There is a series of offers available for drug addicts to tide them over homelessness. A recent survey carried out by the *Laender* in the reference year 2010 showed that in 12 *Laender*, which could provide data on housing, 465 offers were made for assisted living with 12,962 places. The transition from inpatient therapy to a fully self-sufficient life is to be facilitated by adaptation facilities. Adaptation therapies are measures of medical rehabilitation of addicted individuals. The patients spend the whole day in adaptation facilities and receive treatment. The therapy offer is geared to the restitution of the working capacity and ability to master everyday activities of the patients. The therapy is meant for people who are professionally and socially disintegrated or have a corresponding risk potential. Adaptation therapies can be either conducted as integrated adaptation therapies in independent wards of specialized clinics for addicted people or in external, so-called solitary adaptation facilities. 115 of these adaptation facilities are spread across the country (data from all *Laender*) offering a total of 1,277 therapy places for addicts (data from 15 *Laender*). Inpatient social therapy facilities in the sense of hostels or temporary shelters according to the criteria of the Social Codes SGB XII §§ 53 ff. or §§ 67 ff. offer at least temporary accommodation for addicts. There are 268 facilities of this type (data from 12 *Laender*) offering 10,794 places (data from 13 *Laender*). As already mentioned under 8.3, differentiation between licit and illicit substances is not possible.

8.3.2 Education, vocational training

In the last few years a series of measures have been tested to facilitate the integration of jobless people with handicaps into working life. Generally, these measures have not been specifically developed for people with substance-related problems, but they are commonly

found among the target group of these activities. Parts of the test results have been taken into account of in the revision of the Social Security Codes II, III and XII.

Many facilities complement therapy by offering promotional programs for drug addicts to support educational attainment and vocational training or to provide orientation for their professional life. Drug addicts are also given the opportunity to catch up on missing school leaving qualifications within the framework of external school projects. Vocational training is made possible through close cooperation between craft and industry. However, in view of the high unemployment figures and the rather declining financial resources allotted to this area, an improvement of the situation is not in sight.

8.3.3 Employment

The anyway tense situation on the labour market makes it difficult for substance dependent people to reintegrate after therapy into professional and social life. The unemployment quota among drug addicts is extremely high – depending on the severity of the problem up to more than 80%. Studies show that social and professional integration is a crucial factor for sustained abstinence.

The integrative approach adopted by the Social Security Codes II (SGB II) enables socio-integrative services to be provided in addition to the instruments of employment promotion. An integral part of these supporting integration services is addiction counselling (§ 16 a SGB II).

Addiction counselling as a service to be provided in respect of SGB II falls – like the other socio-integrative integration services - under the organisational and financial responsibility of the municipalities. The Federal Ministry for Employment and Social Affairs assumes supervisory functions defined by SGB II insofar as the Federal Employment Agency is the service provider but not with regard to services provided by the municipalities. These are placed under the supervision of the *Laender*. This is the reason why the Federal Government currently does not have any computed data at hand on specific measures or activities carried out with regard to drugs and addiction in the field of basic social care for people in search of work.

According to a synopsis of the short reports of the *Laender* (Floeter & Pfeiffer-Gerschel 2011), 253 work and employment projects were run in 2010 across the country offering 4,855 work places to people with addiction related problems (data available from 15 and respectively 13 federal states).

The Land Centre for Addiction Issues of Mecklenburg-Western Pomerania carried out the project FAIRE (government agency for labour market integration and reintegration of addicted people) funded by the Federal Ministry for Health in the period from 01.10.2008 to 31.10.2009. The central goal of FAIRE in Mecklenburg-Western Pomerania was to promote and expand the cooperation between the addiction help system and institutions of labour market integration in order to minimize frictional losses in the integration and reintegration of addicted individuals undergoing rehabilitation therapy by offering appropriate measures and

services. Another goal was to create the basis for facilitating the usage of addiction counselling in respect of § 16 SGB II. In order to reach these goals, the following events were among others organized and carried out in the 13-month demonstration phase:

- Network talks
- In-house trainings for staff of the working groups formed between the municipalities and the employment agencies (Arbeitsgemeinschaften ARGEn) in cooperation with the regional addiction help system
- FAIRE training (SGB II meet practice)
- FAIRE Specialist Conference (experience and results, presentation of experience and results, approaches used by other *Laender*)
- Work-related talks (Rehab clinics – ARGE, creation of foundations for tailored employment offers and qualified further training measures, cross-system case management at the end of rehab (seamless referral to the labour market or employment measures))

The need for further training and courses has been proven by the big demand.

The intensity of cooperation at the interface ARGE/addiction help system is subject to significant regional differences. The demonstration project FAIRE carried out in Mecklenburg-Western Pomerania, showed that the transfer from rehabilitation to employment needs to be improved (e.g. the transfer of the results and experience from work therapy is not guaranteed. In this context, the territorial working principle of the ARGEn proved to be an obstacle). The demonstration projects of overlapping case management with the foundation “Volkssolidaritaet“ and the opting municipality in one region deserve positive mention. In the year 2010, a similar measure was undertaken by the Land Centre for Addiction Issues (Landesstelle fuer Suchtfragen Mecklenburg-Vorpommern e.V. 2011, personal communication).

With a view to promote the professional (re-) integration of addicted individuals undergoing substitution therapy, two demonstration projects were set up in the Rhineland Palatinate to steer and coordinate the necessary help measures and intensive care services on a case-by-case basis. In the district Mayen-Koblenz, the project “Assisted integration of substituted drug addicts into the labour market “ (AIDA) and in the district Bad Kreuznach the project “Intensive care for drug users for labour market integration and assisted living“ (IDIAL) were set up. 20 people respectively can take part in the projects.

Both projects rely on a close cooperation between the local job centres, psychosocial counselling provided by the counselling facilities and the substituting doctors. There is a regular exchange of information between the institutions involved that enables networking between the existing help systems and close client accompaniment.

In both projects, a central role is assumed by educational staff that attend to clients and coordinate the information flows of the institutions involved. The ambulatory outreach work

performed by facility staff on a case-by-case basis facilitates the access to the various help systems. Part of the tasks of facility staff is to provide guidance in vocational orientation, coaching and practical help for everyday living, placement in internships or jobs to maintain motivation for change.

The projects are jointly funded by the European Social Funds, the job centres and the Ministry for Social Affairs, Employment, Health and Demography (Ministerium fuer Soziales, Arbeit, Gesundheit und Demografie 2011, personal communication).

Promotion by the German National Statutory Pension Insurance

Within the framework of the content-related and structural further development of existing rehabilitation offers, the targeted promotion of employment opportunities of jobless rehabilitants by the Pension Insurances has become an integral part of the therapy for persons with addiction-related illnesses. It comprises for example indicative groups with regard to unemployment and trainings for job application. From the viewpoint of the social security administration, the central goal of addiction therapy is to restore the working capacity. Apart from somatic aspects also psychological factors – i.e. personal and social competences of the clients – are taken into account to prepare clients for working life.

Persons with drug-related problems do not seldom form part of the target groups of specific programs offered by employment agencies to promote reintegration of long-term unemployed people on the labour market. However, in general, the available statistical material does not provide specific data on this sub-group, so that measures undertaken and results achieved for this group cannot be presented separately in this report.

A model of the cooperation between rehabilitation and labour administration is the cooperation agreement “Provision of services for people with addictive diseases “ made between the German Statutory Pension Insurance (Deutschen Rentenversicherung, DRV) Central Germany and the regional offices Saxony-Anhalt and Thuringia of the Federal Employment Agency in August 2010. The goal of the cooperation is to open a new gateway from social administration to addiction rehabilitation so that people in need of therapy can start rehabilitation therapy at an early stage with as little institutional frictional losses as possible (Ministerium fuer Arbeit und Soziales, personal communication 2011).

Social assistance and welfare benefits

People suffering from addiction are entitled to the same social assistance services and welfare benefits from the government, employment agencies and social insurance funds as other indigent groups. Outreach services form part of these. Discriminating statistical material is however not available.

9 Drug-related crime, prevention of drug-related crime and prison

9.1 Introduction

Since the possession of drugs is illegal, penal sanctions form part of the most important negative consequences of drug use not only in the EU-member states. The Federal Criminal Police Office (Bundeskriminalamt, BKA) distinguishes in its statistics on drug-related crimes between punishable acts in terms of violations of the Narcotics Act (Betaeubungsmittelgesetz, BtMG) and cases of direct economic compulsive crime. Punishable acts of the first group are recorded according to following four categories:

- General offences in terms of §29 BtMG (especially possession, purchase and distribution, so-called consumption-related offences)
- Dealing/trafficking in and smuggling of narcotic drugs in terms of §29 BtMG,
- Illegal import of narcotic drugs in non negligible quantities in terms of § 30 BtMG
- Other offences against the BtMG

Prosecution of economic compulsive crimes is mainly related to theft and robbery.

9.2 Drug-related crime

9.2.1 Drug law offences

In the year 2010, a total of 231,007 drug law offences (2009: 235,842) were recorded, out of these 165,880 were general offences committed against the Narcotics Act and a little less than 50,000 drug dealing/trafficking offences. With this, the number of drug related offences decreased by 2.1% compared to the previous year (BMI 2011).

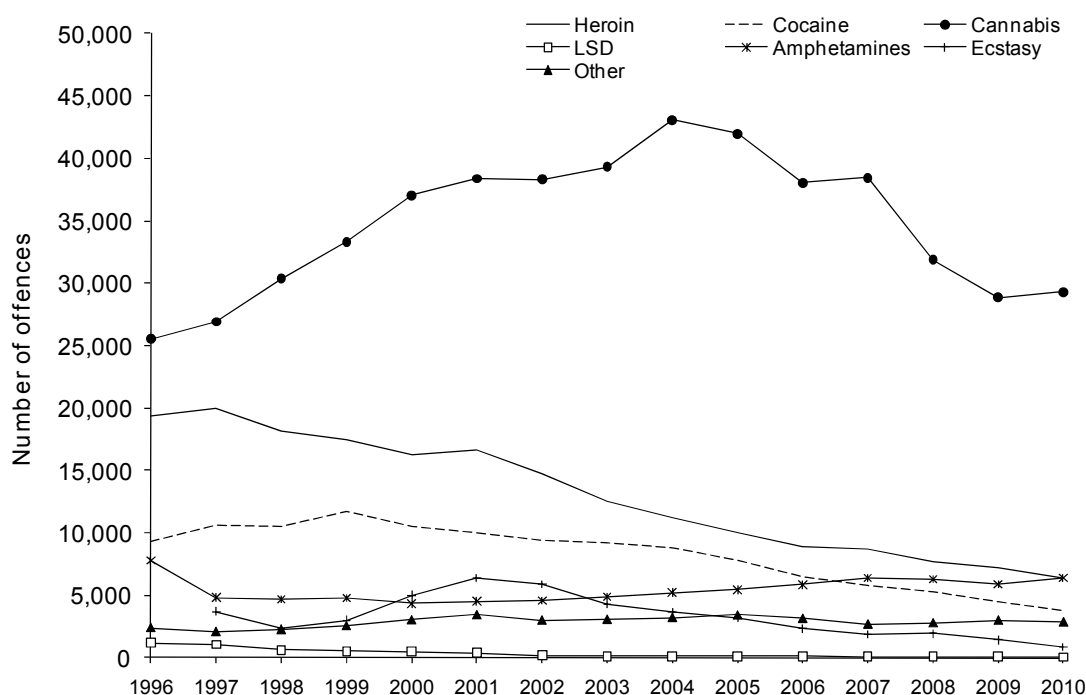
Direct economic compulsive crimes

Direct economic compulsive crimes are taken as referring to all criminal offences committed in order to obtain narcotic drugs, substitute or alternative drugs. In 2010, 2,556 cases (2009: 2,479) of direct economic compulsive crimes were recorded by the Police Criminal Statistics (Polizeilichen Kriminalstatistik, PKS), which corresponds to an increase of 3.1% compared to the previous year. With this, the number of this type of offences has remained at about the same level since 2007. Almost three quarters (70.8%) of these offences were related to forgery of prescriptions or theft of prescription forms to get access to narcotic substances (BMI 2011).

Drug dealing/trafficking crimes

These crimes are related to offences committed in connection with commercial/professional dealing in narcotic drugs or smuggling of larger quantities of narcotic drugs. All drug dealing/trafficking crimes recorded by police are - just as consumption-related crimes - taken account of in this report irrespective of the outcome of later legal proceedings.

Both in terms of portions and absolute figures, cannabis played the most important role in drug dealing/trafficking crimes (29,306 crimes, 59.1% of all crimes; 2009: 28,867 crimes, 56.6%), followed – at a large distance by heroin (6,403, 12.9%; 2009: 7,205, 14.1%; 2008: 7,687, 13.8%) (Figure 9.1). Similar to heroin, the number and portions of trafficking crimes in connection with cocaine (3,763, 7.6%; 2009: 4,522, 8.9%; 2008: 5,278, 9.4%) have slightly decreased over the last years. Since 2000, the portion of trafficking crimes involving amphetamines has been on a continual rise and the case figure too slightly increased again after a slight decline in the previous two years. In 2010, amphetamines accounted for 12.8% (6,372 crimes; 2009: 5,870, 11.5%) in all dealing/trafficking crimes ranking third on this list as in the previous two years (BMI 2011).



BMI 2011.

Figure 9.1 Development of drug dealing/trafficking crimes

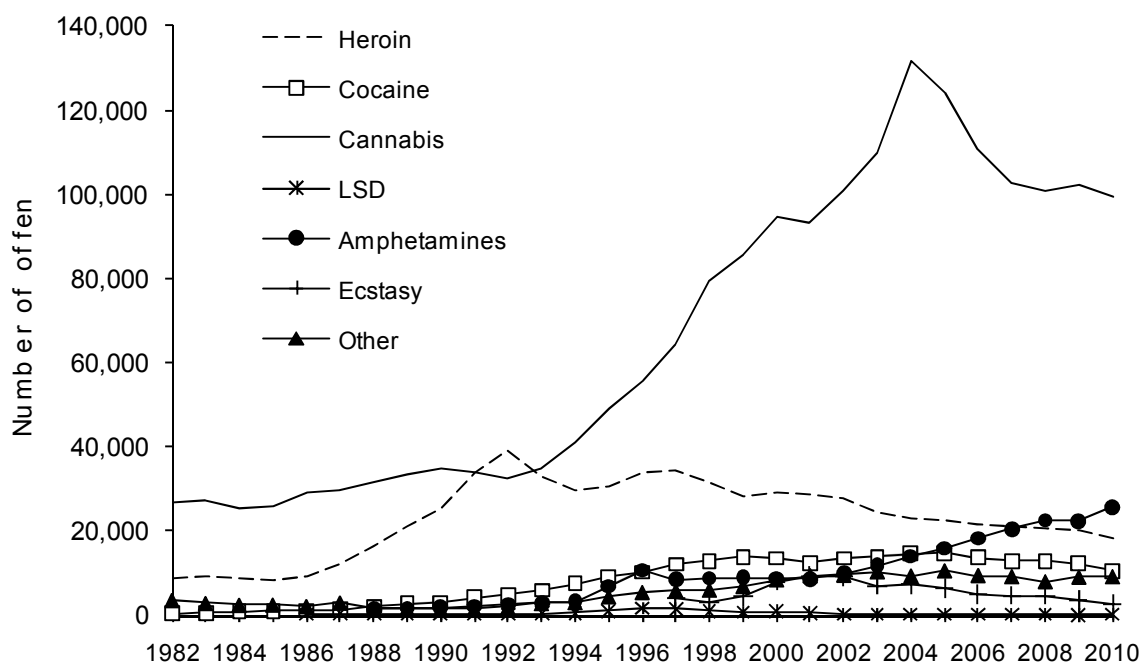
Consumption-related offences¹¹²

This section is about drug offences that are - due to the frame conditions (quantity, persons involved) - classified by police as “general offences” and are therefore taken as referring to consumption-related offences (Figure 9.2).

The police criminal statistics (BMI 2011) show that in this category of offences cannabis also played a predominant role accounting for about 60.0% of all respective cases in 2010. Heroin

¹¹² The term “consumption-related offences” is used to describe general offences committed against the Narcotics Act (Betaubungsmittelgesetz, BtMG). The offences committed in violation of § 29 BtMG comprise possession, purchase and distribution of narcotic drugs and similar offences.

(11.0%), amphetamines (15.5%) and cocaine (6.3%) account together for 32.8% of the recorded cases. The remaining portions are split between ecstasy, LSD and other drugs. In 2010, the total number (165,880) decreased by 2.2% in comparison with the previous year (2009: 169,689). The number of consumption-related offences in connection with amphetamines increased by 14.8% from 2009 (22,387) to 2010 (25,695) and thus continued the trend since the middle of the 1990s. As for consumption-related offences involving other substances, there were either minimal changes (cannabis: -2.5%; LSD: +8.7%; other: +1.2%) or pronounced declines (heroin: -9.7%; cocaine: -14.8%; ecstasy: -26.6%) to be found.



BMI 2011.

Figure 9.2 Development of consumption-related offences

Police, hospitals and psychiatric clinics have an increasing demand for the detection and quantification of synthetic cannabinoids in order to be able to assess the fitness to drive and also offences against abstinence agreements. Therefore, Dresen and colleagues (2011) developed and validated a liquid chromatography-tandem mass spectrometry method after liquid-liquid extraction to quantify JWH-015, JWH-018, JWH-073, JWH-081, JWH 200, JWH-250, WIN 55,212-2 and methanandamid and identify JWH-019 and JWH-020 in human serum. The method was successfully used in 101 serum samples of 80 individuals from hospitals, detoxification wards, forensic psychiatric institutions and police custody: 57 samples (56.4%) were positive.

Kneisel and colleagues (2011) provided mass spectrometric and, as far as available, also infrared spectroscopic data for five new cannabinoid mimetics seized between end of 2009 and November 2010. These are to facilitate the examinations carried out by the forensic institutes since the insufficient mass spectrometric data provided by literature published on

these compounds made it necessary to carry out time consuming and extensive examinations to analyse their structure.

Users of hard drugs who have come to the notice of the police for the first time

Alongside data on drug-related offences, the Federal Criminal Police Office also publishes statistics on persons who have come to the notice of the police for the first time in connection with hard drugs. These statistics represent a kind of incidence measuring. However, the entries made on these persons have to be erased after a certain legally defined period of time provided no new offences have been committed in the meantime (generally, the data are stored for a period of ten years for adults, for a period of five years for adolescents and for two years for children; in cases of minor importance, the periods may be shortened respectively). In this way, an unknown number of repeat offenders is wrongly classified as “having come to the notice of police for the first time“ and the measured incidence overestimates the actual value.

When analyzing the trends, it needs to be taken into account that the number of those coming to police notice for the first time, also depends on the intensity of criminal prosecution. Drug-related crimes are control crimes, i.e. the higher the control, the higher the number of detected crimes. Through triangulation, a comparison with trends in other recorded areas, e.g. the number of treated cases, can help to evaluate trends more reliably.

The overall figure of users of hard drugs increased from the year 2009 to the year 2010 by 2.7% to a total of 18,621 (2009: 18,139). As in the previous years, pronounced declines were found for heroin (2010: 3,201; 2009: 3,592; -10.9%) and cocaine (2010: 3,211; 2009: 3,591; -10.6%). As in the previous years, the number of ecstasy users who came to the notice of the police for the first time strongly declined (2010: 840; 2009:1,357; -38.1%). Following the trend of previous years, the number of users of amphetamines who came to the notice of the police for the first time¹¹³ increased (+12.8%) and reached a new peak in 2010 (12,043 cases; 2009: 10,679).

At respectively low overall figures, the figures for methamphetamine users who came to the notice of police for the first time increased strongly (2010: 642; 2009: 364; +76.4%) and so did the ones for crack (2010: 311; 2009: 181; +71.8%), whereas figures for LSD (2010: 141; 2009: 127; +11.0%) and other “hard“ drugs (2010: 333; 2009: 321; +3.7%) increased slightly.

First-time offenders in connection with amphetamines accounted for little less than 2/3 (64.7%) of the total of first-time offenders (heroin: 17.2%; cocaine: 17.2%, ecstasy: 4.5%, crack: 1.7% and others including LSD: 2.5%)¹¹⁴in 2010. In this statistical documentation

¹¹³ Including users of methamphetamine who came to the notice of police for the first time.

¹¹⁴ Each person is only counted once in the overall figure under the acronym “EKHD“ (Erstauffälliger Konsument harter Drogen - first-time offender using hard drugs). However, to shed some light on the polytoxicomaniac use behaviour, it is possible to count one person several times for several drug types so that the percental breakdown by drug type exceeds 100%.

cannabis users are not taken account of since only so-called hard drugs are recorded (BKA 2011a).

Verurteilungen nach dem Betaeubungsmittelgesetz und Strafvollzug

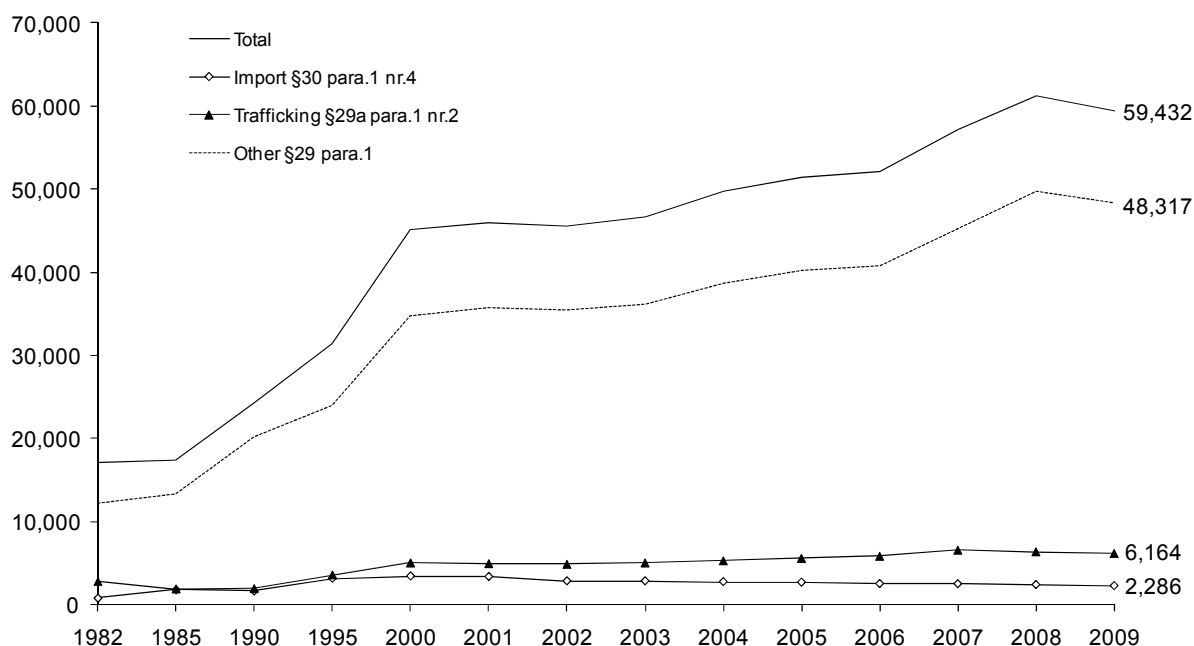
According to the sentencing statistics of the Federal Statistical Office (Special series 10, part 3) 59,432 persons (2008: 61,256) were convicted in 2009 for offences committed against the Narcotics Act (data for 2010 are not available yet). 51,723 convictions were rendered under the general criminal law relating to adults (2008: 53,334) and 7,709 (2008: 7,922) relating to juvenile offenders. As for the convictions rendered in respect of the general criminal law, 18,013 (2008: 18,195) prison sentences were passed – out of these 11,706 (2008: 11,627) were suspended on probation - and 33,710 (2008: 35,139) fines were imposed (Statistisches Bundesamt 2010b).

The overall figure declined for the first time (-3.0%) in comparison to the previous year (2007-2008: +7.2%). The slight decline is to be observed in all age groups, i.e. in adult, young adult¹¹⁵ and juvenile¹¹⁶ offenders. With regard to the type of crime, the decline is equally attributable to the lower case figures for the unspecific consumption-related offences (§29 para.1 BtMG) (2009: 48,317; 2008: 49,801; 2007-2008: -3.0%), the dealing/trafficking crimes (2009: 6,164; 2008: 6,375; -3.3%) and the offences in respect of §30 para.1 no. 4 BtMG (2009: 2,286; 2008: 2,412; -5.2%) (Figure 9.3).

As in 2008, convictions rendered for violations of the Narcotics Act accounted for 7.0% of all convictions imposed in 2009, whereby the portion of convicted males was about double as high as the one of convicted females (7.7% vs. 3.9%). Referred to juveniles, the share of convictions imposed for violations of the Narcotics Act was 3.5% while young adults aged between 18 and 21 years had a considerable higher share at 9.8%. As a result, drug-related offences committed by this age group have an above-average share in the overall crime rate. 63.1% of those convicted for offences committed against the Narcotics Act, have already been sentenced at least once before (males: 64.5%, females: 50.7%); in 62.5% of the cases, the crimes were committed by repeat offenders who had been sentenced at least three times before (Statistisches Bundesamt 2010b).

¹¹⁵ Young adults means persons who are aged 18 through 20 years at the time of the offence (§ 1 JGG). They can either be adjudicated according to the general criminal law or the criminal law relating to young offenders.

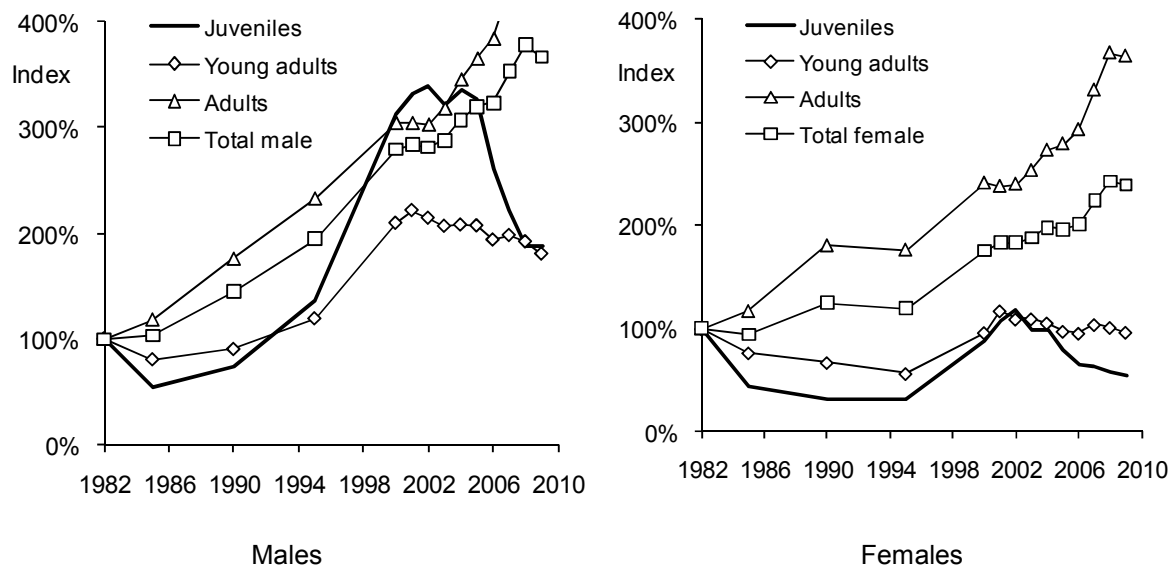
¹¹⁶ Juveniles means individuals who are 14 through 17 years of age at the time of the offence (§ 1 JGG). They are adjudicated under the criminal law relating to juvenile offenders.



Statistisches Bundesamt 2010b.

Figure 9.3 Convictions rendered under the Narcotics Act

As in the previous years, about nine times more men than women were convicted for violations of the Narcotics Act in the year in 2009 (males: 53,301; females: 6,131). The development trends of the last 27 years also show marked differences. Using the figures of 1982 as an index (=100%), the number of convictions of men almost quadrupled while the one of women more than doubled until 2009. Significant differences were found between juveniles and young adults. While for juvenile (55%) and young adult (96%) females the number of convictions rendered in 2009 remained far and respectively slightly below the levels of 1982, the number of convictions of male juveniles (187%) and young adult males (180%) approximately doubled. This enormous increase in the convictions of male juveniles and young adults mainly happened between the years 1995 and 2000. Between the years 2000 and 2005, there were hardly any changes in these two groups. From 2005 to 2008, the number of convicted juvenile male offenders almost dropped by half (-42.8%), whereas between 2008-2009 no further changes were found. The number of female juvenile convicts has been on a continual decline since 2002 (index: 118) and amounted to only 54.9% in 2009 in comparison with 1982. Among the young adult offenders, the number of convictions has been on the decline since 2001 (index: 222; Index 2009: 180), while it has hardly changed among the female young adults between 2001 (index: 108) and 2009 (index: 96) (Figure 9.4). Information on violations of the Narcotics Act can be found in standard table 11.



Statistisches Bundesamt 2010b.

Figure 9.4 Trends in the convictions rendered under the Narcotics Act

According to the Hamburg basic documentation system BADO 2010 (Oechsler et al. 2010), more than a third of the clients of the Hamburg outpatient addiction help system had problems with criminal justice authorities (38%) in 2009. With this, the portion fell back to the level of the year 2005 after having increased in between to 42%. Especially the portion of clients currently serving a prison sentence declined in the last five years (from 17% to 12%). At the same time the portion of individuals who have been awarded probation conditions has increased from 6% to 9%. Opiate and cocaine clients have most of the problems with the judicial authorities. Respectively half of the opiate and cocaine clients report that they are in conflict with the law. They account for the largest portions of clients serving a prison sentence (opiates: 18%; cocaine: 20%) and are very often involved in judicial proceedings (opiates: 12%; cocaine: 8%) or are awarded probation conditions (12% each). The cannabis group is subdivided into clients only using cannabis (32% with current judicial problems) and clients with by-consumption of alcohol (43%). Particularly striking are last but not least the divergences between male and female clients as regards their conflicts with the judicial authorities. Currently, 45% of the males but only 19% of the females have problems with the law. Among the individuals serving a prison sentence, the portion of the males is three times (15%) bigger than the one of the females (5%).

More than half of the clients documented by the documentation system BADO Hamburg in 2009, have at least been convicted once in their lives (52%). This portion declined by four percent points in respect of the year 2005. As regards the type of crime in this period, there was a decline to be observed especially in the portion of drug law offences (from 37% to 32%), the economic compulsive crimes (from 29% to 26%) and the other or respectively unknown offences (from 28% to 25%). The highest share in convicts is to be found again in the group of the opiate clients (78%). Little less than two thirds have already been convicted because of violations of the Narcotics Act (62%), half of them because of economic

compulsive crimes (51%) and more than a third because of unknown or respectively other offences (39%) and a quarter because of bodily injury offences. In the cocaine group, approximately one in five has already been convicted because of bodily injury and little less than a quarter because of drug law offences and other or respectively unknown offences (23% respectively). When looking at the convictions rendered among the cannabis group, the gap between the “cannabis-only” clients and those with additional alcohol problems widens even more than it has with regard to the current problems with the judicial authorities: cannabis clients who have an additional alcohol problem have, in total, a higher share in the number of convicts (46%; “cannabis-only” clients: 19%) and, at closer inspection, have strikingly more convictions for bodily injury (23%; “cannabis-only” clients: 5%), other offences (22%; “cannabis-only” clients: 6%) and economic compulsive crimes (11%; „cannabis-only“ clients: 4%). Just as for the current problems with the judicial authorities, there are also significant gender differences to be found in the convictions: On the whole, women are less frequently convicted (females: 33%; males: 59%) and they have lower shares in the convictions for all offences than the males. Particularly striking is the divergence in the bodily harm offence which about one male in four (23%) but only one women in twenty (6 %) was convicted of.

A total of 43% of all clients report that they have already been in prison at least once in their lives. This is three percent points less than in 2005. The average length of internments among the group of clients with prison experience was at 45 months in 2009. The by far largest share of clients with prison experience is to be found in the group of opiate clients (70%). On average, the opiate clients spent a total of 50 months in prison. With this, the average length of internment of this group increased by four months in comparison with the year 2005, while it decreased in all substance groups during the same period of time. 41% of the cocaine clients have served at least one prison sentence in their lives, the total length of internment was 29 months on average. Alcohol clients have the lowest share in the persons with prison experience (16%), however, if they have already been in prison, the total length of their imprisonments (40 months) was on average longer than among the cocaine and cannabis clients. The latter can be subdivided again in “cannabis-only” clients and those with additional alcohol problems since not only the prevalence of imprisonment (32% vs. 12%), but also the average length of imprisonment (21 months vs. 18 months) is longer among the cannabis clients with concurrent alcohol problems. Last but not least, mention is here also made of the gender differences. Far fewer female clients report prison experience (females: 5%; males: 22%) and on average shorter prison sentences than their male counterparts (females: 25 months; males: 48 months).

The questionnaire used within the framework of the study conducted in the Frankfurt drug scene (Mueller et al. 2011) contained for the first time questions on prison experience and the respective reasons for imprisonment. Only 22% of the scene members have not been in prison yet, which corresponds to the number of opiate clients in the BADO Hamburg. Among the 78% of the members of the Frankfurt drug scene with prison experience, the frequency of previous imprisonments is relatively equally spread: respectively 12% of all interviewees

have been in prison once or twice, 14% three times, respectively 10% four or five times, 7% six times, 5% seven times and 8% eight times or more. The interviewees with prison experience have been 4.6 times on average in custody. A similarly equal distribution is to be found for the total time spent by the interviewees in prison. For 23% of the interviewees with prison experience, the length of internment was limited to a maximum of 12 months. 13% spent 1-2 years, 15% a maximum of 3 years, 10% a maximum of 4 years, respectively 11% a maximum of 5 and 7 years and 10% between 7 and 10 years in prison. A further 7% of those with prison experience spent more than ten years behind prison walls. The average time spent in prison among interviewees with prison experience is approximately 4 years (51.9 months). Among the reasons for imprisonment, robbery was mentioned most frequently with 27%. 21% reported that they had served a prison sentence in lieu of an imposed fine (without closer specification of the offences that lead to the respective fine). A further 12% were in prison for possession of drugs, 10% for bodily injury and 8% for drug dealing. Respectively 7% gave robbery and fraud as reasons for their imprisonment. Respectively 3% of the interviewees with prison experience served a prison sentence for burglary and driving without a driving licence. There was furthermore respectively one interviewee who had been in prison for drug trafficking and murder or respectively manslaughter. Summarizing, it can be said that a large majority of the interviewees have prison experience. For the most part, prison sentences added up to considerable lengths of several years. The most common reason for imprisonment were property crimes followed by drug law offences. But a non-negligible number of interviewees have been in custody because of violent offences.

9.2.2 Other drug-related crime

Drug use and road accidents

Since 2003, the Statistical Report on Road Accidents published by the Federal Statistical Office has been providing information on the question as to whether the operator of a motor vehicle involved in an accident was under the influence of intoxicating substances other than alcohol. Since 1998, driving under the influence of drugs has been legally classified as a regulatory offence. This also applies to cases where unfitness to drive could not be proven. According to a Supreme Court decision, a THC-content of below 1.0 ng/ml in the blood cannot be taken as constituting an acute impairment of the fitness to drive (Bundesverfassungsgericht 2004).

In the year 2010, police-registered accidents on German roads totalled 288,297 cases with damage to persons and with 445,306 operators of vehicles being involved (Table 9.1). Out of these, 14,237 (4.9%) were under the influence of alcohol and 1,151 (0.3%) under the influence of "other intoxicating substances" (Statistisches Bundesamt 2011c). This means that the downward trend observed since 2003 also continued in 2010 and that total the number of accidents with damage to people and accidents under the influence of alcohol declined in comparison with the previous year.

In 2010, the number of accidents under the influence of other intoxicating substances was somewhat below the levels of previous years. However, since alcohol is easier to detect than drugs, it is still to be assumed that drug-related cases are underrepresented in German road accident statistics.

Table 9.1 Drug use and road traffic accidents – person-related causes

Year	Accidents with damage to persons	Person-related causes	Drivers under the influence of ...	
			alcohol	other intoxicating substances
2004	339,310	417,923	21,096	1,457
2005	336,619	413,942	20,663	1,343
2006	327,984	403,886	19,405	1,320
2007	335,845	410,496	19,456	1,356
2008	320,641	388,181	18,383	1,440
2009	310,806	377,733	16,513	1,281
2010	288,297	350,323	14,237	1,151

Statistisches Bundesamt 2011c.

Kagerer (2010) described the medical psychological assessments conducted in the year 2008 to assess the fitness to drive. According to the survey, 103,137 medical psychological assessments were conducted by more than 20 of the German assessment centres. 57% of the assessments were conducted in connection with alcohol, 18% in connection with drugs or respectively medications, whereby the severity of the problem ranged between occasional use to substance dependence. While drugs/medications appear to have only a small share in road accidents (7%), intoxicating substances play a more important role in medical psychological assessments (approximately 24%).

Beck (2010) compared the fitness to drive of opiate dependent patients who were in a stable replacement therapy with L-polamidone or methadone to the fitness to drive of control groups from the general population¹¹⁷. The individuals substituted with L-polamidone performed better in the reaction tests than the ones substituted with methadone, but for the rest no further differences were found. In comparison with the control groups, the individuals in replacement therapy did not come off significantly worse than the control group, which leads the author to the conclusion that from a medical point of view not the substitution therapy but lacking compliance of the patients paired with regular by-consumption is decisive for the revocation of the driving license.

¹¹⁷ The study compared N=69 (out of more than 500) opiate substitution patients 1:1 to control persons from the general population matched by age, gender and education level and an overall control group (N=157) in their performance in the original "Vienna test battery" (reaction test, cognitron, visual pursuit test, adaptive tachistoscopic traffic perception test).

The Federal Ministry for Transport, Building and Urban Development (Bundesministerium fuer Verkehr, Bau und Stadtentwicklung, BMVBS) carried out several projects among others together with the German road safety organisation "Deutsche Verkehrswacht" (DVW) to prevent road accidents caused by drunk and drugged driving. Among them were road safety spots broadcasted in television under the name "U-turn" and information campaigns run for example at the occasion of the youth trade show "YOU" (Deutscher Bundestag 2010).

Crime experienced by drug users themselves

Since 2005, the Hamburg Basic Documentation System BADO has been showing a stable share of approximately 60% of the clients who have had experience with physical violence (Oechsler et al. 2010). As for sexual violence, the share has been at a good 20% for years. Comparing the different substance groups, one finds that the clients who have sought help from the Hamburg ambulatory addiction help system for opiate-related problems are particularly affected in this respect. Among these, more than two thirds report in the period under enquiry that have already been victims of physical violence (69%) and more than one in four have been victims of sexual violence (26%). Experience with sexual violence is least common in cannabis clients (12%). Experience with physical violence is somewhat less prevalent both among cannabis clients and alcohol clients (respectively 51%) in comparison. Here, it needs however to be differentiated again between "cannabis-only" clients and cannabis clients with additional alcohol problems: The latter become by far more often victims of physical violence than "cannabis-only" clients (61% vs. 40%).

The gender differences are however by far more pronounced than they are between the substance groups. This applies to the experience with physical violence (females: 67%; males: 58%) and, to a much larger extent, to sexual violence. In the year 2009, 52% of all female clients report that they have fallen victim to sexual violence, among male clients the share is 8% by way of contrast. Among the females, opiate clients are the ones who are the most affected by crime. More than two thirds of them report experience with physical violence (77%) and a little less than two thirds experience with sexual violence (64%).

9.3 Prevention of drug-related crime

Apart from consequent repression, multifarious measures of criminal prevention are also required to combat crime successfully. Therefore, police has set a particular focus on prevention measures at a national level with the programme "Police criminal prevention of the *Laender* and the Federal Government". The goal of this programme is to inform the population, multipliers, media and other groups who are active in prevention about different forms of crime and possibilities of preventing them. This is done, among others, by criminal preventive PR-work and the development and publication of media, measures and concepts that support the local police offices in their preventive activities.

Another form of prevention are identity checks carried out by the police among the drug scene. A total of 56% of the interviewees of the open drug scene in Frankfurt/M. experienced at least one police check of this type during the data collection for the MoSyD scene study

2010 (Mueller et al. 2011). Most of the interviewees had only a few checks (one check: 16%, two checks: 10%, 3-5 checks: 15%). However, about one in seven was comparatively often checked: 4% were checked six to ten times, 6% eleven to twenty times and a further 5% even more than twenty times. When taking a closer look at the various groups, one finds that individuals who have been frequenting the scene for a longer time (more than two years) have been checked a bit more frequently (3.8% on average) than scene goers who have been part of this environment for less than two years (2.4 times). Other analyses like for example the comparison between Germans and Non-Germans did not reveal any differences in the density of checks. Summarizing, it can be stated that the majority of the interviewees are regularly checked – at least once per month – in the public by the police. More than one in ten was checked more than 10 times in the last month. Based on these results, the density of checks can be described as quite high.

9.4 Interventions in the criminal justice system

9.4.1 Alternatives to prison

According to §63 and §64 of the Penal Code (Strafgesetzbuch, StGB) it is possible under certain circumstances to order the placement of mentally ill or addicted offenders in special closed correctional facilities (like psychiatric facilities or withdrawal clinics).

The Narcotics Act (BtMG) allows the suspension of proceedings in cases of minor guilt or lack of public interest in prosecution (§31a BtMG). This applies mainly to consumption-related offences, in particular when they occur for the first time and third parties are not involved. These regulations are subject to different regional application as shown by a study carried out by Schaefer & Paoli (2006). With regard to the prosecution of consumption-related offences involving cannabis, there has recently been a move to greater convergence of the definitions of limit values for “small quantities“ in the *Laender* in line with the guidelines passed by the Federal Constitutional Court. Further details can be found in chapter 1.2.2.

It is moreover possible to defer a prison sentence of up to two years to provide the drug addict with the chance to undergo therapy (“therapy instead of punishment“, §35 BtMG).

The Federal Association for Inpatient Addiction Help (buss 2010) notes that since 2010 an increasing number of petitions for the deferment of sentences according to §35 BtMG have been rejected on the grounds of „lacking causal connection“ between the offence and drug dependence. A more restricted interpretation of the causal connection has recently lead to a in part massive decline in the admissions to therapy facilities which is intensified by a judgement rendered by the Federal High Court of Justice on 04.08.2010 (5 AR (VS) 23/10) abolishing the common practice of reversing the prosecution order with the effect that a lot of petitions for the deferment are bound to be rejected.

9.4.2 Other interventions in the criminal justice system

There are possibilities, under certain circumstances, to cease criminal proceedings at all levels. Often, a few hours of community service are a first response of authorities to deal with problematic behaviour in connection with drugs.

There is a series of other possibilities available to curb drug crime and also economic compulsive crimes. Many cities have created legal possibilities to ban drug users from certain places to prevent the formation of open drug scenes¹¹⁸.

At public prosecution level, it is possible to stop prosecution of crimes committed by adolescents¹¹⁹ and young adults¹²⁰, who fall under the juvenile law or to discontinue proceedings in respect of the Juvenile Offenders Act (JGG, §§ 45 und 47). This is mostly applied in cases involving only small quantities.

Within the framework of the scene study 2010 carried out in Frankfurt/M. (Mueller et al. 2011), the members of the open drug scene were asked whether they had had been given move on directions or banning orders in the previous month. 34% of those who had also been checked by police in the previous month also had been issued move on directions and banning orders. This corresponds to 20% of the overall sample. The larger part of the group (20% of the ones checked by the police or respectively 12% of the overall sample) had been issued one move on direction and one banning order. A further 10% of the scene members checked by the police or respectively 6% of all interviewees had been given two to five injunctions of this type and 4% and respectively 2% had been given a move on direction or a banning order more than five times.

In nearly all *Laender*, local prevention measures like for example the widely spread programme “Early Intervention in First-Offence Drug Consumers – FreD“ is used as a possibility to intervene without starting criminal proceedings right away. The programme addresses 14- to 18-year-olds but also young adults up to 25 years who have come to the notice of the police for the first time due to their consumption of illegal drugs (for more information on the programme FreD see also the REITOX Reports of the years 2007 and 2008 as well as chapter 1).

9.5 Drug use and problem drug use in prisons

Poehlmann-Moore and colleagues (2010) report from the closed detoxification ward of the Isar-Amper-Clinic in Munich that the patients admitted to treatment ordered by a judge according to §64 BtMG increasingly use herbal mixtures with synthetic cannabinoids or

¹¹⁸ A move on direction is a police measure to avert danger. It is limited to 24 hours. A banning order is an administrative act that can be passed by a municipality and can be referred to a longer period of time and a larger area than a move on direction.

¹¹⁹ Adolescents are taken as referring to individuals aged 14 to under 18 years at the time of the offence (§ 1 JGG). They are adjudicated under the criminal law relating to adolescent offenders.

¹²⁰ Young adults are taken as referring to individuals who are aged 18 to under 21 years at the time of the offence (§ 1 JGG). They can either be adjudicated according to the general criminal law or the criminal law relating to young offenders.

opioids. Since the multitude of new, hard to detect drugs render it almost impossible to guarantee a drug-free zone necessary for a successful therapy outcome in the therapy wards through drug tests alone, the effort was undertaken to create and maintain an addiction therapeutic climate that provides relapsing patients with the possibility of self-reporting the drug use. This practice opened up the possibility of therapeutically processing the relapses in all patients.

Detailed information on drug use and problem drug use in prisons can be found in the Selected Issue 11 and in the standard table 12.

9.6 Response to drug-related health issues in prisons

Detailed information on the responses to drug-related health issues in detention facilities such as drug treatment as well as prevention and drug-related harm reduction are contained in the Selected Issue 11.

9.6.1 Prevention, treatment and care of infectious diseases

Placement on a hospital order

The 19 patients who underwent interferon therapy on a hospital order since 2008 to be treated for HCV in the Vitos Clinic for Forensic Psychiatry Hadamar had a SVR rate of 100%, which is an indication that HCV infected patients can be successfully treated with interferon and ribavarin on a hospital order (Wolf et al. 2010).

Information on the prevention, treatment and care of infectious diseases are contained in the Selected Issue 11.

9.6.2 Prevention of overdose risk upon release

In its action plan on the implementation of the HIV/AIDS strategy, the Federal Government established that prisons represent a setting that requires specific health care measures to be undertaken. Therefore, talks are being held with representatives of the ministries for justice of the *Laender* with a view to promote substitution therapy in prison. In particular the transition from prison to life in freedom carries a special risk of overdose.

Given the high mortality risk of IDUs after prison release, the revised guidelines passed by the German Medical Association on the opioid substitution therapy - OST (BÄK 2010) explicitly allow the start of an OST for currently abstinent dependents.

9.7 Reintegration of drug users after release from prison

With regard to the preparation of the release of detainees from prison, the legal framework establishes that detainees are to receive assistance upon prison release (§ 74 Prison Law in connection with § 15 Prison Law) with a view to promote societal integration after prison. In order to reach this goal prison services are to cooperate at inter-departmental level (§ 154 Prison Law).

Moreover, providers of social security services are to form networks and cooperate with the

competent agencies to complement each other in the pursuit of the same goal (§ 68 paragraph 3 Social Code XII and § 16 paragraph 2 Social Code II). Corresponding strategies and measures are developed and implemented under the term transition management. On the one hand, it is tried to facilitate a smooth transition from prison to freedom with integration into training, work and employment, on the other, to tackle problems linked with detention and criminal careers. The main task of transition management is to improve the situation of the clients by offering them counselling and care but also possibilities of professional qualification and training as well as job placement.

Although from an historic viewpoint there have been corresponding efforts undertaken already 150 years ago with the introduction of the assistance for offenders and the introduction of the probation service in the 1950s, the discussion and the implementation of a transition management still require further development.

With the support of the German Centre for Addiction Research in Childhood and Adolescence (Deutsches Zentrum fuer Suchtfragen des Kindes- und Jugendalters, DZSKJ) the detention facility Fuhlsbuettel (JVA Fuhlsbuettel) introduced a national innovation in the year 2008 by setting up a special therapy preparation station for drug dependent and substance-abusing detainees at the start of their prison sentence. The DZSKJ carried out an accompanying summative evaluation of the newly implemented therapy preparation station. The complex setting of the therapy preparation station comprised an access group, skills training according to Linehan, relapse prophylaxis training, a free conversation group and supportive recreational group activities. Negative results in the urine tests were the precondition for admission and stay at the preparation station. A total of 26 male detainees from two Hamburg detention facilities took part in the study. The retention quote at the therapy preparation station was at a total of 92.3%. 80.8% (3 months after discharge) and 69.2% (6 months after discharge) of the detainees were reached by the follow-up. Six months after the discharge, 61.1% of the discharged participants started a follow-up treatment and 45.5% of those who started a follow-up treatment, completed it according to schedule¹²¹.

¹²¹ s.a. <http://www.uke.de/zentren/suchtfragen-kinder-jugend/index.php>

10 Drug markets

10.1 Introduction

Indicators of the situation on the illicit drug market are, apart from the perceived availability and supply of illicit substances, also the number and size of seizures, prices and levels of active ingredients or purity of the substances respectively. The attempt to get a grasp of new drugs, their structure and effects, is associated with considerable expense in the form of complex chemical analyses. Such analyses are carried out for example by the Forensic Science Institute of the Federal Criminal Police Office (BKA). Information on seizures is also available from the BKA or the Land Criminal Police Offices (Landeskriminalämter, LKÄ).

Availability and supply

Availability and supply are two different perspectives of the drug market: the perspective adopted by the buyer on the one hand and by the supplier on the other. The availability of illicit substances as perceived by the population or the users can be assessed by means of statements made in surveys on how 'easy' or 'very easy' they are to obtain during a certain period of time. In Germany, these data are regularly collected by the Epidemiological Survey on Addiction (ESA) (the last time in 2003), the Drug Affinity Study (DAS) carried out by the BZgA and within the framework of regional monitoring systems (e.g. MoSyD Frankfurt). The perceived availability reflects the situation on local and regional drug markets but also personal opinions. Other aspects of availability are indicators like the price, purity and seizures. Seen from the perspective of the suppliers, the market situation is reflected by the number, quantity, price and quality of seized drugs.

Seizures

In Germany, in particular at the borders with neighbouring countries and at airports, large quantities of narcotic drugs are regularly seized. For some of the seized substances, police and customs authorities identify the country of departure, origin or transit. The BKA statistics presented in the following contain all data on the seizures made by the police offices of the *Laender*, the BKA and the customs offices.

Price

At the end of the year 2002, the Land Criminal Police Offices and the Federal Criminal Police Office agreed on an expanded collection of data on domestic drug prices. Since then, apart from the highest and lowest prices, the so-called "predominant market prices" at street and wholesale level have been recorded, whereby, based on an agreement made at European level on the initiative of the EMCDDA, data collection for the latter is differentiated for the first time in terms of trade volumes from 0.5 to < 1.5 kg (respectively 500 to < 1,500 consumption units), 1.5 to < 10 kg (1,500 to < 10,000 consumption units) and 10 kg to < 100 kg (10,000 to < 100,000 consumption units). In order to guarantee a maximum of representativeness of the

price survey, data are generally collected at four to six locations in the *Laender* (by police offices in urban and rural areas) and then transferred to the respective LKA. The Land Criminal Police Offices join the data from the measuring locations and further available information in a standardized table and transfer the current market prices of drugs in their Land to the BKA once a year. Based on these data, the BKA calculates the average drug prices for Germany.

The thus established drug prices can only be interpreted as rough approximate values, particularly since differences in purity and quality categories are not taken into account in establishing the prices. Furthermore, things are rendered even more difficult by the fact that prices only get known in connection with a few incidents, so that random effects may substantially alter these figures.

In 2010, the EMCDDA published a manual with guidelines on the collection of data on drug prices at street-level. Apart from describing methodological difficulties like for example geographic coverage, representativeness and weighting, the manual also gives examples of drug price calculations from several European countries. In France, Norway or the Netherlands for example, expert groups from the health area and criminal prosecution or respectively from various “scenes” give estimates of current drug prices (EMCDDA 2010).

The trend scouts and scene surveys conducted within the Frankfurt MoSyD provide estimations on the prices of various drugs.

Purity

Apart from establishing prices, the Federal Criminal Police Office also ascertains the purity of different drugs on the market. Samples taken from drug seizures serve as a basis for the analysis of purity and content of active substances. For better comparability the contents of psychotropic ingredients are related to the chemical form of the base, irrespective of the form in which the illicit preparation of the substance is found. All figures given may only be interpreted as rough values because large differences in purity levels of the individual substances seized may lead to marked random effects. As the distribution of values diverges considerably from the normal distribution, median values are used instead of arithmetic means.

The presentations are based on data provided by the BKA upon request of the DBDD. The active ingredients of the seized substances are quantified and broken down into three levels: street trafficking (< 1g), retail (1g to <1,000g) and wholesale (\geq 1000g). Results are presented in a discriminating manner insofar as considerable differences in purity levels at wholesale and street trafficking level were found. The reason for this is that active substances are increasingly diluted from the wholesale to the street trafficking level for profit maximization. Apart from the data on active ingredients, the most frequently found additives are reported. Insofar as these are pharmacologically effective, they are categorized as adulterants (e.g. caffeine) or otherwise as diluents or fillers (e.g. sugar).

10.2 Availability and supply

10.2.1 Perceived availability of drugs, exposure and access to drugs

Within the framework of the DAS 2008¹²², the teenagers and adults aged 12-25 years were asked: “How easy would it be for you to get hold of hashish or marijuana within 24 hours?”. A little less than 40% of the interviewees answered that it would be “very easy” or “rather easy” and a third said that it would be impossible to get hold of cannabis within a day. Striking is the finding that each category that comprises possible availability within the next 24 hours in comparison with the category “not possible at all” is significantly larger among males than among females. This means, conversely, that it is impossible for more female than male teenagers and young adults to get hold of marijuana within 24 hours (Table 10.1).

Table 10.1 Perceived availability of cannabis broken down by gender (DAS 2008)

Question: How easy would it be for you to get hold of hashish or marijuana within 24 hours?

	Total	Male	Female
Very easy	19.2	21.6	16.7
Rather easy	19.4	20.3	18.4
Rather difficult	15.7	16.1	15.2
Very difficult	11.4	11.6	11.2
Impossible	32.7	28.9	36.5
Don't know/Not specified	1.8	1.5	2.0

All data in percent.

Bold print: Figure diverges at a statistically significant scale from the figure for the female interviewees.

Multinomial logistic regression with the covariates age and gender. Reference category: “Not possible at all”.

Results are weighted.

BZgA 2010 Special evaluation.

The group of interviewees who stated in the DAS that it would be “very easy” to get hold of cannabis, were also asked where they would get the cannabis from. Two thirds of the interviewees get their cannabis from friends or acquaintances and little less than half get it on the street. Approximately a sixth of the interviewees (16.8%) think that they could buy cannabis in headshops. Girls and young women obtain cannabis mainly from friends and

¹²² In the drug affinity study 2008 (BZgA 2010) a representative sample of 3001 adolescents and young adults aged 12-25 years was surveyed. Data collection was done with computer-based telephone interviews (CATI). The interviews were conducted in February and March 2008. The random sample was drawn according to the ADM-sampling design for telephone interviews. From a telephone master sample containing all relevant telephone numbers, landline numbers were drawn by means of an unrestricted random sampling with equal selection probability. After calling the numbers, it was established if a private household, in which adolescents and young adults were living, had been sampled. If there were one or more adolescents and young adults aged between 12 and 25 years living in one of the households reached, the person who last had his birthday, was selected. In the case of children in the age of 12 and 13 years, permission of one the parents was obtained prior to interviewing.

acquaintances, but, in contrast to the male interviewees, far less frequently on the street, in coffee shops or at school (Table 10.2).

Table 10.2 Places of cannabis availability in persons with perceived very easy availability (DAS 2008)

Question: Wherefrom do you get the drugs?			
	Total	Male	Female
Friends and acquaintances	66.1	63.8	69.2
On the street	47.6	53.5	39.7
Discos	37.7	36.8	38.8
Coffee Shops	25.2	28.5	20.9
School	23.3	27.3	17.9
Cannabis-Shops	16.8	16.3	17.6
Pubs	15.9	15.5	16.4
Holiday resorts	13.8	13.5	14.1
Youth centers	13.5	15.2	11.1
Family or relatives	3.2	2.6	4.0
None of these	1.9	1.9	2.0

All data in percent. Multiple answers possible.

Bold print: Figure diverges at a statistically significant scale from the figure for the female interviewees.

Binary logistic regression with the covariates age and gender.

Results are weighted

BZgA 2010 Special evaluation.

Looking at the trends since 1997, one finds that, similar to the ones of the prevalences (see chapter 2) in the same period of time, the availability was at a peak at the beginning of the 2000s and has been declining since. About double as many young adults (18-25 years) have very easy access to hashish or marijuana than teenagers (12-17 years). The differences have become more pronounced since 1997 because the quick availability of cannabis has become more difficult for teenagers while it has hardly changed in the young adults between 2004 and 2008 (Table 10.3).

Table 10.3 Trends of the very easy cannabis availability (DAS 1997-2008)

Question: How easy would it be for you to get hold of hashish or marijuana within 24 hours?
Answer: Very easy

	12 to 25 years			12 to 17 years			18 to 25 years		
	Total	Males	Females	Total	Males	Females	Total	Males	Females
1997	20.4	21.8	18.9	15.3	13.6	17.1	23.9	27.6	20.1
2001	27.3	30.7	23.7	19.8	20.9	18.7	32.9	38.1	27.5
2004	20.8	24.2	17.3	13.8	15.7	11.8	26.1	30.5	21.5
2008	19.2	21.6	16.7	10.4	11.7	9.0	25.1	28.3	21.9

All data in percent.

Bold print: Figure diverges at a statistically significant scale from the figure of the year 2008.

Binary logistic regressions with the covariates year and age (total as well as gender columns).

Results are weighted

BZgA 2010 Special evaluation.

Information on the availability of illicit drugs in the open drug scene in Frankfurt can also be gleaned from the annual report on the scene study conducted within the framework of the MoSyD Frankfurt/M. (Mueller et al. 2011). According to the survey conducted in 2010, the availability of heroin (easy/very easy: 97%), crack (99%) and benzodiazepines (94%) has never been rated so high by the scene members in any of the previous surveys since 2002, while the portion of scene members for who cocaine is easily or very easily available has slightly declined and currently is at 25%.

The so-called research chemicals (RC) or legal highs are a relatively new phenomenon. "RC" is the abbreviation used in circles of experimental drug users for synthetic psychoactive substances of different substance categories (e.g. piperazines, cathinones or also cannabinomimetic substances) that have not (yet) been placed under the Narcotics Law and that have in part similar effects like the more known drugs (e.g. amphetamines, ecstasy, cannabis). Declared as "bath salts", "fertilizer tablets", "air fresheners" or similar things, such substances are legally available on the retail market or from online shops and head shops (without indication of the concrete ingredients) (Werse et al. 2010b).

Under the lead management of the Institute for Legal Medicine of the University Clinic Freiburg and under participation of the Federal Criminal Police Office, the EU project "Spice and new synthetic cannabinoids" researches new synthetic cannabinoids and their effects. It moreover develops contemporary detection methods and approaches for the prevention work in the area of "legal highs". "Spice and synthetic cannabinoids" is a co-operation project between Germany and various organisations from Poland, Finland, Austria and Switzerland (see chapter 1.3.2).

10.2.2 Drugs origin: national production versus imported

According to the Federal Criminal Police Office (Bundeskriminalamt, BKA, 2011a), illicit drugs, apart from cannabis (c.f. Kipke & Floeter 2009) and to a comparatively small extent also synthetic drugs are almost exclusively imported from abroad. The trade routes are described in chapter 10.2.3.

According to the BKA (2011a), cannabis was extensively cultivated outdoors and indoors again in 2010. The number of detected and seized outdoor plantations sank from 67 to 46 (-31%) while the one of indoor plantations slightly increased from 342 to 348 (+2%). Among the 46 outdoor plantations were one professional plantation (cultivation capacity of more than 1,000 plants), nine large plantations (100-999 plants) and 36 small plantations (20-99 plants) with a total of 5,470 (+3%) seized cannabis plants. The 348 indoor plantations are composed of 22 professional plantations, 105 large plantations and 221 small plantations with a total of 74,502 (-18%) impounded cannabis plants. Most of the outdoor plantations were recorded in Bavaria (19%), most of the indoor plantations in Baden-Wuerttemberg and Lower Saxony (respectively 13%).

10.2.3 Trafficking patterns, national and international flows, routes, modi operandi and organisation of domestic drug markets

The overall number of registered seizures of narcotic drugs declined in the year 2010, whereby the individual drug types were subject to different developments. Increases were especially found for amphetamines/methamphetamines and biogenetic drugs. A large number of cases were, as usual, related to the smuggling of relatively small quantities of drugs that were imported within the framework of drugs runs by users or retailers from the Netherlands to Germany. Apart from being smuggled overland, narcotic drugs were also transported by flight messengers or as airmail to Germany at high frequency. The drugs were often bound for other European countries but seldom for countries outside of Europe. Seaborne smuggling remained an exception although in the few cases that were detected, large quantities were transported. As regards seizures, German nationals were identified as suspects in the large majority of cases for nearly all drug types. Their portion was particularly high in seizures of synthetic drugs and cannabis plants. Only in connection with seizures of khat, German nationals appeared comparatively seldom as suspects (BKA 2011a).

Cannabis

Seizures of cannabis products showed a varied picture in 2010. Hashish was imported to Germany mainly from the Netherlands but also from Morocco via Spain and Portugal and at higher case figures from Belgium, France and Austria. Furthermore, airmail deliveries from India, intended for further inner-European transport among others to Austria, Portugal, Spain or Scandinavia, were seized at various German airports, especially at Frankfurt/M.

Marijuana was smuggled to Germany at a high frequency from Belgium, Austria and the Czech Republic. The largest individual quantity seized - 232 kg - was hidden in a semi-trailer truck that was on the way from Albania via Italy, Austria and Germany to the Netherlands.

Marijuana hidden in parcels from Africa and addressed to recipients in China, was seized in several cases in the low- to medium digit kilogram range at German airports, mainly in Frankfurt/M.

Among the non-German suspects who were identified in connection with the seizures of cannabis products (in particular marijuana), Turkish nationals play a predominant role. Italian nationals dominate as suspects in the seizures of hashish (BKA 2011a).

Heroin

The origin of larger quantities of heroin seized in Germany in 2010 could only seldom be traced back to countries further than the Netherlands. Sporadically identified in seizures of heroin smuggled by land were in this context Belgium, Austria, Poland, countries of the Balkans or Turkey. In addition, several smaller parcels from Asian or Middle-Eastern regions bound for other European countries, mainly Spain, were seized at German airports.

Among the non-German suspects who were identified in connection with the seizures of heroin, Turkish nationals play a predominant role (BKA 2011a).

Cocaine

In comparison to the previous year, 2010 saw again an increase in individual quantities seized. The largest individual quantity of cocaine ever seized in Germany – 1.3 t – was detected at Hamburg harbour. The narcotic drug was smuggled on a ship container from Paraguay loaded with wooden briquettes. Several other containers also from Paraguay had approximately 351 kg cocaine hidden amidst sandstones. Furthermore, 342 kg cocaine was detected in North-Rhine Westphalia in a banana delivery that had been shipped from Columbia via Antwerp. The modus operandi of smuggling cocaine in banana deliveries from South-America has been observed quite a few times in Germany.

Airborne smuggling from South America to Germany takes place at a high frequency, with Argentina and Brazil being again the main countries of origin or transit.

In many cases, the cocaine seized in Germany was meant for distribution within Europe. Often, transport was planned especially to Spain and Great Britain. As in the previous year, several airmail deliveries with smaller quantities were in transit into the direction of China.

Among the non-German suspects identified in the seizure cases, mainly Turkish nationals were involved followed by Italians.

As in the previous years, the by far largest part of the total quantity of crack seized was impounded in Hamburg in 2010. In connection with seizures of crack, Turkish nationals dominated the scene among the non-German suspects (BKA 2011a).

Amphetamines

More than half of the overall quantity of crystal methamphetamine ("crystal") seized in 2010, was seized in Saxony and approximately a fifth in Bavaria. North-Rhine Westphalia and Hesse too registered sporadic cases involving sizeable quantities of this drug that is mainly

smuggled from the Czech Republic to Germany. As in the previous year, numerous cases with however relatively low individual quantities were registered in Thuringia. See on this also an article from the Czech Republic online (2011).

Whereas the large majority of amphetamines were verifiably smuggled from the Netherlands to Germany, smaller quantities also entered Germany from Belgium, Austria or the Czech Republic. In individual cases, amphetamines and methamphetamines from South-America were seized at Frankfurt airport. The drugs were intended for further transport to Japan. Furthermore, several airmail deliveries with mephedrone that is similar to amphetamines were seized at the airport in Leipzig.

In connection with seizures of amphetamine and methamphetamine, especially Turkish but also Polish nationals were identified among the non-German suspects (BKA 2011a).

Ecstasy

The large majority of the ecstasy tablets seized in 2010, whose origin could be traced back, came from the Netherlands.

Sporadically, large quantities in four- to five-digit numbers of pills were intended for transport to Bulgaria, Rumania, Ireland, Switzerland and Swaziland.

Among the non-German suspects who were identified in connection with the seizures of ecstasy, Dutch and Turkish nationals play a predominant role (BKA 2011a).

10.3 Seizures

10.3.1 Quantities and numbers of seizures of all illicit drugs

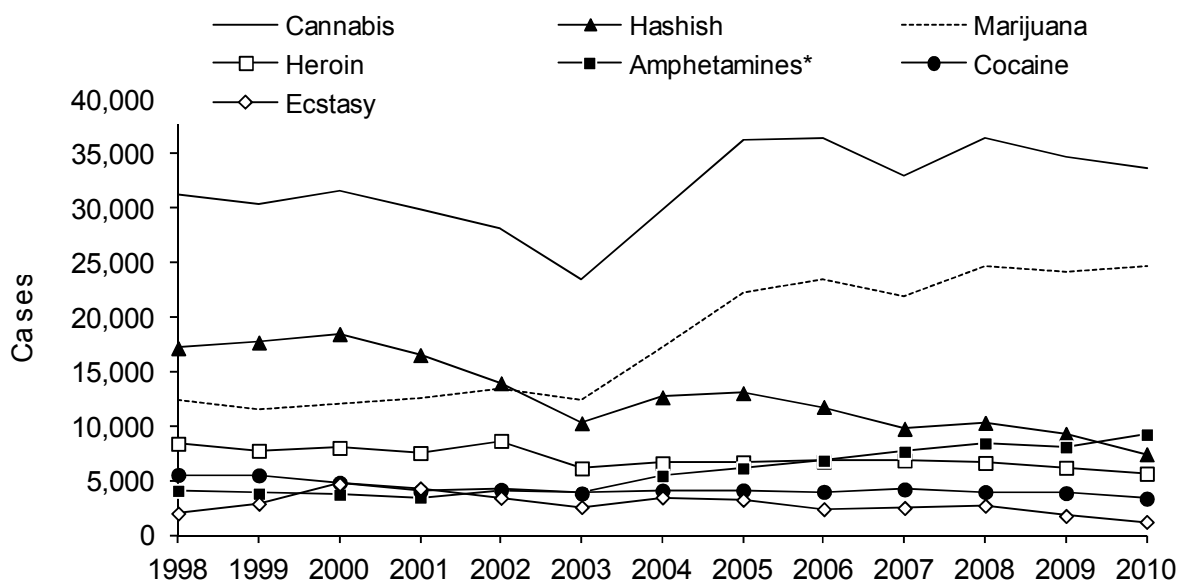
When comparing the years 2009 and 2010, one finds that the seized quantities of cocaine, methamphetamine (at a comparatively low overall quantity), khat and mushrooms very strongly increased and the ones of marijuana strongly increased, while the seized quantities of heroin, ecstasy as well as crack and LSD (at a comparatively low overall quantity) very strongly declined, amphetamines strongly and hashish slightly declined. The main reason for these fluctuations are large individual seizures that considerably increase or, if there are none, decrease the figures in comparison to the previous year. The increase in the seized quantity of cocaine between 2009 and 2010 (+77.6%) is mainly attributable to several large individual seizures (1.3 t, 351 kg and 341 kg; see 0). The decline in the overall quantity of the seized heroin (-37.5%) in the comparison between 2009 and 2010 is mainly attributable to the decline in seized quantities in the two-digit kilogram range in 2010, while 2009 saw relatively many individual seizures of this type. After having increased for eight consecutive years until 2009, the quantity of seized amphetamines declined for the first time from 2009 to 2010 (-12.9%), since there were no individual seizures like in 2008 (284 kg) and 2009 (360 kg) (BKA 2011a). The quantity of seized methamphetamine, by way of contrast, almost tripled (at a comparatively low overall quantity). Table 10.4 gives an overview of the quantities of illicit drugs seized in Germany in 2009 and 2010.

Table 10.4 Seized quantities of illicit drugs in Germany 2009 and 2010

Substance	2009	2010	Change
Heroin	758.4 kg	474.3 kg	-37.5 %
Cocaine	1,707.0 kg	3,030.8 kg	+77.6 %
Crack	4.6 kg	3.2 kg	-30.4 %
Amphetamines (thereof Crystal)	1,382.7 kg (7.2 kg)	1,203.7 kg (26.8 kg)	-12.9 % (+272.2 %)
Ecstasy	521,272 KE	230,367 KE	-55.8 %
Hashish	2,220.0 kg	2,143.7 kg	-3.4 %
Marijuana	4,298.0 kg	4,874.7 kg	+13.4%
LSD	20,705 Tr.	4,279 Tr.	-79.3 %
Khat	24,004.5 kg	30,389.3 kg	+26.6 %
Mushrooms	12.2 kg	16.0 kg	+31.1 %

BKA 2011a.

A precise indicator for (short-term) trends is the number of seizure cases (Figure 10.1). The total number of seizures of heroin, opium, cocaine, crack, amphetamines (incl. crystal), ecstasy, cannabis products and LSD was in 2010 (52,841 cases) 3.4% below the one of 2009 (54,728). The decline is mainly attributable to the low case figures for hashish seizures (-20.1%), but also the case figures for ecstasy (-31.3%), cocaine (-13.2%), heroin (-8.7%) and LSD (-8.9%) declined. The case figures for amphetamines and especially for methamphetamine (+79%), by way of contrast, increased in part considerably. The number of marijuana seizures, however, hardly changed in the comparison between 2009 and 2010 (+2.4%) (BKA 2011a).



*) The category amphetamines also contains seizures of „crystal“, which was recorded separately for the first time in 2006.

BKA 2011a.

Figure 10.1 Number of seizures of Narcotic drugs in the Federal Republic of Germany from 1998 to 2010

When looking at the seized quantities and the number of seizures, one can see that figures increased since 2000 especially for amphetamines (+344% and respectively +148%) and declined for ecstasy (-86% respectively -74%) (Table 10.5). The case figures 2010 for heroin and cocaine declined respectively by approximately 10% (heroin -9%; cocaine -13%) in comparison to 2009 and respectively by approximately 30% in comparison with the year 2000 although the changes in the seized quantities were very different from each other. In 2010, approximately 37% less heroin was seized in comparison to 2009 and approximately 40% less in comparison with the year 2000 while the quantity of cocaine seized in 2010 very strongly increased compared to the years 2009 (+78%) and 2000 (+232%) mainly because of few large individual seizures (cf. also 10.2.3 and 10.3.1) in 2010 (BKA 2011a).

Table 10.5 Changes in number and quantity of seizures

	2010 vs.	Heroin	Cocaine	Amphe- tamines	Ecstasy	Can- nabis	Mush- rooms	Khat
Cases	2009	-9%	-13%	+14%	-31%	-3%	+52%	+40%
Amount	2009	-37%	+78%	-13%	-56%	+8%	+31%	+27%
Cases	2000	-30%	-30%	+148%	-74%	+7%	-40%	+160%
Amount	2000	-40%	+232%	+344%	-86%	-51%	-55%	+754%

Note: Increases >10% are marked by framed fields and declines >10% by shaded fields.

BKA 2011a.

10.3.2 Quantities and numbers of seizures of precursor chemicals used in the manufacture of illicit drugs

In the year 2010, 101,549 cannabis plants were seized in 1,517 cases (Table 10.6), which corresponds to a significant decline in seized plants (-20.5%) and an increase in the case figure (+11.6%). With this, the seized quantity has reached the lowest level since 2005, whereas the case figure is the second highest since 2000, which seems to be an indication of a larger number of producers running smaller plantations (BKA 2011a).

Table 10.6 Seizure of cannabis plants

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Amount ¹⁾	68,696	29,352	35,863	68,133	93,936	190,241	135,252	121,663	127,718	101,549
Cases	785	887	750	1,008	1,035	1,121	1,463	1,526	1,359	1,517

1) in units.

BKA 2011a.

In addition to the basic material and chemicals (cf.10.3.3) seized in illicit drug laboratories, 46 kg ephedrine, 150 pills containing ephedrine and 280 pills containing pseudoephedrine were seized in 2010 that were apparently intended for the manufacture of illicit drugs (BKA 2011b).

10.3.3 Number of illicit laboratories and other production sites dismantled; precise type of illicit drugs manufactured there

In the year 2010, 16 illicit drug laboratories were uncovered, which corresponds to a decline in comparison with the previous year (24 laboratories). As in the previous year, the detected production sites were mainly small laboratories that produced methamphetamines to meet the operators' private demands or to supply a limited circle of local buyers. For the first time, a laboratory manufacturing synthetic cannabinoids was detected (BKA 2011a).

On the whole, 0.39 kg amphetamine, 0.52 kg methamphetamine and 1 g synthetic cannabinoids were seized in the detected laboratories. Basic material found was acetic anhydride (12.0 l), phenyl acetic acid (1.5 kg), hydrochloric and sulfuric acid (24.8 l and respectively 12.1 l), acetone (31.3 l), ethyl ether (1.5 l), potassium permanganate (0.3 kg), toluol (18.9 l), pseudoephedrine (0.1 kg), pills containing pseudoephedrine (182 consumption units) as well as very small quantities of ephedrine, pills containing ephedrine, isosafrole, norephedrine and sassafras oil (BKA 2011b).

The medical journal "Aerzteblatt" (aerzteblatt.de 2010a) reports on a joint participation of the Federal Criminal Police Office and other German authorities in an awareness week to combat the trade in counterfeit and illegal medications on the Internet. According to the BKA, about 100 Internet websites were identified on which putative German dealers offer illicit medications for sale. Preliminary proceedings have been opened against the owners of various websites for the suspicion of violating the Narcotics Act. The owners of the websites are charged with selling illicit medical drugs that are hazardous to health. According to the

BKA, 40 countries took part in the worldwide operation "Pangea III". It was the so far most important operation to support the international task force in their combat against counterfeiting medical drugs. During targeted intensive checks performed by customs on mail and courier services, 532 parcels containing 30,000 pills were seized. Apart from a sizeable number of potency pills, performance enhancing substances and overdosed vitamin preparations, customs officers also detected anti-depressants, painkillers, anti-allergy medicines and weight-loss pills. The BKA also reported several arrests during the awareness week. The BKA was not able yet to provide the precise number of people arrested worldwide and the number of the preliminary investigations opened in Germany.

Dresen and colleagues (2010) published an article on the results of their observations made on herbal mixtures that were commercially available between June 2008 and September 2009. In that period of time, 140 samples were tested for bioactive ingredients and synthetic cannabinoid mimetics. It shows that the composition of the products changes very quickly as a reaction to the prohibition of the ingredients and criminal prosecution of the dealers with the result that neither the vendor nor the customer are able to identify the current contents of a product. The detection of the synthetic opioid o-desmethyltramadol in a product sold under name Kratom indicates a sustained trend of mixing potentially dangerous synthetic chemicals/medications into originally natural products.

An overview on the most recent seizures is contained standard table 13.

10.4 Price / purity

10.4.1 Prices of illicit drugs at retail level

The average drug prices (Table 10.7) did not show any significant variations in the comparison between 2009 and 2010.

At retail level, the prices for heroin (-2%), LSD (+7%), cocaine (+5%), hashish (+4%) and ecstasy (+0%) remained relatively stable. Only the national average of the prices of amphetamines (+19%) and marijuana (+10%) increased significantly, whereas the one of crack (-15%) declined. After the pronounced price increases of previous years, the average street price for one gram crystal declined reaching 67.3 € (2009: 71.3 €, 2008: 59.3 €; 2007: 50.6 €) in 2010 (2009-2010: -6%).

Prices at wholesale level are difficult to compare to prices of the previous years. An international expert group led by the EMCDDA initiated a harmonization of the data collection procedures for drug wholesale prices in Europe which led in a first step to a clearer differentiation of the large quantities in the categories from 0.5 to < 1.5 kg (or respectively 500 to < 1,500 consumption units), 1.5 to < 10 kg (1,500 to < 10,000 consumption units) and 10 kg to < 100 kg (10,000 to < 100,000 consumption units) and larger¹²³. This differentiation was also implemented by the BKA.

¹²³ Generally, data are also supposed to be collected in the category above 100 kg. However, due to the very thin data basis, the BKA does not have any substantive representative values (Bundeskriminalamt, SO 51).

But it seems like the prices for large quantities of all drug types except cocaine were higher than in 2009.

The overview of current drug prices is contained in standard table 16.

Table 10.7 Prices of various drugs 2009 - 2010 (all prices in €)

		Heroin	Cocaine	Crack	Ecstasy	Amphetamine	Marijuana	Cannabis resin	LSD	
Small quantities¹⁾	2010	36.2	65.6	49.5	6.6	12.5	8.7	7.1	9.0	
	2009	36.9	62.4	58.3	6.6	10.5	7.9	6.8	8.4	
	Change	-2%	5%	-15%	0%	19%	10%	4%	7%	
Large quantities²⁾	2009	19,214	41,115	--	1,936	4,040	3,702	2,654	--	
	0.5 to <1.5kg (500 to <1,500KE)	2010	24,548	40,383	--	2,797	4,832	4,285	2,836	--
	1.5 to <10kg (1,500 to <10,000KE)	2010	17,000*	37,625*	--	2,725*	3,627*	3,831	1,897	--
	10 to <100kg (10,000-100,000KE)	2010	--	--	--	--	1,626*	4,650*	2,500*	--

1) Price per gram. * Median value is based on a very small data basis (less than five *Laender*)

2) Price per kilogram.

Bundeskriminalamt, SO 51.

In the scene study conducted within the framework of MoSyD (Mueller et al. 2011), the scene members were asked about their perception of price trends. It showed that the gram price of 100 Euro for crack remained at the same relatively high level that was already reported in the previous survey, while the price for heroin (50 €) and cocaine (70 €) went slightly up. The price for benzodiazepines also went up: while the estimated price for one pill remained unchanged at 1,50 € since 2004, it increased to 2 € in 2010.

Profits from the sale of marijuana

According to the information provided by the forensic institute of the Land Criminal Police Office in North Rhine-Westphalia, it is possible to obtain at least 25 g consumable marijuana from the appropriate cultivation of a full-grown cannabis plant. The average value of about 50 cannabis plantations with plants ready for harvesting or harvested plants respectively has been slightly higher than 40 g of consumable dried marijuana in North Rhine-Westphalia. Professional plantations even reach 50 g. The average value assumed for the profit and loss calculation is rounded down to 40 g. For the calculation of the proceeds of an indoor cannabis plantation, the minimum and average value are established by multiplying the number of plants by the minimum quantity (25 g) or respectively the average quantity (40 g) of potentially consumable marijuana. The calculated weight is then multiplied by the current street price (2010: 8.70 €/g) or by the wholesale price respectively (2010: 3,831 €/kg). From these values the costs for the plants (one cutting costs for example 2.50 € in the

Netherlands) and the pro-rata re-usable technical equipment to the total amount of 10 € per plant are then deducted. The costs for the energy supply are not included in the calculation here since the electricity needed for the operation of an indoor plantation was illegally branched off in the large majority of seizure cases. To summarize, 1000 cannabis plants yield profits ranging between 207,500 € and 338,000 € at retail level and between 85,775 € and 143,240 € at wholesale level.

For the year 2010, this means a non-realized profit from 101,549 seized plants ranging between 8.7 million € - 14.6 million € at the wholesale level and between 21.1 million € and 34.3 million € at the retail level (Bundeskriminalamt, SO 22 and own calculations).

10.4.2 Purity / Potency of illicit drugs¹²⁴

Composition of illicit drugs and drug tablets

The figures presented on the active substances contained in amphetamines, cannabis, ecstasy, heroin and cocaine are based on the forensic data provided by the BKA upon request by the DBDD. Table 10.8 gives an overview of the development of the levels of active substances contained in amphetamines, cocaine and heroin since 2000. After having been on a continual decline since 2003, the potency of amphetamines increased again between 2009 (4.8%) and 2010 (6.6%). The potency of cocaine at wholesale level has been relatively stable for the last ten years (around 70%). In 2010, the concentration of active ingredient both at wholesale and retail level slightly increased in comparison with the previous year, but still lies within the range of the last 10 years. Apart from a few outliers, the level of active ingredient in heroin at retail level has been on a continual rise since 2000 and has reached with almost 25% the highest values since 2000. At wholesale level, the concentration of active ingredient almost doubled between 2005 (36.5%) and 2009 (60.3%), but plummeted to 34.1% in 2010.

The most recent values are given in standard tables 15 and 16.

¹²⁴ If not marked differently, the data on the contents of active ingredient stem from personal communications of the forensic laboratories of the BKA (KT 34). The interpretation of the data was done by the DBDD.

Table 10.8 Concentration of active ingredients in various drugs from 2000 to 2010 (median) in percent

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Amphetamines	3.3	5.0	6.0	7.5	7.9	7.7	7.1	6.2	5.4	4.8	6.6
Cocaine street trafficking	35.5	42.6	38.5	32.0	34.5	34.2	24.6	32.0	40.4	33.8	37.8
Cocaine wholesale	69.1	73.0	73.9	76.7	75.0	68.8	72.2	75.3	70.6	66.7	72.4
Heroin street trafficking	11.1	12.0	9.9	17.0	19.9	15.0	15.6	20.3	18.2	21.7	24.6
Heroin wholesale	35.1	45.8	27.0	7.3	48.8	36.5	38.1	46.5	51.1	60.3	34.1

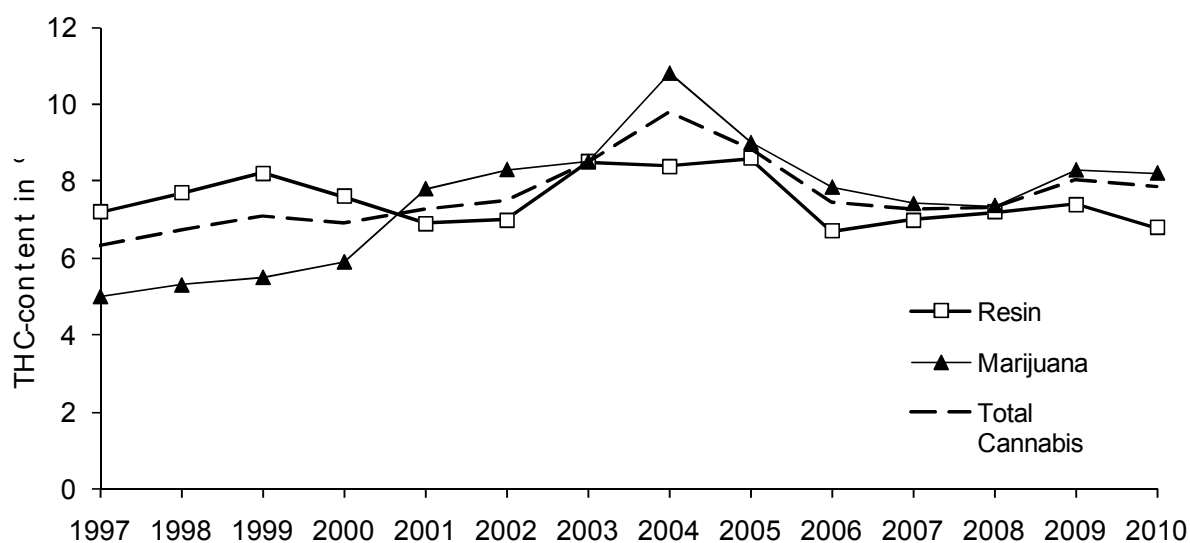
Source: see footnote 124.

Cannabis

The contents of active ingredient¹²⁵ are separately recorded and evaluated for each cannabis preparation. In 2010, the THC content was established on the basis of the seizures of 2,487 samples of herbal cannabis, 5,165 samples of sinsemilla and 7,652 samples hashish resin by the BKA, LKÄ and customs authorities' laboratories. Since 2006, all participating laboratories have been reporting their data differentiating between herbal cannabis and sinsemilla, since the more potent flowering tops without the leaves have increasingly been emerging on the illicit drug market.

In 2010, the active ingredient content of sinsemilla was at 11.2% (2010: 11.2%), and in herbal cannabis at 2.0% (2009: 2.1%). For the calculation of the concentration of active substance in marijuana, the percentages found for herbal cannabis and sinsemilla were taken into account in relation to the respective number of samples. The median THC-content of marijuana continually declined from 2004 (10.8%) to 2007 (7.4%). No changes were found between 2007 and 2008. In 2009, it slightly increased again to 8.3% and remained almost unchanged in 2010 (8.2%). After having strongly declined between 2005 (8.6%) and 2006, falling to the lowest level of the last ten years at 6.7%, the median THC-content of hashish increased again to 7.4% in 2009 and fell to 6.8% in 2010 (Figure 10.2). In the comparison with the data of 1997, only minor changes are to be found, whereby the content of active ingredient in marijuana slightly increased and the one of cannabis resin even slightly decreased.

¹²⁵ In the reported concentrations of active substances, tetrahydrocannabinol (THC) additionally formed under thermal load is also taken account of.



Source: see footnote 124.

The calculations of the contents of active ingredient in marijuana and total cannabis were performed by the DBDD.

Figure 10.2 Content of active ingredient in cannabis

Patzak and Goldhagen (2011) have calculated the arithmetic medians of hashish, marijuana and sinsemilla between 1993 and 2008 (BKA: Median), which leads to a stronger weighting of the extreme values. In the case of missing seizures, the case law needs to resort to estimates of the contents of active ingredient. On the basis of their compilations/calculations, the authors suggest estimates of 7.5% for hashish, 4.0% for marijuana (leaves and flowering tops) and 10.5% for cannabis flowering tops in order to take account of the growing popularity of cannabis flowering tops.

The German Hemp Association (DHV 2010) graphically presented all reports of drug cutting received from a German postal code area between 21.05.2009 and 02.12.2010¹²⁶. In the period under enquiry a total of 1,230 cut drugs were reported from nearly all postal code regions in Germany. In two thirds of the reported drugs, brix was mentioned as a cutting agent, but also sand, hair spray and sugar were commonly used diluents. In most cases, the identification of the cutting agent was derived from observations of unusual burning behaviour, peculiarities of the ashes, effects and side effects.

Ecstasy

In the year 2010, a total of 140,895 tablets and capsules (2009: 208,000) – referred to as consumption units in the following – were analyzed for their content of active substance. 97.1% (corresponding to 136,865) of all consumption units (2009: 98.6%) contained a psychotropic agent (monopreparations). Among the monopreparations, 1-(3-chlorophenyl)-piperazine (mCPP) plays a dominant role at 61.1%. It is followed by 3,4-methylenedioxy-N-

¹²⁶ <http://hanfverband.de/index.php/nachrichten/aktuelles/1382-geographische-analyse-der-streckmittelmeldungen>

methyl-amphetamine (MDMA) at 22.7%, amphetamine at 13.6%, methamphetamine at 1.8% and 2C-B at 0.8%. Until 2008, the only psychoactive substance contained in ecstasy was MDMA (2008: 96.8% monopreparations) and in 2009 still nearly two thirds of the monopreparations (31.8%) contained MDMA. As described above, almost two thirds of all monopreparations contained mCPP as a psychoactive substance and not even a quarter contained MDMA. While the portion of monopreparations containing mCPP did not increase further, the portion of amphetamine in ecstasy tablets increased significantly. Combination preparations only accounted for a very small portion of the overall quantity.

The concentrations of active substances calculated as base for the individual substances of the monopreparations is shown in Table 10.9. As can be seen from the table, the median potency of MDMA slightly increased again from 2009 to 2010 (58 mg/consumption unit) after having decreased between 2007 (55 mg/consumption unit) and 2008/09 (51 or respectively 50 mg/consumption unit). The concentration of m-CPP is slightly up on the previous two years (2010: 30 mg/consumption unit; 2009: 27 mg/consumption unit) after having relatively strongly fallen between 2007 (39 mg/consumption units) and 2008 (28 mg/consumption units).

The most commonly used additives found in the mono- and combination preparations were caffeine, lactose and cellulose.

Table 10.9 Concentration of active substance in ecstasy in mg/consumption unit

Active substance	Quantity				Median			
	2007	2008	2009	2010	2007	2008	2009	2010
MDA	27 ¹⁾	9.9 ¹⁾			27 ¹⁾	9.9 ¹⁾		
MDE								
MDMA	0.5-215	0.2-168	0.6-170	0.1-140	55	51	50	58
Amphetamines	3-33	0.5-20	0.2-37	0.3-21	13	0.8	2	3
Methamphetamine	27 ¹⁾	0.4-26	0.1-15	1.7-33	27 ¹⁾	13	0.5	5
m-CPP 1(-3-Chlorphenyl)-piperazin	26-76	0.7-43	2.7-53	0.1-100	39	28	27	30

1) Only one seizure.

Note: Concentrations of active substance were calculated as base.

It needs to be noted especially for ecstasy tablets that the data collection within the framework of the Drugs Data File (Falldatei Rauschgift, FDR) does not necessarily prescribe the recording of the active ingredient (as a result, active ingredients can only be researched via a search item that can be optionally entered into a non-obligatory field). It needs moreover to be taken into account that the results of forensic analyses are often recorded with some delay or not all. Therefore it cannot be excluded that the data presented in the table only reflect parts of the actual case figures.

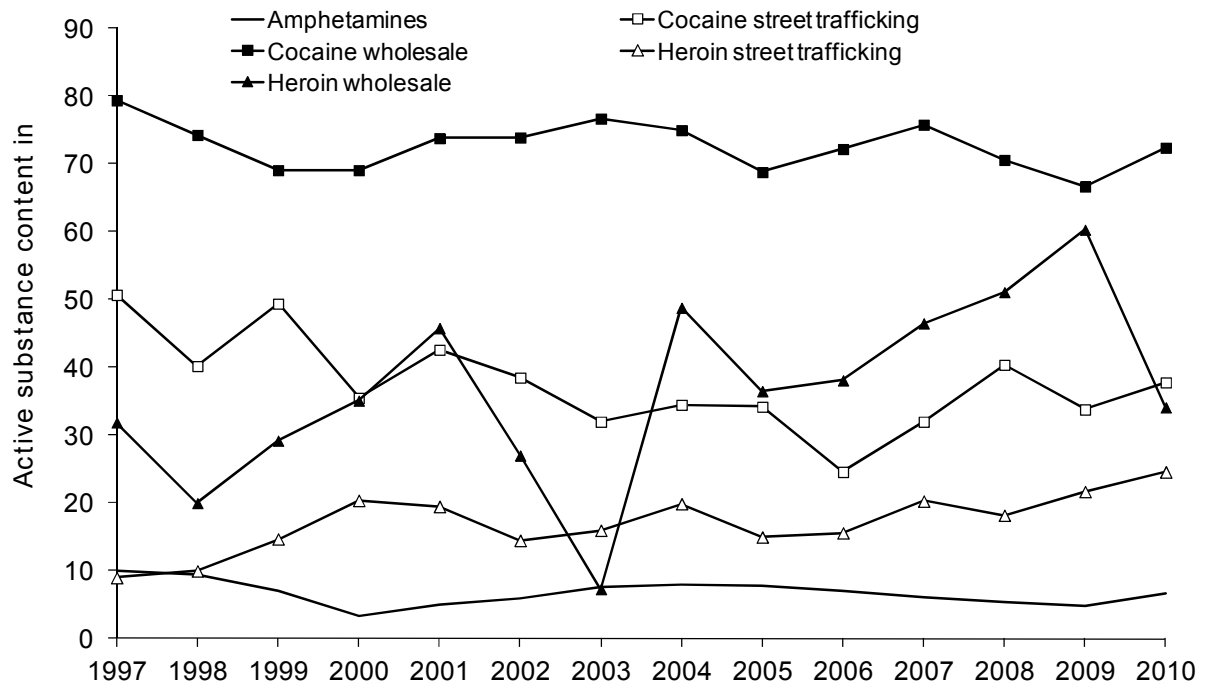
Source: see footnote 124.

Heroin, cocaine and amphetamines

For 2010, 4,111 (2009: 4,304) heroin samples were analyzed for their concentration of active substance (Figure 10.3). While the concentration of active ingredient in seizures at wholesale level considerably fluctuated between 1999 and 2004 (with the min. 7.3% in 2003 and max. 48.8% in 2004), it continually increased from 2005 onwards and reached in 2009 its highest level to date at 60.3%. However, the content of active ingredient of heroin almost dropped by half in the comparison between 2009 and 2010 (34.1%) and sits in the range of the years 2005 and 2006. In 2010, the concentration of active ingredient of heroin at retail level was slightly above the levels of 15% to 20% recorded between 1999 and 2009 reaching a new peak at 24.6%. As in the previous years, the most common adulterants found were caffeine and paracetamol. Lactose was the most commonly added diluent.

In the year 2010, 3,116 (2009: 3,060) cocaine samples were analyzed. Cocaine is mainly offered as hydrochloride on the market. In the following, no differentiation is made between cocaine hydrochloride and cocaine base. At retail level, the concentration of active ingredient was at 40% in the period from 2000 to 2005 with a slightly declining tendency. After the median had reached its lowest value since 1997 at 24.6% in 2006, the median concentration of active substance increased again to 40.4% in 2008 and was at 33.8% in 2009 and in 2010 at 37.8%. As in the previous years, the concentration of active ingredient at wholesale level was slightly above 70% in 2010 (72.4%) (Figure 10.3). The most common adulterants found in 2010 were tetramisol/levamisol, phenacetine and lidocaine. Lactose was the most commonly admixed diluent. Canadian Harm Reduction (2010) warns against the side effects of levamisol that is apparently cut into the cocaine during manufacture and that is contained in 60%-90% of the cocaine sold worldwide.

In the year 2010, a total of 2,774 (2009: 2,825) amphetamine samples were analyzed for their concentration of active substance. Sitting at an average of 6%, it was for the first time since 2004 not lower than in the previous year (Figure 10.3). Since the level of active ingredients in amphetamines does not depend on the size of the seized quantity, no differentiation was made between street and wholesale trafficking. The most commonly admixed adulterant was caffeine; lactose and creatine were the most commonly found diluents.



Source: see footnote 124.

Figure 10.3 Concentration of active substance in heroin, cocaine and amphetamines

PART B: SELECTED ISSUES

11 Drug-related health policy and health services in prison

11.1 Prison systems and the prison population

The execution of criminal justice in Germany is the domain of the German *Laender*. Since 2006 the *Laender* have also been responsible for legislation in this area. All of the *Laender* have in the meantime issued laws on the execution of criminal justice for youth. Baden-Wuerttemberg, Bavaria, Hamburg, Lower Saxony and Hesse have issued their own prison laws for adults. The general Prison Law (Strafvollzugsgesetz) continues to apply in the remaining *Laender*. There is no national data collection procedure on the health of prison inmates in Germany. Instead there are above all regional data surveys and individual studies, in some cases focusing on sub-populations of individual facilities.¹²⁷

The Federal Ministry of Justice (FMJ) has compiled data for the indicator database of the World Health Organisation (WHO) and the European Network on Drugs and Infections Prevention in Prison (ENDIPP) from the individual German *Laender* and hence 195 prisons as of 31 March 2008 (Indikatoren datenbank, BMJ 2009). Pertinent results from this survey will be commented on in the following at the appropriate places. One major limitation on all this data is that information is always only available from some German *Laender*, which means that the results cannot be clearly attributed or assigned to specific *Laender*.

The WHO's indicator database has prompted Baden-Wuerttemberg to initiate an annual health report on inmates in Baden-Wuerttemberg (Reber & Wulf 2009, Reber 2011). The data survey at the level of prison facilities was performed for the first time in 2008. The last report was published in the summer of 2011.

In addition to the data which has already been collected, the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (Deutsche Beobachtungsstelle fuer Drogen und Drogensucht – DBDD) has requested the Federal Government's Commissioner on Narcotic Drugs and the ministries of justice of the German *Laender* to answer a comprehensive questionnaire on the health situation of inmates in their *Laender*. The topics in this survey include inter alia medical and psychosocial health care structures at penal institutions, training of prison guards on how to deal with prisoners who consume drugs, tests for drugs and infectious diseases as well as intramural therapy services for prisoners who consume drugs. As of the completion of this report, the DBDD had received answers from 13 German *Laender*. Responses had yet to be received from Bavaria, Hamburg and the Saarland. In addition, a survey was conducted by the DBDD with the *Laender* ministries of justice in 2005 which was commissioned by the Working Group for the German Statistical Report on Treatment Centres for Substance Use Disorders (AG DSHS). The situation regarding treatment of addictions and substance abuse disorders was surveyed

¹²⁷ See chapter 11.5.2 regarding the considerable limitations of the data.

at penal institutions in the individual German *Laender*. The results of this survey can be examined in the REITOX Report 2008 (chapter 9.3.1).

In November 2010 the DBDD carried out a workshop entitled “Drugs and Imprisonment” with financial support from the Commissioner on Narcotic Drugs and the Federal Ministry of Health. The objective of the event, which approximately 120 persons attended, was to foster the exchange between experts in the fields of theory and practice and stimulate a joint discussion. Speakers included representatives from the ministries of justice of the Federal *Laender* North Rhine-Westphalia, Hesse and Berlin as well as the Rhineland-Palatinate Pension Insurance Scheme and Paritaetische Baden-Wuerttemberg. International speakers included experts from the Spanish Ministry of the Interior, the European Monitoring Centre for Drugs and Drug Addiction and the Federal Health Agency of Switzerland. The conference helped stimulate the discussion about reasonable health care of inmates consuming drugs and with substance addictions. The different activities in the treatment and care provided to offenders addicted to drugs within Germany and in the EU became evident at the conference. The key importance of comparable data was stressed and the offices responsible in the areas of criminal justice and health at the *Laender* and national levels were encouraged to jointly establish an appropriate monitoring system. The Federal Ministry of Health will investigate to what extent financial support can be made available for “consensus events”, the aim of which could be the compilation of appropriate data and the establishment of more uniform treatment standards for inmates addicted to drugs in Germany.¹²⁸

This chapter refers to drug consumers, drug addicts and intravenous drug users depending on the particular study. As a result of the different indicators used for these respective terms – and especially to demarcate these from disorders relating to ICD – it is frequently only possible to compare research results produced by these studies to a limited extent.

11.1.1 Contextual information

Under the provisions of the Prison Rules and Guidelines (Vollzugsgeschaeftsordnung, VGO Nr. 73), prisons are required to report the numbers of inmates at the end of the reporting month as well as incoming and outgoing inmates in the reporting month. The Federal Statistical Office issues summaries on Germany for three selected calendar months (March, August and November) based on the aggregated figures submitted by the *Laender* and publishes these in the Internet. These summaries cover the prison facilities of the *Laender*. Closed correctional facilities (psychiatric hospitals and withdrawal facilities, Maßregelvollzug) or juvenile correctional facilities (Jugendarrestanstalten) are not included (Statistisches Bundesamt 2010c).

According to the annual survey carried out by the Federal Statistics Office (DeStatis), there were 60,693 inmates and detained persons in German detention facilities and prisons on 31 March 2010. The percentage of women among inmates has risen slightly over the last few years, but at about 5% is still low (Statistisches Bundesamt 2010c). 55.9% (33,907) were

¹²⁸ The charts used in the presentations can be downloaded at www.dbdd.de.

servicing sentences of up to two years, 29.7% (18,018) terms of between 2 and 15 years and 3.4% of inmates (2048) were serving life sentences (Statistisches Bundesamt 2010c). In 2009 there were 10 times as many persons beginning prison sentences as inmates (637,552). Of these, 17% (108,832) were first-time incarcerations, while there were approximately the same number of releases (608,204) (Statistisches Bundesamt 2010a). Table 11.1 provides an overview of the number of penal institutions, their capacity and the actual number of inmates as of 31 August 2010 in the individual German *Laender*. This shows that as of this date there were 185 organisationally autonomous prisons with a capacity totalling almost 80,000 prisoners as of this date, which were 90% full with more than 70,000 prisoners at the point in time of the survey (Statistisches Bundesamt 2011b).

Table 11.1 Prisons and capacity as of 31 August 2010 broken down by German *Laender*

<i>Laender</i>	Individual prisons	Capacities		Occupancy as a % ¹⁾
Germany (total)	185	77,995	70,103	90
Baden-Wuerttemberg	19	8,126	7,337	90
Bavaria	36	11,942	11,706	98
Berlin	8	5,172	4,774	92
Brandenburg	6	2,123	1,510	71
Bremen	1	748	616	82
Hamburg	6	2,593	1,772	68
Hesse	16	5,767	5,222	91
Mecklenburg-Wst. Pomer.	2	1,547	1,426	92
Lower Saxony	14	7,107	5,595	79
North Rhine-Westphalia	37	18,343	17,181	94
Rhineland-Palatinate	10	3,606	3,473	96
Saarland	3	896	833	93
Saxony	10	3,840	3,438	90
Saxony-Anhalt	5	2,456	2,073	84
Schleswig-Holstein	6	1,695	1,353	80
Thuringia	6	2,034	1,794	88

1) Occupancy is expressed as a % of capacity in each of the *Laender*

Statistisches Bundesamt 2011b.

Because the percentage of addicts and consumers of illegal drugs in German penal institutions cannot be clearly quantified, the number of persons incarcerated as a result of violations of the Federal Narcotics Act (*Betaeubungsmittelgesetz*) is frequently used. This estimate is relatively imprecise, however, because first of all it counts people who, although they have violated the law in connection with drugs, may not themselves have consumed any illicit substances, as could be the case, for example, with some dealers. Secondly, a large percentage of drug consumers are not taken into account because for example persons who

are sentenced as a result of offenses in connection with procurement of drugs are listed under other categories of violations against the Federal Narcotics Act in the statistics. A total of 67,025 persons were charged with violations of the Federal Narcotics Act in 2009¹²⁹ (Statistisches Bundesamt 2010a) and 59,432 sentenced, among them 17% children and adolescents (Statistisches Bundesamt 2010b). There were a total of 8,880 persons (14.6% of all inmates) serving time in prison facilities as a result of violations of the Federal Narcotics Act as of 31 March 2010. Of these, 5.7% (507) were female, while 3.6% (319) were serving sentences as juvenile offenders. Table 11.2 shows that the percentage of inmates sentenced for violations of the Federal Narcotics Act has declined only slightly, but continuously, since 2008. This trend can be witnessed for all types of criminal offenses and among both genders. In 2009 a total of 51,723 persons were sentenced to prison (7.1% of all imprisonments) including short-term military imprisonment (Strafarrest) under the Federal Narcotics Act, of these 18,013 actual incarcerations (including 11,706 suspended sentences) and 33,710 fines. Of the actual incarcerations, 8,840 were for less than one year and 9,173 for more than one year (Statistisches Bundesamt 2010a).

Table 11.2 Number of detainees and drug-related crimes

		Detainees and persons under preventive detention			Adult detainees		Juvenile detainees		Preventive detention
		Total	Males	Females	Males	Females	Males	Females	
2010	Detainees N	60,693	57,568	3,125	51,056	2,917	5,979	205	536
	BtMG N	8,880	8,373	507	8,074	486	298	21	1
	BtMG %	14.6	14.5	16.2	15.8	16.7	5.0	10.2	0.2
2009	BtMG %	15.0	14.9	16.5	16.2	17.0	5.1	10.5	0.4
2008	BtMG %	15.3	15.1	18.2	16.3	18.9	6.7	9.8	0.7
2007	BtMG %	14.9	14.8	17.4	16.2	15.0	6.2	8.9	0.2
2006	BtMG %	14.8	14.7	18.2	15.7	18.8	6.8	11.4	0
2005	BtMG %	14.6	14.4	19.2	15.4	20.1	7.3	10.2	0

Note: „BtMG N“: Number of persons detained for offences committed against the BtMG, „BtMG %“: share of persons detained for offences against the BtMG.

Statistisches Bundesamt 2010c.

11.1.2 Characteristics of the population

Out of 60,693 inmates as of 31 March 2010, 5.1% (3,125) were females and 22% (13,374) non-German nationals (Statistisches Bundesamt 2010c). 66.2% (40,174) were single, 17.5% (10,642) married, 1.3% (765) widowed and 15.0% (9,112) divorced. 15.2% (9,204) of inmates were on day-release. 0.4% (222) of the inmates were between 18 and 21 years of

¹²⁹ Persons charged mean persons who have appeared before court and for whom a ruling has been issued. Persons who are not sentenced are, for example, acquitted, the procedure is dropped or similar; for details regarding the reasons see DeStatis Fachserie 10, Reihe 3 “Abgeurteilte nach Art der Entscheidung”.

age, 28.0% (17,015) between the ages of 21 and 30, 48.6% (29,515) between 30 and 50 and 11.9% (7,221) over 50.

11.2 Health policy in prison

11.2.1 Framework conditions surrounding health services in prisons

Legal framework conditions

The German Prison Law (Strafvollzugsgesetz) from 1976 still applies in most of the German *Laender*. It governs “the act of imprisonment in penal and correctional institutions” (§1 StVollzG). Since the reform of the Federalist system, which was adopted by the German Bundestag on 30 June 2006 and entered into force on 1 September 2006, law-making power has been devolved from the Federal Government to the *Laender*. The German Prison Law is being replaced step by step by the respective *Laender* prison laws and administrative regulations (§125a of the German Constitution (GG¹³⁰)), which in part cite the German Prison Law. The German Prison Law still applies in 11 German *Laender*. There are *Laender* prison laws now in Baden-Wuerttemberg (JVollzGB since 1 January 2010), Bavaria (BayStVollzG, since 1 February 2010), Lower Saxony (NJVollzG, since 14 December 2007), Hamburg (HmbStVollzG, since 14 July 2009) and Hesse (HStVollzG, since 28 June 2010). The *Laender* prison laws are largely based on the Federal German Prison Law and usually only differ in terms of various details. The type and scope in the rendering of services in the area of health care is based on the Federal Social Code (SGB V)¹³¹ in all five of the German *Laender* with their own prison laws, for example.

The seventh title of the German Prison Law lays down regulations governing health care for prisoners. Generally speaking, there is an obligation to care for the physical and mental health of prisoners (§56 StVollzG). In addition to this, prisoners are “entitled to treatment when they are ill if this is necessary to diagnose or heal an illness, prevent it from becoming more acute or to alleviate it”. This means *inter alia* treatment by a physician and the supply of medication, bandages and dressings (§58 StVollzG). The provisions of Social Code V apply to the type and scope of health services (§61 StVollzG). No individual references are made in the German Prison Law to drugs, substitution or addictions. Medical care of inmates is paid for by the ministries of justice of the *Laender*. A health insurance scheme or the *Laenders'* respective accident insurance scheme assume the costs of work-related accidents (Indikatorenbank BMJ 2009).

Although the *Laender* codes scarcely differ from the German Prison Law or from each other, there are nevertheless subtle differences. The Hessian Prison Law stipulates a right on the part of inmates to psychological or psychotherapeutic treatment or care (§26, section 2 HStVollzG). In Lower Saxony the need to inform inmates about healthy living habits is

¹³⁰ Grundgesetz (the Basic Law, or German Constitution).

¹³¹ SGB V governs the organisation, insurance obligation and services provided by statutory health insurance schemes as well as their legal relationship to other service providers such as, for example, physicians, dentists and chemists.

codified (§23, section 1 HStVollzG and §32, section 1 JVollzGB). The codes of Hesse and Baden-Wuerttemberg furthermore state that it is possible to exercise controls to combat abuse of addictive substances (§4 HStVollzG and §64 JVollzGB).

Implementation of the principle of equivalency

Resolution 37/194 of the General Assembly of the United Nations (Office of the United Nations High Commissioner for Human Rights 1982) states that health-care personnel in prisons have a duty to ensure that prisoners in custody receive protection of their physical and mental health and, if they are ill, that they receive treatment of disease commensurate in quality and standard to that afforded to persons who are not imprisoned or detained. In dealing with prisons and detained persons, the Council of Europe recommends under the caption "Equivalence of care" that health policy in prisons accord with national health policy and be integrated in it. Furthermore, conditions in prison which constitute violations of human rights cannot be justified by a lack of resources (CPT 2010).

In Germany penal laws and regulations themselves stipulate what medical services prisoners are entitled to and with regard to the type and scope of such refer to the Social Code (SGB V) (Meier 2009). Under these provisions, prisoners are not entitled to the entire spectrum of health services which statutory health insurance schemes (GKV) are obligated to provide.

Number of health-care personnel

According to the Annual Penal Statistics of the Council of Europe (SPACE I, Aebi & Delgrande 2011), there were a total of 37,174 employees (in full-time equivalent units) working in German prisons as of 1 September 2009, almost all of them (98.7%) behind prison walls. At 73.6%, general prison guards accounted for by far the largest group of employees in German prisons. By comparison, physicians and nurses were the smallest group with 0.7%. 1.5% were appraisers or psychologists (RM 1321). Each general prison public employee is responsible for 2.7 prisoners on average. For personnel in other areas such as, for example, treatment or educational training, there are 15.5 prisoners for each public employee by comparison.

There are an average of 257 patients for each practicing physician in the general population in Germany, with considerable variation within the country (from 174 to 304 inhabitants per practicing physician) (status: end of 2008, see Table 11.3) (Greß & Stegmüller 2011). There are approximately 260 inmates for each prison physician on average (Meier 2009). This is roughly at the average level for the population as a whole. If one takes the significant fluctuations in the prison population into account (375,671 entries into prison in 2004 with an average of 79,752 inmates for the year), it would be more realistic to set the health-care ratio at 1:560. In interpreting these figures, it must be kept in mind that persons generally consult physicians more in prison than when they are free as a result of the greater strain on health in prisons. No data is available in Germany quantifying this fact in precise terms. The results of a study carried out in all Belgian prisons show that on average penal institutions consult a physician 3.8 times as much as a demographically equivalent group of the general population (Feron et al. 2005). If one assumes a similar level of consultation by inmates in

Germany, a prison physician is accordingly subject to a much higher level of stress and strain with the same care ratio as in extramural health care as a result of the greater demand for his or her services. With the same health-care key (number of physicians and health-care personnel) intramural and extramural, the usually much higher health strain on prisoners displays a structure of health inequality (Stoever et al. 2009). This could be an indication that a denser network of physicians would be needed in intramural health care compared to outside prisons in order to ensure a comparable level of health care. Table 11.3 provides an overview of the intramural and extramural health-care situation with general practitioners per inmate or inhabitant.

Table 11.3 Intramural and extramural health-care ratios

Federal state	Intramural 2004 ¹⁾			Extramural 2008 ²⁾
	Number of physicians	Average occupancy of correctional facilities	Relation of care (physician: patient)	Relation of care (physician: patient)
Baden-Wuerttemberg	26	8,604	1:331	1:261
Bavaria	45	11,964	1:266	1:242
Berlin	34	5,318	1:159	1:197
Brandenburg	11	2,308	1:210	1:304
Bremen	1	733	1:733	1:195
Hamburg	15	3,123	1:205	1:174
Hesse	21	5,883	1:280	1:252
Mecklenburg-West. Pomer.	7	1,634	1:233	1:262
Lower Saxony	32	6,951	1:217	1:292
North Rhine-Westphalia	63	17,727	1:281	1:261
Rhineland-Palatinate	9	3,873	1:430	1:264
Saarland	1	931	1:931	1:242
Saxony	25	4,253	1:170	1:288
Saxony-Anhalt	13	2,822	1:217	1:294
Schleswig-Holstein	3	1,577	1:526	1:259
Thuringia	0	2,051	-	1:282
Total	306	79,752	1:261	1:257

1) Meier 2009.

2) Greß & Stegmueller 2011.

A summary of offices and facilities in the area of medical and psychosocial care of inmates reported by the ministries of justice in response to an enquiry by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) in 2011 is provided by Table 11.4. Saxony-Anhalt reported in addition that one staff member each had been appointed commissioner for addictions at a total of eight prison sites. They have been

assigned the task of supervising the performance of addiction-related work. In addition, 16 staff members have been used as aids for persons afflicted with addictions, performing tasks commensurate with 5.3 full-time positions. Counselling for addicts is offered through external staff at one prison within the framework of a so-called public-private partnership at a juvenile detention centre in Saxony-Anhalt. This is why it is not possible to provide more details on manpower used in this connection here (Saxony-Anhalt Ministry of Labour and Social Affairs, personal information).

According to the indicator database, the number of hospital beds at penal institutions in ten German *Laender* in 2008 was 1,015, with five German *Laender* reporting 230 psychiatric beds (Indikatoren datenbank, BMJ 2009). As a result of the difficulty in attributing the data to specific *Laender*, however, it is not possible to calculate a health service ratio for specific *Laender* or to make any comparisons with the general population, nor can this data be compared with current data.

Detailed information is moreover available for Baden-Wuerttemberg and Munich Prison. There were a total of 32.65 prison physicians (including 7.65 positions for non-full-time prison physicians) available for 7,748 prisoners at prisons and 14 physicians at Hoenasperg Prison hospital in Baden-Wuerttemberg in 2010. There were a total of 304 hospital beds, among them 94 psychiatric ones, at the prisons of Baden-Wuerttemberg at this point in time (Reber 2011). There were a total of 7 physicians and 82 persons from the nursing care service for 1,249 inmates available at Munich Prison in January 2011 (Stumpf 2011).

11.2.2 Health policy in prison

National drug policy in prisons

The respective *Laender* parliaments adopt the laws governing the penal systems of the Federal *Laender*, while the respective ministries of justice are in charge of executing these laws. At the national level this is the domain of the Penal System Committee of the *Laender* (Strafvollzugsausschuss der *Laender* – BMJ 2011, personal information). This is a sub-committee of the Conference of the Ministers of Justice and prepares meetings of this committee. The participants are the heads of the departments in charge of the penal system at the *Laender* ministries of justice. The Penal System Committee of the *Laender* discusses current topics relating to the penal system which are of general interest to the *Laender*. The aim of this meeting is to coordinate developments at the national level. This produces arrangements which, however, are non-binding. When binding agreements are desired, an interstate treaty can be concluded. The Federal Ministry of Justice takes part in the meeting of the Penal System Committee of the *Laender*, but only has the status of an observer.

Drug-related health policy in prison

In the survey carried out in 2011 by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD), the ministries of justice of the *Laender* reported that, with regard to therapy on offer to inmates, most of the *Laender* followed the guidelines of the German Medical Association (*Bundesaerztekammer*). In

addition, some *Laender* cited the guidelines issued by the Association of the Scientific Medical Societies in Germany (Arbeitsgemeinschaft der Wissenschaftlichen Medizin – AWMF), the guidelines of the Deutsche Gesellschaft fuer Suchtmedizin (German Society for Addiction Medicine) and the guidelines for new examination and treatment methods of the Bundesausschuss der Aerzte und Krankenkassen (Federal Committee of Physicians and Health Insurance Schemes) (NUB-Richtlinien).

In response to a survey of Deutsche Aidshilfe (DAH) in the autumn of 2006, with regard to the substitution treatment (Opioid Substitution Therapy, OST) of inmates all of the German *Laender* except for Schleswig-Holstein cited the Narcotics Act (Betaeubungsmittelgesetz – BtMG) and the Amending Regulation on the Prescription of Narcotic Drugs (Betaeubungsmittel-Verschreibungsverordnung (BtMVV) (Knorr 2008). Almost all of the *Laender* furthermore reported that they followed the guidelines of the German Medical Association regarding substitution therapy for opiate addicts. Schleswig-Holstein moreover stated that it followed the Guidelines on the Assessment of Physicians' Examination and Treatment Methods¹³², which govern substitution in the statutory physicians' care system. These are actually not binding with regard to substitution in closed prisons, as inmates are not insured under the statutory health insurance schemes while in prison.

¹³² Non-recognised Examination and Treatment Guidelines (NUB-Richtlinien) and the Guidelines on the Assessment of Physicians' Examination and Treatment Methods have been updated and are now primarily cited under "Guidelines of the Joint Federal Committee on Examination and Treatment Methods of Treatment by Accredited General Practitioners", "Guidelines on Methods in Treatment by Accredited General Practitioners" (Joint Federal Committee 2011).

Table 11.4 Scope of medical and psychosocial care of inmates in the German *Laender*

Land	Medical Service			PSB	
	Working hours per week	Proportion treatment of drug users (internal, %)	Proportion treatment of drug users (external, hours)	Internal (%)	External (hours)
Baden - Wuerttemberg	6,432.5	15%	0	5%	15 positions
Berlin	230 x 40	25%	Not applicable	No separate illustration possible, in medical treatment (e.g. in OST) included	Decisive calculation of hours not available
Brandenburg	Physicians: 150, Care providers: 1,360	<1%	Not applicable	0	0
Bremen	5.600	70%	0	50%	0
Hesse	Physicians: 915 Care providers: 4.370	Physicians: approx. 5%-10% Care providers: approx. 5%	0.4-1.2	Calculation of percentage not possible; PSB included in OST	10-60 hours/week (depends on size of facility)
Mecklenburg-West. Pomer.	1,070	Not specified	0	Not specified	0
Lower Saxony	In-prison: 915.2 Locum tenens doctors: 720	30%	Not specified	Not specified	Not specified
North Rhine-Westphalia	Prison: 9,750 Prison clinics: 3,750	30%-40%	0	1,320 hours/week (incl. external facility)	270 Std./Wo.
Rhineland-Palatinate	1,764	approx. 15%-20%	113	10%	Not specified
Saxony	Physicians: 240 Medical institutions: 1,780 Hospitals: 1,360	approx. 1%	Not applicable	Not applicable	Not applicable
Saxony-Anhalt	1,830 (without extraofficial physicians)	Not specified	0	Not specified	0
Schleswig-Holstein	998	5%-80% (je nach JVA)	0	2-5% (depends on correctional facility)	35.5 hours/week
Thuringia	1,148	approx. 20%	approx. 6 hours	approx. 20%	approx. 15 hours/week.

Models for the rendering of services for drug consumers in prison

Frequently it is not only public penal institutions employees who are available to provide medical and psychosocial care for inmates in prisons, but also external specialists as well. In 2008, for example, in 15 out of the 19 facilities in Baden-Wuerttemberg there were HIV help services at 9 correctional facilities and external health services at 10 facilities (Reber & Wulf 2009, Reber 2011). Approximately 62% of regional AIDS helpers also work at penal institutions in Germany as a whole, primarily in the areas of counselling and support or in conducting group activities or staging information events for inmates and public employees (Knorr 2011). According to SPACE I, there were 1,541 persons employed in the penal system who were not part of the prison administration in 2009 (Aebi & Delgrande 2011). This figure breaks down among individual professions as follows: teachers (24.3%), medical personnel (11.5%), security personnel (8.1%), social workers and probation officers (10.8%). In Bavaria there were a total of 49 full-time positions for external addiction counselling in penal institutions in 2010, which means an increase of 6 full-time positions compared to 2009 (Poth 2011). These were funded by the Bavarian State Ministry for the Environment and Health.

In the short *Laender* reports the Federal *Laender* stated the number of facilities and staff positions which are available in internal and external services for counselling and treatment in prisons (Floeter & Pfeiffer-Gerschel 2011). 11 *Laender* provided statistics on the number of internal services. The data from 9 *Laender* add up to a total of 125 services with a total of 227 staff positions (the latter according to statistics from 10 *Laender*). In addition, 12 *Laender* provided information on the number of external services. The data provided by 11 *Laender* add up to a total of 157 services with 179 staff positions (the latter figure is based on the data from 10 *Laender*). By the same token, the individual *Laender* differed with respect to the weighting of internal and external services. Thus in some *Laender* (for instance, Hamburg and North Rhine-Westphalia) counselling and treatment is provided primarily internally, while in others (e.g. Bavaria and Saxony) it is primarily offered through external facilities.

11.3 Provision of drug-related health services

11.3.1 Prevention and treatment

Drug prevention and information campaigns for inmates

As a result of the high rate of consumers and persons addicted to illegal drugs in German prisons, drug-related prevention and treatment programmes are especially needed there. Deutsche AIDS-Hilfe has been staging a series of events on the topic of "HIV prevention and medical care in the penal system" for several years now, with these events also taking place in penal institutions since 2010 and focusing both on inmates as well as public employees (DAH 2011, personal information).

In response to the enquiry by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) to the ministries of justice in the summer of 2011, 10 out of 13 German *Laender* replied that they distribute information material on

prevention of drug-related health damage, 3 organise information events or training programmes for the inmates and 5 offer to discuss things with the inmates, for example explaining to them their rights or giving them individual counselling.

According to the indicator database of the WHO (BMJ 2009), information material on the prevention of drug-related health damage was provided at all penal institutions in 15 German *Laender*. Counselling was offered by drug specialists or medical personnel at all facilities in 14 German *Laender*. Peer education programmes and safer use training programmes were possible at several facilities in 2 German *Laender*. The greater scope of preventive measures in the penal system in 2008 in comparison to the present statistics need to be interpreted cautiously. It can clearly be seen that the distribution of information material comprises the most widespread method of informing inmates about health risks at both points in time.

More discriminating statistics are available on Baden-Wuerttemberg, Saxony-Anhalt and Bavaria (Nuremberg). Information material, primarily on infectious diseases, was available at 18 penal institutions in Baden-Wuerttemberg in 2008. In addition, there are internal or external drug specialists at all penal institutions, peer education programmes at six and safer use training programmes in nine and counselling is offered for public employees at 17 facilities (Reber & Wulf 2009, Reber 2011). The key tasks of addiction counselling in Saxony-Anhalt include information and motivation work with inmates who are willing to undergo treatment (Saxony-Anhalt Ministry of Labour and Social Affairs, personal information). Raising awareness and informing people is aimed at underscoring the health, material and social repercussions of consuming controlled substances. The “emergency training for drug consumers” project carried out by *mudra-Drogenhilfe* in Nuremberg addresses consumers in the facilities offering assistance, drug addicts incarcerated in the penal system and professional helpers in the field of drug-related work (*mudra e.V.* 2011). In training programmes, drug consumers are to be trained to provide first aid in the event of an overdose. The objective of the training is to remove helpers’ fear that they will be subject to penalties and dispel absurd notions of help measures in widespread practice among drug users. Moreover, participants are instructed in safer-use rules, while their understanding of risks and consumption processes is broadened in order to help avoid overdoses. Beyond this, the participants are impressed with the need to seek aftercare in the clinic so that others can benefit from their knowledge and experience. Finally, it is intended to instil first aid among drug consumers as a reaction with positive connotations.

Types of drug treatment and the number of patients

The types of drug treatment and the number of prisoners treated are presented in the following. Not all offenders dependent on controlled substances are held in German penal institutions, however. The principle of “therapy instead of penalty” namely makes it possible to refrain from imposing a legally effective prison term if the offender who is dependent on controlled substances undergoes therapy (§ 35 of the Narcotics Act). Additional background information on the topic of “therapy instead of penalty” can be found in the 2008 REITOX report (chapter 11). There were a total of 147,582 placements under probationary supervision under general criminal law in 2009 (Statistisches Bundesamt 2011d). Of this

amount, 9,578 sentences were postponed (in accordance with § 35 of the Narcotics Act) respectively placed on probation (in accordance with § 36 of the Narcotics Act). A total of 2,748 in this category were ended in 2009, 1,173 of these suspensions of sentences alone which were related to violations of the Narcotics Act. The Rhineland-Palatinate Pension Insurance Scheme (Kulick 2010) cited studies conducted in the Rhineland-Palatinate on this within the framework of the DBDD workshop “Drugs and Imprisonment” which confirm that medical rehabilitation for persons whose sentences have been suspended under the Narcotics Act with the intention of abstaining from drugs and (re-)integration in working life can be just as successful as in the case of other rehabilitated offenders who undergo drug-withdrawal treatment. The crucial factor determining the success of this measure is above all an approvals process based on criteria which is consistent and transparent for the prisoners, as lack of clarity in the perception of the prisoners can be demotivating and lead to a “revolving door” effect. It is only possible to extrapolate the positive results of rehabilitation to the national level to a limited extent, however.

Substitution practice in the various German Laender

Substitution practice in the German *Laender* is marked in part by considerable differences. To obtain detailed information on the current situation, the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) contacted the ministries of justice of the *Laender* in the summer of 2011. All 13 German *Laender* from which information was received replied that detoxification as well as substitute treatment are offered to inmates in their *Land*. Sustained OST can be performed by the same token in 9 Federal *Laender*. OST is only used to reduce dosage levels among new inmates in Brandenburg, Saxony and Saxony-Anhalt. Inmates are offered to begin an OST shortly before being released from prison in Rhineland-Palatinate, while a high dosage of OST is possible before release from prison in 6 German *Laender* (Baden-Wuerttemberg, Berlin, Mecklenburg-Western Pomerania, Lower Saxony, North Rhine-Westphalia and Rhineland-Palatinate).

According to the indicator database of the WHO (Indikatorendatenbank, BMJ 2009), the following types of drug treatment were available at all penal institutions in 2008: rapid medically assisted detoxification (in 14 German *Laender*), rapid detoxification without medication (in 7 Federal *Laender*), abstinence-based treatment with psychosocial assistance (PSB) (in 11 German *Laender*), treatment with antagonists (in 4 German *Laender*) and substitution treatment (in 9 German *Laender*). Psychosocial assistance was only provided in addition to this in all cases in 6 German *Laender*. Rapid medically assisted detoxification was thus being offered at the times of both surveys in almost all of the German *Laender* and even sustained substitution treatment by more than half of the German *Laender*. According to the results of a study by Schulte et al (2009b), substitution treatment is only possible in approximately 75% of the surveyed prisons (n=31).

Saxony-Anhalt¹³³ in addition stated that assistance and counselling for inmates suffering addictions are *inter alia* part of the main areas of focus for social services (Saxony-Anhalt Ministry of Labour and Social Affairs 2011, personal information). These tasks may be performed by other public employees as well, however.

Because in a survey conducted in the autumn of 2006 by Deutsche Aidshilfe (DAH) no response was received from Hesse, Lower Saxony or Saxony-Anhalt, the answers submitted by these *Laender* for a survey conducted by DAH in 2002 were used (Knorr 2008). This survey indicates that substitution treatment was generally possible in all the German *Laender* at this time. It should be noted, however, that in Bavaria and Saxony the inmate must have a serious or life-threatening illness at the same time. In the Saarland in 2006, OST was only offered in day-release facilities, where inmates are generally covered by statutory health insurance. Further treatment of a substitution which was commenced in an extramural setting was possible in almost all of the German *Laender* at this point in time. In Bavaria and Saxony this was decided on a case-by-case basis (in Bavaria, for example, substitution treatment was continued when the period of imprisonment was only a few weeks), while in Brandenburg on the other hand substitution treatment was discontinued at the time when people went into prison. When an indication was for substitution for the first time in prison, it was possible in most of the German *Laender* at the point in time of the survey to begin treatment, although in Bavaria and Saxony-Anhalt this was only the case when inmates were seriously ill or during pregnancy. It was not possible to begin OST after entering into prison at all in Brandenburg, the Rhineland-Palatinate or Thuringia in 2006. OST during pregnancy, which constitutes an indication for substitute treatment (Bundesaerztekammer 2010), was only offered in Baden-Wuerttemberg, Bavaria, Bremen, North Rhine-Westphalia, Rhineland-Palatinate and Saxony. The length of time of substitution was generally not limited at that time in Baden-Wuerttemberg, Bremen, North Rhine-Westphalia, the Saarland, Saxony and Schleswig-Holstein. Otherwise it was as a rule only offered within the framework of medically supported withdrawal. Methadone and polamidone were used for OST at that time in 15 German *Laender*; while buprenorphine was used in 7 German *Laender*. Hamburg and Mecklenburg-Western Pomerania were the only German *Laender* in 2006 which did not offer psychosocial assistance to support substitution treatment. When substitution was supposed to be performed but no such service was available in the penal facility, it was possible to move the inmates to another prison in all of the German *Laender* except Berlin and the Saarland in 2006.

Substitution was not offered as a "programme" or "therapy" in Bavaria at the point in time when the survey was carried out by the DAH in 2006, but was performed when ordered by the facility physician in individual cases. Substitution can be performed for the following groups of inmates at Bavarian penal institutions (Knorr 2009):

¹³³ The applicable regulations governing internal work with addictions in prisons in Saxony-Anhalt can be found in the administrative decrees of the Ministry of Justice from 6 October 2006 – 4558 – 305 – Mbl. LSA Teilausgabe B no. 47, page 349.

- Inmates who were already receiving substitution before entering prison and who only have to serve prison sentences of a few weeks,
- Pregnant women who are using drugs,
- Sentenced juvenile offenders,
- Seriously ill persons for whom withdrawal would lead to a deterioration in the illness afflicting them and
- Inmates undergoing substitution who are being transported or who have been admitted in connection with a court hearing.

The Senate of Bremen provided information in a notice in September 2006 in response to a large-scale enquiry by the parliamentary party groups of the CDU and the SPD on the topic of "methadone – substitution in Bremen penal institutions and aftercare following release from prison". According to this information, treatment with methadone for persons in custody awaiting trial was generally continued in Bremen if substitution had been performed at least six months prior to imprisonment and the inmate did not also use opiates, benzodiazepines, cocaine or alcohol. Treatment with buprenorphine was continued under the same conditions, but using methadone. No new substitution treatment was commenced for persons in custody awaiting trial. The same conditions governing continuation applied during incarceration in Bremen as for persons in custody awaiting trial. In addition, it was possible to begin OST in the case of severe illnesses such as HIV, hepatitis or tumours (somatic indication) or within the framework of a psychosocial treatment strategy for inmates with long histories of drug addictions, unsuccessful therapy attempts and repeat delinquencies (psychosocial indication) to stabilise their health situation. The term of methadone treatment in Bremen at that time was generally not limited. The actual length depended, however, on the previous history (for example the period of time of drug addiction), the personality structure and personal development of the inmate in prison. Consumption of other drugs was monitored by means of urine tests. The treatment could be discontinued if other drugs were taken¹³⁴. Persons who are at risk as a result of additional consumption are supposed to have their dosage reduced and be released from the treatment program. Generally speaking, additional consumption has always been subject to sanctions; this was taken into account, for example, in granting privileges like leaving prison during the day and the planning of release from prison.

The first expert meeting "Heroin in prison – new challenges and opportunities for the penal system", which was organised by Deutsche AIDS-Hilfe, furthermore took place in 2010. Staff from ministries of health and justice, AIDS services and prison physicians took part in it. The reason for the meeting was that outside of prisons diamorphine was to be administered as part of primary care. This was why the possibility of administering diamorphine in prison was discussed. The meeting of experts concluded that the required preconditions for such would be an expansion of intramural substitution treatment and sufficient political backing. In

¹³⁴ Additional consumption of opiates can be an indication that the methadone dosage is too low and it is necessary to raise it.

addition, attitudes towards drug consumers in prison would have to be addressed and reflected upon in a more focused way.

Because detailed information, much of it relatively outdated, however, is only available from individual German *Laender* and not all of the German *Laender* responded to the national surveys, it is not possible to make any definite statements regarding trends in the availability and conditions surrounding execution of OST in German penal institutions. Here it might be more useful to examine the number of substitution treatments in prison.

Number of inmates undergoing treatment for addiction in the individual German Laender

According to the indicator database, a total of 1,361 inmates underwent substitution treatment in 11 German *Laender* in 2008. This corresponds to a share in 4 German *Laender* ranging from 2.5% to 14%, with two German *Laender* even registering 20% and 50% of intravenous drug consumers respectively. In 4 German *Laender* OST was only possible for persons who were already undergoing substitution prior to imprisonment. The continuation of a substitution treatment commenced before imprisonment was the primary indication for treatment at that time (Keppler et al. 2009). Stoever (2011) found that treatment of previously substituted patients upon entering prison was discontinued in 70% of cases among participants in the IMPROVE Study¹³⁵. Although the remaining 30% still underwent substitution after entering prison, there was a clear intention of abstinence.

A total of 674 inmates were provided assistance by prisons' internal addiction counselling service in the penal institutions of Saxony-Anhalt in 2010 (Saxony-Anhalt Ministry of Labour and Social Affairs, personal information). 85 applications were filed for addiction-treatment measures, of which 69 cases were accepted and the costs assumed. A total of 50 cases were admitted to in-patient or partial in-patient withdrawal treatment.

1,486 inmates underwent rapid medically supported withdrawal in Baden-Wuerttemberg in 2010 (Reber 2010), with 108 inmates undergoing rapid detoxification without medication. 276 inmates received psychosocial support in a treatment having abstinence as the objective and 2 prisoners were treated with antagonists. 524 inmates underwent substitution treatment, although this was only for acute detoxification at 15 facilities. OST was possible for inmates who had undergone substitution before entering prison at 17 facilities, with this being possible without any time limit at 11 facilities. Psychosocial treatment was offered to support substitution in more than half of the cases at 12 facilities, while this was offered in fewer than half of the cases or none at all at 11 facilities.

Approximately 120 inmates were undergoing substitution treatment at Berlin prisons in May 2011 (Senate Administration for Health, the Environment and Consumer Protection Berlin 2011, personal information).

¹³⁵ A total of 400 persons with opioid dependencies at drug-counseling centers and physicians' practices in 11 German cities were surveyed in the IMPROVE Study. Of the persons surveyed, approximately 2/3 had already served prison sentences. Only approximately 30% of this group underwent substitution while they were serving their sentences. 70% had to interrupt OST when they entered prison.

In addition, the DAH survey from 2006 cited above also enquired as to the number of inmates undergoing substitution treatment (Knorr 2009). The answers submitted by the ministries of justice are presented in the following. A substitution treatment was possible for inmates at five prisons in Rhineland-Palatinate. An average of 10 inmates received substitution at that time. There were no closed prisons where substitution was provided in the Saarland at the point in time of the DAH survey. For this reason, it was not possible to transfer prisoners to another penal institution within the Saarland offering treatment possibilities. In North Rhine-Westphalia, OST was generally possible at all penal institutions in 2006.

It was reported at a conference staged by akzept e.V. (2010) that the number of substitution patients in North Rhine-Westphalia had tripled since the launch of the treatment recommendations on therapy for opioid dependency in prisons at the beginning of 2010 (the number of substitution patients in prison in April 2011 was approximately 1000). This trend was also reported at the DBDD workshop “Drugs and Imprisonment”, which took place in November 2010 (Husmann & Render 2010).

The number of substitution places in Bremen is not fixed. Approximately 100 to 120 inmates received substitution at Bremen prisons in 2006, however. According to a study carried out in 2005, 30% of inmates at Bremen prisons were drug addicts (notice by the Senate dated 19 September 2006). Assuming a total of around 700 inmates, there were thus approximately 200 persons with drug backgrounds in prisons in Bremen. According to a notice issued by the Bremen Senate, a total of 101 inmates were being treated with methadone as of 1 September 2006. This corresponds to 12% (Bremen) or 16% (Bremerhaven). According to information provided by the Hessian Ministry of Justice, there were a total of 1,407 drug withdrawals and 339 withdrawals in the case of mixed intoxication carried out in 2004. A majority of these took place at the beginning of prison sentences (Koetter 2010). Substitution treatment was carried out in continuation of treatments which began outside of prison in most of the cases (500 continuations in 2009), with a lower number also starting while the treated persons were serving sentences (20 cases in 2009). OST was discontinued in 9% of the cases, generally as a result of repeated consumption of other drugs. Psychosocial treatment was offered by the internal prison social service or external drug-counselling offices at Hessian prisons in 2004.

No data is available from other German *Laender* on the number of treatment places or actual cases of substitution (Knorr 2009). The number of places has not been determined in Brandenburg to date because of the limited need for treatment. Substitution treatment is generally speaking possible in all facilities in Hamburg, Lower Saxony, Schleswig-Holstein, and Thuringia, while it is possible in some facilities in Mecklenburg-Western Pomerania.

The German Statistical Report on Treatment Centres for Substance Use Disorders (DSHS) has kept a series of tables on ambulatory counselling during prison sentences since 2008 (Pfeiffer-Gerschel et al. 2011c). Because this series of tables only comprises eight facilities and it cannot be ruled out that individual results are only available for one or two facilities or heavily influenced by them, these figures must be interpreted extremely cautiously, as no information whatsoever is available on the mechanisms for selecting participation, nor can

anything be said regarding the representativeness of the participating prisons. In addition there are indications that there are problems with the documentation. For instance, some persons crop up in the overall data set, but not in the separate tables on external counselling in prisons. The average age of men with illegal drug problems who made use of ambulatory aid in prison in 2010 was 28.3 (N=582) (2009: 30.2 years of age; 2008: 29.2 years of age; 2007: 28.3 years of age), while the average for women was 32.2 (N=21) (2009: 29.9 years of age; 2008: 28.4 years of age; 2007: 26.9 years of age). Thus the average age of men in 2010 declined compared to the previous year for two years in a row after it had risen in each of the two previous years. Among women the average age has increased continuously by 1.5 to 2.5 years of age each year. It is particularly interesting that 71.4% (2009: 82.4%) of women serving sentences in prison who underwent treatment as a result of a drug problem were treated for a primary opioid problem, while this percentage among men was only 24.2% (2008:28.2%). In prison the percentage of men whose main diagnosis is stimulants (47.1%) who are undergoing treatment is significantly higher than among persons who undergo outpatient treatment outside of prisons. In contrast to this, treatment of men in prison as a result of cocaine (7.7%) is of a similar magnitude to outside prisons and a primary cannabis problem (18.4%) plays a smaller role than with ambulatory treatment outside of prison; no case is documented for women (Table 11.5).

Table 11.5 Outpatient treatment of drug problems in prison

Main diagnosis	Male		Female		Total	
	N	%	N	%	N	%
Opioids	141	24.2	15	71.4	156	25.9
Cocaine	45	7.7	0	0.0	45	7.5
Stimulants	274	47.1	6	28.6	280	46.4
Hypnotics/Sedatives	5	0.9	0	0.0	5	0.8
Hallucinogenics	1	0.2	0	0.0	1	0.2
Cannabinoids	107	18.4	0	0.0	107	17.7
Mult./other substances	9	1.5	0	0.0	9	1.5
Total	582	100.0	21	100.0	603	100.0

Pfeiffer-Gerschel et al. 2011c.

Effectiveness

The project "Health Care in Prison", which is being carried out by the German Centre for Addiction Issues affecting Children and Adolescents (DZSKJ) and the judicial authorities of the Free and Hanseatic City of Hamburg, is currently performing an evaluation of a therapy preparation station for drug addicts and abusers who are incarcerated in Hamburg prisons. It is to be evaluated to what extent a therapy preparation station can have a positive impact on acceptance of further treatment following release from prison. The survey of data, which took

place between April 2008 and March 2010, also examined whether the treatment program had an influence on the motivation of participants to undergo therapy and not drop out. The final results were not yet available at the point in time of this report (DZSKJ 2011, personal information).

In a survey of the literature on the effectiveness of substitution treatment in prison, Stallwitz und Stoever (2007) found that this type of treatment reduces both heroin consumption as well as the frequency of injections and risks of infection associated therewith, such as, for example, sharing syringes and needles. OST can moreover contribute to health services available in prison being used more frequently. In addition, participation in methadone programs in prison leads to a decline in activities in the drug-related subculture and drug-related penalties. Moreover, there is evidence that long-term substitute treatment during imprisonment in tandem with psychosocial care can encourage inmates to undergo drug treatment after being released from prison. It has furthermore been demonstrated that inmates undergoing substitution are involved in drug trafficking less often, have a lower risk of dying directly after being released from prison, more frequently undergo subsequent drug treatments and exhibit lower rates of relapse when receiving long-term substitution than persons not undergoing substitution (Keppler et al. 2011).

Prisons can also profit from substitution treatment (Stoever & Michels 2010). For instance, withdrawal symptoms of inmates can be controlled more effectively, the ability of inmates addicted to drugs to work and their productivity is raised and inmates undergoing substitution are more approachable, improving their integration in everyday prison life.

Treatment of drug-related infectious diseases

Schulte et al (2009b) have analysed data from physicians in 31 German prisons representing 14,537 inmates. They found that 14.3% of inmates were infected with hepatitis C and 1.2% with HIV. These results thus confirm prevalence rates established in an earlier study (Radun et al. 2007). This prevalence rate is many times greater than that of the general population (see Table 11.6). Approximately 90% of persons who were HIV positive and only barely 6% who were hepatitis C positive were undergoing treatment at the point in time of the survey in 2008. At the workshop "Drugs and Imprisonment" (see chapter 11.1) staged by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction, representatives of prison facilities voiced doubt that these findings could be extrapolated to the overall population of Germany. It is namely unclear which prisoners (e.g. with short or long prison terms) are represented by the random samples examined.

Table 11.6 Infectious diseases in prison

	Injecting drug users	Hepatitis C	HIV
Detainees	21.92–29.61 %	14.32–17.01 %	0.81–1.22 %
General population	0.3%	0.4–0.7%	0.05%
Factor	73–98	26–32	16–24

Radun et al. 2007;Schulte et al. 2009b.

Study results from the project “Infectious Diseases in German Prisons – Epidemiological and Sociological Surveys among Inmates and Staff” indicate that roughly one in every 11 inmates is unaware of his infection with AIDS/HIV, one in every 10 is unaware of his infection with tuberculosis and one in every nine unaware of his infection with hepatitis B and C (Eckert & Weilandt 2008). In this study 2.0% stated that they were HIV-positive, 2.3% stated that they had a positive infection status for tuberculosis, 6.2% for hepatitis B and 16.4% believed that they were infected with hepatitis C.

13 German *Laender* responded to the enquiry carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in the summer of 2011. Of these, only three *Laender* provided information on the number of tests for infectious diseases conducted when persons entered prison. 50% percent were tested in Baden-Wuerttemberg (8,630 out of 17,298 persons entering into prison), approximately 13% in the Rhineland-Palatinate (approximately 300 out of 2,389); Schleswig-Holstein stated that approximately 40% of cases had been tested for infectious diseases. Only 5 German *Laender* (Hesse, Saxony-Anhalt, Saxony, the Rhineland-Palatinate and Schleswig-Holstein) provided information on the number of infected inmates. According to the figures, 0.6% of inmates tested HIV positive upon entering prison in these *Laender*, 1.5% for hepatitis B (the information comes from 2 German *Laender*), approximately 15% for chronic hepatitis C (the information comes from one of German land) and 0.03% (three persons) for tuberculosis (this information comes from 2 German *Laender*).

In a survey conducted by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in the summer of 2011, all 13 German *Laender* stated that there was a possibility for inmates to undergo antiretroviral therapy (against HIV). Aside from Saxony, an antiviral therapy (against HCV) is also possible in prison in these *Laender*. None of the German *Laender* whatsoever were able to provide any information on the scope of therapies performed and the utilisation of therapy places.

In the survey performed for the indicator database of the WHO (Indikatordatenbank, BMJ 2009) the number of persons infected varied considerably among incarcerated intravenous drug users depending on the infectious disease and the German *Land* which was reporting. Thus in 2008, for instance, the share of HIV infections reported was between 1% and 20% (3

Laender), hepatitis A infections 0% (2 *Laender*), hepatitis B infections between 5% and 44% (3 *Laender*) and hepatitis C infections between 75% and 82% (3 *Laender*). It was possible to be inoculated against hepatitis B at all prisons free of charge in 15 German *Laender*, while risk groups were vaccinated in 12 German *Laender* and vaccination was available upon request. In 3 *Laender* vaccination was offered to all inmates when they entered prison. An antiretroviral hepatitis C therapy was possible for inmates at all penal institutions in 14 German *Laender*. Five *Laender* stated that they had a total of 692 prisoners with hepatitis C. 118 inmates were treated for hepatitis C in 7 *Laender*. 8 *Laender* stated that they had a total of 168 HIV-positive inmates. And HIV therapy was possible at all penal institutions in 13 German *Laender* at that point in time. 6 *Laender* reported that 142 inmates were receiving antiretroviral therapy. It is almost impossible to extrapolate the total number of infected persons and the number of treated persons. Because differing numbers of *Laender* responded to the questions, the numbers of treated persons and infected persons cannot simply be placed in relation to one another.

According to health reports on inmates in Baden-Wuerttemberg in 2010 (Reber 2011) 44 inmates were undergoing hepatitis C therapy while 43 were receiving antiretroviral treatment (HIV) in the year under report.

Drug fatalities during and after incarceration

Criminal police data and data from drug consumption rooms show that drug users are especially at risk of dying from an overdose after being released from prison (Frietsch et al. 2010). The WHO estimates that the risk of fatality for drug-dependent former inmates who have relapsed is more than 100 times greater in the first few weeks after release from prison. One study showed that the risk of dying of an overdose two weeks after release from prison was 34.2%; 12 weeks after release from prison this rate was 7.7% (Wolff 2010). These fatalities frequently occur as a result of unsupervised overdoses. According to Stoever, the crucial factor in these accidents is the lower tolerance of the body following temporary abstinence, ignorance as to the level of purity of the drugs used and different drug-consumption behaviour (akzept e.V. 2011). On top of this there are frequently social stress factors following the stay in prison such as, for example, homelessness, unemployment and lack of social contacts. For this reason a major attempt is being made in Hesse to sensitize inmates to the danger of drug fatalities following release from prison (Koetter 2010). DAH and akzept e.V. assume that a reasonable substitution treatment in prison could reduce the number of these drug fatalities because the probability of an overdose following release from prison and the danger of infection during prison could be reduced significantly. The German Medical Association also adopts this position in its guidelines (Bundesaerztekammer 2010). Studies conducted on drug-related emergency cases and fatalities back in the 1990s established these correlations (Herckmann et al. 1993; Soellner 1995). The national model project on the prevention of drug-related emergencies was created in response. This realisation has nevertheless not been integrated as a regular element of practice in prisons. For this reason the issue of prevention of overdoses following release from prison needs to be addressed more.

There are also fatalities resulting from overdoses during imprisonment as well, however. No national data is available on this. The Landtag of Lower Saxony (2010) reports a total of 121 fatalities among inmates (in Lower Saxony between 2003 and 2009) during incarceration, among these 50 suicides and 6 drug fatalities. Because of the dearth of national data, it is not possible to extrapolate any trend or the actual dimension of the problem here, however.

Harm Reduction

9 German *Laender* responded to the enquiry carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in the summer of 2011 (Baden-Wuerttemberg, Berlin, Bremen, Hesse, Mecklenburg-Western Pomerania, Lower Saxony, North Rhine-Westphalia, Saxony and Schleswig-Holstein), stating that condoms and in some cases lubrication is distributed to inmates free of charge. Almost all German *Laender* moreover stated that they offered inmates tests for infectious diseases.

According to the Indicator Database of the WHO, inmates in 13 German *Laender* allowed themselves to be voluntarily tested for HIV upon entering prison in 2008, while all prisoners were tested in 4 German *Laender* (Indikatoren datenbank, BMJ 2009). HIV counselling always took place before and after the test in only 11 *Laender*. In 11 *Laender* it was possible to take a test for hepatitis B and C upon entering prison on a voluntary basis, while these tests took place with all persons entering prison in 3 *Laender*. Tests for infectious diseases were carried out upon release from prison much less in all of the German *Laender* in 2008. No tests whatsoever were offered in 10 (HIV) and 11 *Laender* (hepatitis B and C) upon release from prison. Condoms were available free of charge at all penal institutions in 12 *Laender* in 2008, while these could also be purchased in 6 of the *Laender*. No disinfection substances were available in any of the *Laender*. In both surveys (2008 and 2011) the *Laender* stated that tests for infectious diseases were generally possible and that condoms were also frequently available free of charge. In neither case was it reported that disinfection substances were made available.

In order to minimize the risk of infection, tattooing in penal institutions is in addition generally prohibited. In spite of this, the number of inmates in prisons with piercing in the month of March in Baden-Wuerttemberg was estimated at 3%, while the number of inmates with tattoos was estimated at 10% (Reber 2011). In order to support inmates attempting abstinence in their endeavour, there were drug-free sections available at some penal institutions in 6 German *Laender* in 2008 (Indikatoren datenbank, BMJ 2009). There were a total of 55 prison places in these sections at 3 prisons in Baden-Wuerttemberg in 2010 (Reber 2009).

Only one project remained in existence in Germany in the wake of the model project "dispensing syringes in prison", which was subsidized by the Deutsche Forschungsgemeinschaft (DFG) until the end of 1998 (Berliner AIDS-Hilfe e.V. 2011). Women addicted to intravenous drugs can exchange sterile syringes at syringe vending machines anonymously at the prison for women in Berlin Lichtenberg. This is aimed at reducing the risk of infection with HIV and hepatitis during imprisonment. In addition, staff of Berliner AIDS-Hilfe e.V. regularly offer information and confidential counselling discussions

without the presence of a guard. Baden-Wuerttemberg in addition stated that no bleach was available at penal institutions in 2010, either. Condoms were distributed free of charge in this *Land*, while in others they were available for purchase. All inmates had the possibility of receiving vaccination against hepatitis B to prevent infectious diseases (Reber 2009).

Trust and confidence in the confidentiality of the physician providing treatment is an important precondition motivating inmates to undergo HIV or hepatitis tests (Knorr 2011). In some regions physicians at facilities pass information on existing HIV infections of inmates to the management of the facility, who then for their part "inform" the staff about existing infections. This data is routinely disclosed and does not depend on the conduct of the inmates. Because the physician-patient relationship is already possibly weakened as a result of the lack of ability to freely choose one's physician, disclosing this information on an existing infectious disease may also have an impact on the future testing behaviour of the inmates. The DAH is currently attempting to obtain a binding clarification of the lawfulness of this mode of procedure (2011).

Preparation for release and continuity of supply following release

For many former inmates, the beginning of medical rehabilitation measures for addicts is fraught with difficulties. Thus a survey conducted at in-patient help facilities for addicts indicates that a majority of persons just released from prison do not have any health insurance (Buerkle et al. 2010): at the facilities surveyed (n=141) 28.7% of the patients from the indication area of drugs had come directly out of prison. 77.3% of them did not have any health insurance. These figures underscore a need for action to be taken to regulate the therapy-related transition between prison and freedom. Some changes are already taking place: for example, inmates with drug dependencies are entitled to a binding commitment to assumption of the costs for drug therapy by the statutory old-age pension scheme since an order issued by Fulda Social Court in November 2010 (AFP 2010). This applies when release from prison before the expiry of the sentence depends on the assurance of a therapy place.

In October 2010 an integration agreement has been concluded among various institutions in Hesse: the Hessian Ministry of Justice and Ministry of Social Affairs, the Regional Directorate of the Federal Employment Agency (Bundesagentur fuer Arbeit), the Hessian Landkreistag and Staedtetag, the Hessian Statutory Welfare Association (Landeswohlfahrtsverband) and the Hessian Amalgamation for Aid to Prison Inmates (Landeszusammenschluss fuer Straffaelligenhilfe Hessen) (Hessian Ministry of Justice 2011, personal information). The aim of this agreement is to establish the required framework conditions for an orderly reintegration in society at the point in time when an inmate is released from prison (Koetter 2010). Thus, for example, social benefits are supposed to be clarified at this point in time. It is not only the question of the funding of therapies, however, but also the communication of this which makes it difficult under certain circumstances for inmates to start therapies after their release. In addition, inmates in Hesse with special needs for help have already been receiving assistance in prison through services offered by non-statutory help services for inmates since 2007.

In Saxony-Anhalt prisoners are referred to in-patient and ambulatory addiction withdrawal programmes already while they are still in prison, while the required legal, organizational and financial preconditions for this are established (Saxony-Anhalt Ministry for Labour and Social Affairs 2011, personal information).

According to the response of the Lower Saxony Landtag from August 2010 to a large-scale enquiry (Drucksache 16/2755), the staff members of the Social Service in Lower Saxony are particularly involved in tasks relating to preparation for release from prison. At present there are almost 200 persons working in this area at Lower Saxony prisons. In addition, the Ambulatory Prison Social Service of Lower Saxony (ambulantes Justizsozialdienst Niedersachsen – AJSD) offers a large spectrum of services from local offices for persons released on probation or under supervision of conduct. In addition to these regional offices and consultation times, the staff of the AJSD can be contacted at additional sites for the persons affected within the framework of visits to their homes and consultation meetings outside their homes. Here there was one probation officer for more than 80 persons participating in clinical trials throughout Lower Saxony in 2009 on average. The contact points for non-statutory aid to inmates primarily concentrate on persons released from prison who are not assigned to any probation helper. The Criminological Service in Lower Saxony will receive data on various strategies and measures which facilitate the transition from prison to freedom and are aimed at promoting integration beginning in 2012. Beyond this, evaluations of a training measure which is designed to prepare inmates with drug dependencies for in-patient drug withdrawal (within the framework of § 35 of the Narcotics Act) are being planned.

The after-care project “Chance” (Kaiser 2010) initiated in Baden-Wuerttemberg addresses persons released from prison who do not have any probation helpers, offering the participants intensive assistance before and even up to 6 months after release from prison. The project has been developed for all persons released from prison and is also accordingly being used with persons dependent on addictive substances in prison. “Chance” is supposed to assist inmates in the transition from prison to freedom on the one hand by helping them with practical everyday things, while on the other hand offering them a continuous contact. The Paritaetische Wohlfahrtsverband Baden-Wuerttemberg states that this release-management supports the resocialisation of inmates, thus reducing the risk of reversion to criminality. The activity of the case managers has led to an improvement in the situation of a number of clients (Institute for Criminology at the University of Heidelberg and Tuebingen 2010). This especially goes for the areas of housing, job and finances. A six-month period of assistance may be too short for clients with multiple problems, however. In these cases it is important to ensure that they receive follow-up assistance. According to the health report on inmates in Baden-Wuerttemberg (Reber 2011), substitution is offered as a supportive measure preparing inmates for release at 12 facilities, continuation of substitution is carried out at 16 facilities, while in 16 facilities inmates are referred to external drug-aid associations. At 11 facilities constant assistance is ensured.

In North Rhine-Westphalia as well, inmates with addictions receive comprehensive aid and counselling services after they are released from prison in order to protect them better

against the dangers of a relapse (North Rhine-Westphalia Ministry of Justice 2011). This is set out in a framework agreement pursuant to so-called transition management for inmates with addictions, which was signed in Duesseldorf on 7 April 2011 by representatives of the Ministry of Justice and the peak associations of the non-statutory welfare care associations, the Staedtetag, the Staedte- und Gemeindebund and the North Rhine-Westphalia Landkreistag. Under this agreement, the penal institution where the inmate is serving his sentence up until his release is to conclude an agreement with a selected aid facility setting out clearly defined measures in the future. This aid facility furthermore offers practical help in everyday things, inter alia looking for a dwelling, counselling on debts or referral to healthcare facilities – for example to resolve insurance issues, to have costs paid by insurance schemes and help arrange further medical treatment.

According to a notice from the Senate in response to a large survey, prisoners in Bremen are usually given the name of institutions providing aftercare in the case of substitution following release from prison to prepare them for release (Bremische Buergerschaft 2006). The patients have to contact these institutions after their release. In order to guarantee a smooth transition from prison to freedom, the Bremen prisons provide substitution four additional weeks after release from prison. In addition, inmates can consult a physician outside the prison prior to release in order to have a preparatory meeting to discuss treatment after release from prison. The prison bears the costs of this.

In response to an enquiry by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction carried out in the summer of 2011, 6 German *Laender* (Baden-Wuerttemberg, Berlin, Mecklenburg-Western Pomerania, North Rhine-Westphalia, Lower Saxony and Rhineland-Palatinate) reported that an increase in dosage is offered to opioid consumers within the framework of an ongoing OST prior to release from prison. Berlin, Saxony-Anhalt, Schleswig-Holstein and Thuringia state that inmates are referred to external addiction therapies, inter alia for an OST. In Bremen a transition substitution is possible after release from prison for inmates and Rhineland-Palatinate offers general transition management. Lower Saxony, Baden-Wuerttemberg and Mecklenburg-Question Pomerania stated that preparation for release is possible if this is necessary, but did not state any specific measures.

More differentiated statistics on preparation for release are provided in the data collection for the indicator database of the WHO (Indikatorendatenbank, BMJ 2009) than for 2011. Thus, for example, information material was handed out at almost all prisons in 12 German *Laender* in 2008, inmates are given counselling on risks and the prevention of drug-related health damage at all penal institutions in 15 German *Laender*, substitution treatment can be initiated at all prisons prior to release from prison in 4 *Laender* and inmates are referred directly to external drug-aid services in 12 *Laender*.

11.3.2 Drug tests

Guidelines on the execution of drug tests

Brandenburg, Baden-Wuerttemberg and North Rhine-Westphalia are the only German *Laender* which issue detailed rules for the health-care system in prisons in so-called

technical regulations. Neither the technical regulations of the *Laender* Brandenburg, Baden-Wuerttemberg or North Rhine-Westphalia (none were available for the other *Laender* at the point in time of the research in the summer of 2011) nor the Infection Protection Act (IfSG) (national) stipulate an exact procedure for testing for drug consumption and infectious diseases in German prison facilities, however. Although the technical regulations of North Rhine-Westphalia stipulate that the status of drug dependence of inmates is to be determined upon admission and release from prison in the physical examination conducted by the medical service, nothing is stated regarding the exact procedure here, either. Instead, the procedure is individually regulated by each of the German *Laender* and frequently even by each facility. Thus there is no uniform, obligatory arrangement regarding this measure, either for the management of the prison or for the inmates.

Number of drug consumers in prison

Experts assume that in Germany approximately 30% of all male and more than 50% of all female inmates are intravenous drug addicts and that the rates of drug-consuming inmates is many times greater than that of the general population (Keppler et al. 2010). Studies conducted in individual German *Laender* showing that roughly one in every two inmates is "at risk with respect to drug consumption" (North Rhine-Westphalia Ministry of Justice 1992) while one in every three persons must be considered "in need of therapy" (Dolde 2002) suggest that these estimates tend to be conservative. A survey conducted at Oldenburg Remand Prison indicates, for example, that 76% of all inmates receiving medical care have been treated for drug problems (Tielking et al. 2003).

In response to an enquiry carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in the summer of 2011, all 13 German *Laender* from which responses were received stated that drug tests were carried out in the case of suspicion or known previous drug history when persons entered prison. Only 4 *Laender* were able to provide statistics on the number of positive tests and information on the drugs consumed, however. Lower Saxony stated that approximately 40% and Schleswig-Holstein that approximately 80% to 90% of the inmates tested for consumption of illegal drugs were positive, especially for cannabis. In the Rhineland-Palatinate, around 17% (1,200) of approximately 7,000 inmates tested had a positive test result for illegal drugs, in Thuringia 32% of 19 persons tested (5 cannabis, 1 amphetamine). In addition, all of the German *Laender* stated that tests are performed at irregular intervals as needed or in the case of suspicion of drug consumption during incarceration. Table 11.7 provides details on the execution of drug tests at German penal institutions. The band width of positive test results is enormous, ranging from 17% to 90%. The number of drug tests performed also varies considerably, with no information whatsoever being available on the number of tests or the number of positive test results for most of the German *Laender*.

In the survey conducted for the indicator database of the WHO (Indikatorendatenbank, BMJ 2009) 3 *Laender* stated that in 2008 the portion of inmates who had injected drugs at some point was between 0.5% and 34%. It was reported that drug tests (by means of urine tests) were carried out when there was a suspicion of consumption at all prisons in 2008. Drug tests were carried out on a random basis in 14 German *Laender*, upon entry into prison in 5

Laender, and before home release in 6 German *Laender*. 4 *Laender* stated that in the report year 2008 15% (2,850) of almost 19,000 inmates tested were positive. The ministries of justice have provided the following prevalence rates for consumption of illegal drugs in 2008:

- Cannabis: 15% - 30% (the data comes from 5 German *Laender*),
- Heroin/opiates: 1% - 30% (the data comes from 9 German *Laender*)
- Crack/cocaine: 1% - 20% (the data comes from 9 German *Laender*)
- Amphetamines: 1% - 22% (the data comes from 12 German *Laender*)
- Ecstasy: 1% - 20% (the data comes from 9 German *Laender*)
- Any type of illegal drugs: 8.74% - 36.2% (the data comes from 4 German *Laender*)

At 9% to 36%, the range of values stated for the consumption of any types of illegal drugs in 2008 is relatively great and differs from the values stated in 2011 and moreover varies much more greatly (17% to 90%).

Within the framework of the project "Infectious Diseases in German Prisons – Epidemiological and Sociological Surveys among Inmates and Staff" inmates were surveyed as to how great they expected the percentage of drug consumers to be among the inmates of the prison in which they were incarcerated (Eckert & Weilandt 2008). The average amount stated for alleged consumption of cannabis or hashish by inmates was 65.4%. The inmates estimated on average that 47.4% were opiate consumers. It was estimated that in sum total half (48.9%) of inmates consumed other controlled substances or medication.

The North Rhine-Westphalia Ministry of Justice reported 6,713 inmates in North Rhine-Westphalian prisons who were dependent on illegal drugs and required treatment as of 31 October 2010. This group accounts for 39.2% of the total number of inmates at prisons (North Rhine-Westphalia Ministry of Justice 2011, personal information).

For Hesse it was reported that in 2009 approximately 10% of the urine tests conducted were positive or were refused. Cannabinoids were mainly found here. Unfortunately the number of tests conducted at this time is unknown, so no statements can be made about the actual prevalence of drug consumption. A total of 64 drugs which were found were confiscated in regular checks of inmates in 2009.

In Baden-Wuerttemberg (Reber 2011) drug tests were also carried out in 2010 by means of urine tests upon admission, generally on a random basis and before inmates were granted the privilege of going out, in some cases upon entry into prison as well. Out of 29,934 tests conducted, 4.4% were positive. Out of the 7,423 inmates tested in this manner, 12.0% tested positive. The following substances were consumed before entry into prison: cannabis (40%), heroin/opiates (19%), crack/cocaine (7%), amphetamines (7%) and Ecstasy (5%). In sum total, 21% of inmates took illegal drugs of some sort prior to entering into prison.

Inmates at all prison facilities in Lower Saxony (with the exception of remand pending deportation) were surveyed upon entering prison *inter alia* about their drug consumption prior to entering prison in 2005 (Criminological Service at the Educational Institute of the Lower

Saxony Prison System 2006). In sum, 40.7% of the participants (299 out of 734) reported that they had consumed illegal drugs in the last 28 days prior to entering prison. The amount of females consuming illegal drugs before entering prison was slightly above that of the men (40.6% versus 37.3%). The highest level of consumption of illegal drugs was registered by juvenile detention with 61.7%. Depending upon the substance, between 1.0% and 26.6% of inmates in prison stated that they had consumed illegal substances shortly before entering prison, primarily hashish or marijuana (26.6%) and opiates (16.8%). In addition, 15.1% of inmates reported that they had consumed drugs intravenously before they entered prison.

Schulte et al (2009b) have analysed data from physicians at 31 German prisons representing 14,537 inmates. The portion of former or current intravenous drug consumers at all prisons was 21.9%. The share of intravenous drug consumers in the general population is approximately 0.3%. This amount is thus almost 70 times higher in prisons. The prevalence levels found by Schulte et al. (2009b) confirm the results of a study conducted by Radun et al. (2007). The data is shown in Table 11.6. Based on the values reported in these studies, one can assume that out of 70,000 inmates in German penal institutions, 15,400 to 20,700 are intravenous drug consumers.

Table 11.7 Performance of drug tests broken down by *Laender* in 2010

Land	Drug tests conducted	Positive Tests	Intervals	Miscellaneous
Baden – Wuerttemberg	25,000 tests	1,429	irregular	Not applicable
Berlin	65,000 tests	139	Not applicable	Number of positive tests only available for correctional facility
Brandenburg	Not applicable	Not specified	Decision on by-case basis	Not applicable
Bremen	Not applicable	Not specified	irregular	Tests are carried out to control substitution, to decide about imprisonment, irregularities, privileges, before starting therapy
Hesse	13,619 Tests among 5,775 detainees	344 (incl. 190 detainees refusing examination)	irregular	Decision of medical service
Mecklenburg-Western Pomerania	Not specified	Not specified	Depends on indication	Not specified
Lower Saxony	Approx. 30% of detainees starting sentence	Approx. 40% of tests	if necessary	Not specified
North Rhine-Westphalia	8,000 – 10,000	Not specified	irregular	Not specified.
Rhineland-Palatinate	7,000	1,200	irregular	Tests are carried out in case of suspicion resp. in some cases before and after a decision on privileges
Saxony	Not specified	Not specified	decision on by-case basis	Not specified
Saxony-Anhalt	Not specified	68		Not specified
Schleswig-Holstein	Approx. about 30% of detainees starting sentence	Approx. 80% - 90% of tests	irregular	Not specified
Thuringia	Not specified	170	irregular	Tests are carried out in case of suspicion, preparation of privileges

11.4 Quality of treatment

11.4.1 Guidelines for drug-related health services in prison

Quality assurance for drug-related services in prison

In Germany numerous institutions address quality assurance in the extramural health care system, such as for example the SHI-Accredited Care Services Associations (Kassenaerztlichen Vereinigungen – KV), the statutory health insurance schemes (gesetzliche Krankenversicherungen – GKV) and the medical associations. The quality of intramural health care is reviewed with the aid of independent experts usually assigned to the ministry of health in some countries such as, for example, the Netherlands ("inspectorate system") (Stoever 2006). In Germany controls relating to health care in prison are the domain of the ministries of justice, and thus also for ensuring the quality of drug-related services in prisons. The German penal system maintains its own health care system, comparable with the healthcare system for the police or German army. This means certain differences in care for patients within these systems compared to the general population. Inmates do not have the possibility to freely choose their physician, for example.

As a result of the special structure of prisons, supervision of medical services at German prisons is regulated differently than in the extramural area. Thus, the director of the facility is not entitled to issue technical instructions to the facility physician (Keppler et al. 2010). The physician is subject to technical supervision, however, which may be regulated as follows:

- The person in charge of supervision in the ministry (medical director) is a physician.
- The person in charge of supervision in the ministry is not a physician, but rather a lawyer or psychologist, for example. This person makes use of know-how possessed by medical experts who are not part of the ministry of justice in the case of technical medical questions, for example staff at the ministry of health or external physicians who are not affiliated with any public institution.
- Supervision is not the charge of any one person (staff member of the ministry of justice), but rather external physicians, for example experienced physicians at facilities in another German Land, physicians from the ministry of health or retired physicians.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) acts as an external expert. The European Treaty on this stipulates that prison facilities be visited on a regular basis (European Commission 2002). The next to the last visit by the CPT in Germany took place between 20 November and 2 December 2005 (CPT 2006), in the framework of which 17 facilities were visited. Statements made in the CPT report in connection with "healthcare" are only based on three facilities. It was especially criticized that the prisons do not have general physicians available on a sufficient scale. In the view of the CPT, there should be one general practitioner with a full-time position available for each 300 inmates. In addition, in the opinion of the CPT, psychiatric care and care for inmates with drug dependencies are inappropriate. Moreover it

was criticized that not every inmate entering prison at all prison facilities was informed about healthcare or the prevention of infectious diseases (for example with the aid of an information brochure).

Baden-Wuerttemberg states that the same standards and guidelines apply intramurally for drug treatment as extramurally (Reber & Wulf 2009). A system for regular collection of data has been launched in Baden-Wuerttemberg, "Health Reporting on Inmates in Baden-Wuerttemberg", to provide more precise documentation of this procedure. The items used are heavily based on the items of the indicator database of the WHO. General data is requested, for example, on the penal system, prevalence and prevention of infectious diseases and drug consumption, counselling and treatment, quality assurance, informing inmates and public employees of prisons and risk-prevention.

The effectiveness of an OST with methadone was studied in Bremen by the medical service of the prisons there (Bremische Buergerschaft 2006). It is difficult to determine the degree of success, however, for example with respect to resocialisation, as the medical service of the prisons no longer has access to patients and there is no reliable information structure on the biographies of former inmates. Nor is any reliable data available along the lines of a scientifically founded observation over time such as statistics on relapse of this clientele of prisons.

Controls of medical activities by the Technical Agencies of the Supervisory Authorities are laid down in North Rhine-Westphalia in the "Recommendations for Treatment by Physicians Providing Medical Therapy for Opioid Dependency in Prison" (North Rhine-Westphalia Ministry of Justice & Westphalia-Lippe Medical Associations and North Ryan 2010). It issues orders if the borderlines of conscientious discretion by physicians are exceeded or improperly performed. Orders issued by supervisory authorities are limited to specific individual cases.

Guidelines for treating drugs in prison

Imprisonment continues to increase the risk that substitution commenced before entering a penal institution will not be continued (Stoever 2010a). Guidelines can help remove uncertainty and ignorance on the part of prison health care personnel. In order to provide penal institution physicians more certainty, the framework conditions, i.e. treatment strategies, accompanying psychosocial therapy or criteria for discontinuation, should be clearly described. These must take specific conditions in prison especially into account.

The Euro region of the WHO adopted the "Declaration on Health in Prisons as an Element of Public Health" in Moscow in 2003, in which several basic principles are laid down for the treatment of prisoners. Citing the fundamental principles of the United Nations regarding medical ethics in connection with the role of medical personnel, in particular physicians, in the protection of inmates and prisoners against torture and other cruel, inhuman or humiliating treatment or punishment, principal 1, it is laid down that medical personnel, in particular physicians who are charged with the medical care of inmates and prisoners are obligated to attend to their physical and mental health in the same manner as persons who

are not inmates or prisoners. With reference to principal 9 of the Fundamental Principles of the United Nations regarding the treatment of inmates and prisoners, it is laid down that prisoners are to be granted access to the health services of their country without regard to their legal situation. In addition, the connection between health in prisons and the public health system is stressed and the need arising from this for cooperation between ministries of health and justice. According to the declaration, the quality of healthcare in prisons is of special importance not least because inmates generally constitute a special risk group for health problems and moreover prisons can be risk areas for infection or worsening of illnesses. Moreover, former inmates may act as multipliers for illnesses outside of prison and thus influence the health status of the population at large. This is why it is recommended that staff and medical personnel at prisons be well trained and furthermore have uniform documentation to provide them a better overview of the current situation.

The recommendations for action "Opioid Substitution Treatment in Custodial Settings" (Kastelic et al. 2008), which was compiled by an international group of authors and issued by the WHO and the United Nations, address special aspects of the intramural setting with regard to the recommendations for substitution treatment in prison. A relapse with a high risk of an overdose is likely, according to international studies, if the detoxification has taken place too quickly. That is why the prison doctor should explain to patients in clear terms the advantages and disadvantages of a short or long detoxification so that an appropriate strategy can be selected for the individual case. In contrast to extramural substitution, it is assumed in most countries that a low daily dosage of methadone is sufficient in prison, as it is assumed that 100% of the substitution substance is taken and it is also assumed that consumption of other substances is significantly lower than outside prison. This is supposed to be regularly checked by means of urine tests. A positive urine test should not automatically be reason to discontinue the therapy, according to the international recommendations of the WHO. This should be viewed, rather, as an additional symptom of drug dependence. Generally speaking, according to these international recommendations, substitution treatment should never be used as a reward or punishment, but rather as part of a normal spectrum of treatment.

The physicians' recommendations on treatment and medical therapy for opioid dependency in prisons in North Rhine-Westphalia (North Rhine-Westphalia Ministry of Justice and Medical Associations of Westphalia-Lippe) stress the positive effect of substitution treatment in prison both with regard to the treatment of opioid dependency as well as attainment of the incarceration objective. That is why the objective stated is to "significantly raise the number of substitution treatments in prison". According to the recommendations for treatment, the objectives are

- to prevent fatalities as a result of decreased tolerance in prison and following release from prison,
- a reduction in illegal and subculture activities,
- an improvement in physical and mental health and

- permanent abstinence.

Similar to the situation outside prison, the patient has to sign a treatment agreement at the commencement of the substitution treatment in which rules are laid down. Among other things, it is stipulated in writing when the treatment is to be discontinued (for example in the event of repeated problematic consumption of other substances, drug trafficking or violence in connection with OST) and that discontinuation does not automatically mean permanent exclusion from OST. The decision on termination of treatment is made by the medical service. There are no fixed conditions with respect to recommencement. Generally speaking, in North Rhine-Westphalia patients who have already received substitution continued to be treated after entering into a prison, while the term of the sentence must not have any influence on the indication for treatment. Nevertheless it is recommended here that it should be possible to obtain a place for continued substitution in the event of substitute treatment in remand pending trial and sentences of less than two years. When inmates are released they should be assured of further treatment.

An administrative regulation issued by the Baden-Wuerttemberg Ministry of Justice has regulated substitution in prisons since 2002. It contains clear provisions regarding the general aims of OST as well as requirements regarding indication, exclusion, admittance, execution, documentation and termination of the substitution treatment. In addition, substitution with diamorphine has also been possible since the revised and amended version of the administrative regulation of 15 July 2011 went into effect (Baden-Wuerttemberg Ministry of Justice 2011).

The foundation for substitution treatment in prison in Lower Saxony is a decree from 2003 which for the most part is based on stipulations in the Narcotics Act and the Guidelines on the Evaluation of Physicians' Examination and Treatment Methods (BUB-Richtlinien): The decree sets out the preconditions and stipulates how substitution is to be carried out. Just like with all treatments by physicians, the physician providing treatment is in charge of the indication and establishes by means of an individual examination whether the substitution treatment is warranted and whether the intended purpose can be achieved in any other manner. Substitution is provided based on the principle of equivalency in line with the stipulations of Social Code V and the respective guidelines.

In accordance with the principle of equivalency, the guidelines issued by the German Medical Association (Bundesaerztekammer 2010) in 2010 also apply intramurally. The guidelines apply to all physicians who perform this treatment. Under the guidelines, it must be ensured when patients switch to hospital treatment, rehabilitation, imprisonment or any other form of in-patient care that the treatment is provided on a continuous basis. Furthermore, substitution treatment can also be provided in accordance with ICD F11.21 (opiate dependency, abstinent at present, but in a protected environment – such as, for example, a hospital, therapy community or prison) in individual cases where this is warranted. In the event of consumption of additional psychotropic substances, the cause of such, such as inadequate dosage or selection of the substitution substance or a co-morbid psychological or somatic illness, should be determined and if possible remedied. If this additional consumption

jeopardises the substitution, withdrawal from the additional psychotropic substance is to be initiated.

The aim of the project “Health Promotion for Young Prisoners“, which is being carried out until 2013 and coordinated by the Scientific Institute of Physicians in Germany (Wissenschaftliches Institut der Aerzte Deutschlands (WIAD)), addresses the development and improvement of health promotion of young inmates. The aim of this project is to implement the guidelines relating to this. The needs both of juveniles in detention who are especially at risk as well as prison personnel and non-governmental organisations are to be taken into account in their development.

11.4.2 Training of prison guards

In comparison to other occupational groups, prison guards are especially confronted with persons who consume drugs. That is why these persons should receive separate training to deal with and raise awareness in connection with drug consumers. The ministries of justice have reacted to this by instituting initial and continuing training programmes on this area.

In response to the enquiry carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) in the summer of 2011, 12 out of 13 German *Laender* stated that their prison guards were conveyed specialised knowledge relating to drugs. 2 German *Laender* stated that employees working in prisons received separate special training in drug-related first-aid measures. Beyond this, 3 *Laender* stated that prison guards are trained to become course leaders in prevention programmes for inmates. Other training measures are offered in 9 out of 13 German *Laender* in addition. Of these 9 *Laender*, 4 stated that the topic of drug consumption among inmates is generally treated within the framework of training as a prison guard.

A manual entitled “Minimising damage in penal institutions” (“Schadensminimierung im Justizvollzug”), which is issued by the Wissenschaftliches Institut der Aerzte Deutschlands (Scientific Institute of Physicians in Germany - WIAD) and which was produced by a project funded by the European Commission, is intended to provide continuing training of staff working at prisons (Wiegand et al. 2011). The manual provides suggestions on how the negative impact of certain types of behaviour can be reduced such as, for instance, the transmission of infectious diseases in the case of intravenous drug consumption through needles or sharing of needles. These concepts and strategies especially play a role at prisons, as this involves preservation of and respect for the human rights of prisoners, protection of public health and not least the demonstrated cost effectiveness of preventive measures compared to the costs of treatment, for example after people have become infected. The manual provides information on the topic of infectious diseases and the different ways they are transmitted as well as drug consumption and types of behaviour at risk relating thereto. Among other things, prison guards are to be sensitised to the special challenges of drug consumption. Moreover, the attitudes and understanding of prison guards towards drug consumption and consumers is supposed to be explored.

Baden-Wuerttemberg reported that counselling on the topic of prevention of drug-related health damage to public employees working in the penal system was provided at 17 facilities in Baden-Wuerttemberg in 2010 (Reber 2011). In addition, training in how to cope with drug-related emergencies was carried out at some Berlin prisons (DAH 2010). Here both appropriate behaviour in the event of drug-related emergencies as well as particular risks such as, for example, consumption of drugs following abstinence, are addressed. The administration of naloxon, an opiate antagonist, is also discussed in the training.

11.5 Discussion

11.5.1 Principle of equivalency

The number of substitution treatments outside prison has risen by more than 50% to approximately 80,000 patients at present in Germany over the last five years. Thus around 77,400 of the estimated 81,000 to 171,000 persons with problem consumption of opioids are being reached at present (see chapter 4.2.1). No comparable trend can be witnessed at German penal institutions. Merely approximately 1,700 inmates among the estimated 15,400 to 20,700 opiate consumers are currently undergoing long-term substitution treatment at present (Stoever 2011b). The treatment objectives associated with intramural substitution treatment also place a significantly greater emphasis on the goal of abstinence than substitution treatment outside prison (Schulte et al. 2009b). Thus intramural OST differs in this respect from extramural OST, in which many patients are also provided long-term treatment when they require it¹³⁶. This difference may possibly be explained by the fact that the prison setting is better suited to achieving abstinence than the setting outside prison.

Previously substituted persons were not provided continued treatment when they entered prison in 70% of cases in the IMPROVE study (Stoever 2011). The discontinuation of an OST upon entering prison can, however, lead to physical and psychological problems and increased risk behaviour such as, for instance, sharing of injection devices, and hence raise the risk of drug-related infectious diseases (Stoever & Stallwitz 2008).

The reasons for the relatively low number and in some cases unclear quality of substitution treatments in prison are wide-ranging. Generally speaking, dealing with persons dependent on drugs in prison poses considerable difficulties. Thus for one thing prisons are supposed to resocialise inmates. On the other hand they are confronted with the reality that in spite of an absolute ban against illegal drugs in German penal institutions, a large percentage of inmates consume drugs, some of them in a very destructive manner. On top of this, the possible actions which can be taken by the (medical) prison personnel are often quite limited (Keppler et al. 2011). Thus there are often too few medical personnel available to cope with the number of inmates requiring treatment and the intensity of care they require. Too few

¹³⁶ 5 to 7 years after the baseline survey in the PREMOS Study 46.0% of the participants (n=162) were in a situation of stable substitution, 12.7% in unstable substitution and 11.7% had an unclear substitution situation at the point in time of measurement (Wittchen et al. 2010). This result does not provide any indication about the effectiveness of short-term substitution, however.

guidelines in the area of drug-related health care in prison frequently leads to marked differences in health care among inmates, first of all between the German *Laender*, but also even between individual penal institutions as well. Considerable regional differences can be seen especially when it comes to substitution – differences reflected in north-south, west-east and urban-rural differences in the rate of opioid addicts receiving substitution (Schulte et al. 2009a).

In spite of these difficulties, prisons theoretically offer a suitable setting for continuous treatment of inmates (Keppler et al. 2011). Medical personnel is present right on site, for instance, and the regular prison guards and staff are generally experienced in dealing with inmates who consume drugs, with a majority of them also having received additional training to be able to report medical symptoms to the right persons among the staff of physicians or nurses at the penal facility. By the same token, the additional areas of responsibility and work required of supervisory personnel should not be forgotten, which is why there are so many of these present.

11.5.2 Methodological limitations and gaps in information

Inter alia as a result of the federal nature of the German penal system there are numerous methodological limitations and gaps in information in this area. This results in fragmentation both with respect to the data available as well as in laws and regulations. Individual *Laender* have had their own prison laws for adults for several years, for instance, while the German Prison Law still applies in others. Moreover, some German *Laender* have administrative regulations governing health care at penal institutions, while others do not. That is why drug-related treatment modalities vary, especially in the area of substitution treatment, not only between the German *Laender* at present, but also among various prisons as well (Stoever 2011b).

Thus, although individual data surveys are carried out at the national level on the topic of health care in prisons such as, for example, within the framework of the information collection for the Indicator Database, this data is frequently obsolete or – like in the case of the Indicator Database – it cannot be attributed to particular *Laender*. As a result reference variables are lacking to match the figures reported. Nor can extrapolations or estimates be made on the basis of the data, as the (little) information may be from very small or very large *Laender* and the values would possibly be highly distorted. Moreover, there are numerous individual regional studies, but they are generally not comparable as a result of the lack of networking between statistics and the non-uniform methods of collecting data and classifying it (ICD diagnoses are only made very rarely). As a result, it is not possible to establish any direct linkages between the data. Sequential or comparative analyses are virtually impossible as a result. Closer cooperation between the ministries of health and justice would possibly help document questions relating to health with the aid of tried-and-proven methods to make intervention more effective. A uniform and reliable document culture at prisons could be promoted by making sufficient human resources available in the area of health care.

The absence of clear, uniform guidelines might have the effect of limiting the possibilities of prison guards to take action, as the lack of uniformity creates uncertainties which impact possible action. The importance of objectives being set by the individual ministries of justice for the development of substitution treatment in prison has been illustrated by the recommendations of North Rhine-Westphalia for treatment (NRW Ministry of Justice and Westphalia-Lippe and North Rhine Medical Associations 2010). It was reported at a conference (akzept e.V. 2010) that the number of substitution patients in North Rhine-Westphalia had tripled since the introduction of the treatment recommendation at the beginning of April 2011 to reach approximately 1,000 – i.e. more than in all other 15 German *Laender* put together. The need for uniform rules and regulations in health care for inmates has been described in this chapter in detail. The example of recommendations for treatment in North Rhine-Westphalia and its influence on substitution practice show that such statutory provisions can actually have an enormous impact.

12 Drug consumers with children (dependent parents and child-related issues)

Only incomplete data is available in Germany on how many drug consumers have children and live together with them. Different estimates assume that between 30,000 and 60,000 children of drug addicts live in Germany. Hard statistics are available on drug consumers who are undergoing treatment or receiving assistance in an ambulatory or in-patient facility offering assistance to addicts. The documentation provided by the German statistical report on treatment centres for substance use disorders (DSHS) also provides information on how many of the clients have their own children or live together with children in a household (chapter 12.1). No reliable data is available on drug consumers who are not undergoing treatment.

Various hazards and risks are associated with a dependency-related illness of a parent for the family and individual members of the family. The living circumstances of parents dependent on drugs are frequently marked by poverty and social disadvantage. This poses additional health risks and psychological stress both for parents and children. The healthy development of children is jeopardised by living circumstances in families where there are addictions. Drug consumption during pregnancy can directly harm unborn children and also have repercussions for their health later. Growing up in a family where there is an addiction constitutes one of the biggest risks that children will develop a dependency later in life themselves. Findings regarding the degree of the problem as well as the risks and dangers involved are presented in the first part of this special chapter (chapter 12.1). Political strategies and legal conditions are described in the second part (chapter 12.2).

In Germany there is a complex structure of actors, facilities and institutions which work to provide support and aid to families with addiction problems and carry out campaigns, events and projects. Work with parents and children, families as a whole or family members is by the same token closely intermeshed. Alcohol dependency of parents or one parent constitutes a far greater problem in work with families with dependency problems and many programs and measures no longer distinguish between dependencies on legal or illegal substances. The third part of this special chapter (chapter 12.3) presents some of these programs and activities. There are special counselling and treatment services for families with dependency problems and drug consumers with children in Germany. A special role is assigned to cooperation between different institutions. An important objective is to strengthen and expand structures currently existing at the local and community level as well as create uniform national standards for binding cooperation structures.

12.1 Degree of the problem and risk factors

According to various estimates, between 30,000 and 60,000 children of parents dependent on drugs live in Germany. If one adds alcohol abuse and alcohol dependency, the number of children living in households with dependencies rises to approximately 2.5 to 2.65 million. Thus almost one in every five children grows up in a family with a dependency problem (DHS

2011; Klein 2005; www.nacoa.de). The percentage of drug addicts who have children is estimated at about one-third. In the case of women undergoing substitution treatment, estimates range up to 50% (Klein 2008; DHS 2011).

Many studies in Germany addressing the topic of "families with addiction problems" focus on the children themselves or the family as a whole, but it is rare that it is on the parents. A considerable portion of efforts made to offer aid and assistance to families with dependency problems also focus on the children or the entire family. Moreover, frequently no distinction is made between (in particular) alcohol and illegal drugs; the entire addiction problematic, rather, is addressed.

12.1.1 Data from the German statistical report on treatment centres for substance use disorders (DSHS)

The most reliable data on the dimensions of the problem are documented in the German statistical report on treatment centres for substance use disorders (DSHS). The data of DSHS stems from approximately three-quarters of all specialised ambulatory and roughly half of in-patient facilities¹³⁷. DSHS provides an indication of how many of the clients receiving assistance have children of their own and how many children (biological or non-biological) live in the household of the clients. Because DSHS does not take into account all facilities involved in the treatment of substance use disorders, the data reported is conservative, i.e. the numbers of persons involved are in reality higher than reflected by DSHS.

Drug consumers' own children

The German statistical report on treatment centres for substance use disorders (DSHS) states a total of N=22,567 clients with a substance use disorder relating to the consumption of illegal drugs who have at least one child of their own for ambulatory facilities in 2009. It should be taken into account, however, that it is not known in the case of a relatively large share of clients (depending upon the main diagnosis roughly one-fifth) whether they have children.

¹³⁷ On the mode of procedure and the level attained by German statistical report on treatment centres for substance use disorders (DSHS) see chapter 5.

A total of n=1,297 clients with at least one child were treated at an in-patient facility with one of the aforementioned principal diagnoses and documented in the German statistical report on treatment centres for substance use disorders (DSHS) in 2009 (Pfeiffer-Gerschel et al. 2010a,b,c)¹³⁸.

Clients who are being assisted or treated as a result of a principal diagnosis of opioid dependency and have at least one child of their own represent the largest group (34%). At least roughly one in every three clients whose principal diagnosis is cocaine have at least one child of their own (N=1,641, 35.2%), while this percentage among persons having a disorder relating to the consumption of sedatives/hypnotics is somewhat less than one-third (n=1,309, 30.9%) (see

Table 12.1). The figures for clients whose principal diagnosis is stimulants is by comparison lower (n=494, 25.8%), as is the case with clients whose principal diagnosis is cannabis (n=3,729, 16.4%) (see

Table 12.1).

An examination of the average age of the groups of principal diagnoses shows that clients whose principal diagnosis is sedatives/hypnotics is the oldest, averaging 43.6 years of age. Clients having a principal diagnosis of opioids or cocaine average 33.8 and 31.7 years old, respectively, and clients whose principal diagnosis is cannabis are the youngest (24.2 years of age) (Pfeiffer-Gerschel et al. 2010a;b,c). Among all the groups of principal diagnoses, most of the clients who have children of their own only have a single child (see

Table 12.1).

¹³⁸ Tables 12.1, 12.2 and 12.3 contain data from the 2009 German statistical report on treatment centres for substance use disorders for the reference group “people beginning/ending treatment” and “all persons receiving treatment” at ambulatory facilities. The reference group “all persons receiving treatment” includes *all* persons who were receiving treatment in the year under report (including on a permanent basis). The cross-sectional description of the clientele group “drug consumers with children” requires this reference group be selected in order to make a comprehensive description possible. In this special chapter, the descriptive examination of the group of persons “drug consumers with children” thus relates to the reference group “all persons receiving treatment” designating clients at ambulatory facilities. Generally the reference group “persons beginning/ending treatment” is examined within the framework of the annual REITOX report; this allows a more detailed picture of changes in the demand for assistance/treatment to be obtained. To achieve a certain consistency and comparability of data within the report, the reference group “persons beginning/ending treatment” is also listed on the tables as well as the reference group “persons ending treatment” for clients at in-patient facilities.

Table 12.1 Main diagnosis and number of own children

Main diagnosis	Number of own children					Total with child/ren %*	N	Unknown N	Total N
	Without child/ren* %	one* %	two* %	three* %	more* %				
Opioids									
outpatient, all persons beginning/ending treatment	66.5%	20.5%	9.3%	2.6%	1.1%	33.5%	7,195	5,531	26,978
outpatient, all persons receiving treatment	65.6%	20.9%	9.6%	2.7%	1.2%	34.4%	15,370	11,844	56,583
inpatient, all persons ending treatment	74.7%	15.4%	7.4%	1.6%	0.9%	25.3%	697	202	2,961
Cannabinoids									
outpatient, all persons beginning/ending treatment	84.5%	10.1%	3.6%	1.2%	0.5%	15.5%	2,401	4,096	19,616
outpatient, all persons receiving treatment	83.6%	10.8%	3.9%	1.2%	0.5%	16.4%	3,729	6,088	28,792
inpatient, all persons ending treatment	83.2%	11.3%	4.2%	0.8%	0.5%	16.8%	255	233	1,751
Sedatives/ Hypnotics									
outpatient, all persons beginning/ending treatment	71.2%	15.8%	10.2%	1.6%	1.2%	28.8%	283	261	1,245
outpatient, all persons receiving treatment	69.1%	17.1%	10.1%	2.4%	1.3%	30.9%	494	450	2,051
inpatient, all persons ending treatment	81.6%	13.8%	3.5%	0.7%	0.4%	18.4%	52	23	306
Cocaine									
outpatient, all persons beginning/ending treatment	66.0%	19.3%	9.7%	3.1%	1.8%	34.0%	959	689	3,512
outpatient, all persons receiving treatment	64.8%	20.1%	10.2%	3.1%	1.8%	35.2%	1,641	1,150	5,814
inpatient, all persons ending treatment	72.9%	15.0%	7.7%	3.0%	1.4%	27.1%	152	26	586

Table 12.2 (continued) Main diagnosis and number of own children

Main diagnosis	Number of own children					Total with child/ren %*	N	Unknown N	Total N
	Without child/ren*	one*	two*	three*	more*				
	%	%	%	%	%				
Stimulants									
outpatient, all persons beginning/ending treatment	74.2%	16.6%	6.6%	1.9%	0.7%	25.8%	760	941	3,885
outpatient, all persons receiving treatment	73.2%	17.5%	6.6%	1.8%	0.9%	26.8%	1,309	1,598	6,484
inpatient, all persons ending treatment	77.1%	15.0%	5.6%	1.5%	0.8%	22.9%	140	68	680
Hallucinogenics									
outpatient, all persons beginning/ending treatment	76.7%	15.0%	5.0%	1.7%	1.7%	23.3%	14	25	85
outpatient, all persons receiving treatment	75.0%	19.8%	3.1%	1.0%	1.0%	25.0%	24	46	142
inpatient, all persons ending treatment	85.7%	-	14.3%	-	-	14.3%	1	0	7

*) Percentage values refer to clients having provided information on the item (without unknown).

Children in households of drug consumers

Table 12.3 shows how many children live in the household of the client. This question does not necessarily relate to persons' own children. Here as well, the status of a relatively large percentage of clients is unknown (approximately one-fifth to one-fourth among the various principal diagnoses).

A total of N=11,627 persons receiving supervision/assistance or undergoing treatment live in the same household with at least one child. The largest group of clients (principal diagnosis opioids) are the group living with at least one child in a household (n=7,465, 17.4%) (see

Table 12.3). Clients with a principal diagnosis of cannabis compose the second largest group of clients and also the second largest group living with children in the same household (n=2,340). With other principal diagnoses the figure is 17.1% (n=781) for persons with a principal diagnosis of cocaine, 15.3% (n=713) for persons with a principal diagnosis of stimulants and 20.5% (n=317) for persons with a principal diagnosis of sedatives/hypnotics. With all main diagnoses, more than half of the clients living in a household with children live with one child and more than one-fourth with two children in the same household. (see

Table 12.3).

The majority of clients at ambulatory facilities do not live alone. Out of the total principal diagnosis, the persons not living alone account for between 58.5% (principal diagnosis opioids) and 62.1% (principal diagnosis stimulants). Among these the percentage of persons who live with children varies considerably. While somewhat more than one in every ten clients not living alone with a principal diagnosis of cannabis lives with children (11.0%), among persons with a principal diagnosis of stimulants this figure is almost one in every five (18.2%). The figure for persons with a principal diagnosis of cocaine is 22.8% and a principal diagnosis of opioids is 25.0%. The share among persons with a principal diagnosis of sedatives/hypnotics is even more than one in every three at 36.9% (see Table 12.5).

Table 12.3 Main diagnosis and the number of children living in the household

Main diagnosis	Number of own children					Total with child/ren %*	N	Unknown N	Total N
	without child/ren*	one*	two*	three*	more*				
	%	%	%	%	%				
Opioids									
outpatient, all persons beginning/ending treatment	83.8%	9.9%	4.7%	1.2%	0.5%	16.2%	3,327	6,474	26,978
outpatient, all persons receiving treatment	82.6%	10.5%	5.1%	1.3%	0.5%	17.4%	7,465	13,699	56,583
inpatient, all persons ending treatment	87.2%	7.0%	4.5%	1.0%	0.2%	12.8%	345	259	2,961
Cannabinoids									
outpatient, all persons beginning/ending treatment	89.4%	6.4%	2.9%	0.9%	0.4%	10.6%	1,571	4,746	19,616
outpatient, all persons receiving treatment	89.3%	6.5%	3.0%	0.9%	0.4%	10.7%	2,340	6,967	28,792
inpatient, all persons ending treatment	90.3%	6.3%	2.2%	0.7%	0.5%	9.7%	143	272	1,751
Sedatives/ Hypnotics									
outpatient, all persons beginning/ending treatment	80.8%	12.0%	5.5%	0.8%	0.8%	19.2%	181	300	1,245
outpatient, all persons receiving treatment	79.5%	12.2%	6.3%	1.2%	0.8%	20.5%	317	505	2,051
inpatient, all persons ending treatment	80.9%	12.6%	4.5%	0.4%	1.6%	19.1%	47	60	306
Cocaine									
outpatient, all persons beginning/ending treatment	83.1%	8.5%	5.7%	1.6%	1.1%	16.9%	465	753	3,512
outpatient, all persons receiving treatment	82.9%	9.1%	5.5%	1.7%	0.8%	17.1%	781	1,242	5,814
inpatient, all persons ending	88.9%	6.7%	3.6%	0.4%	0.4%	11.1%	61	36	586

treatment

Table 12.4 (continued) Main diagnosis and the number of children living in the household

Stimulants									
outpatient, all persons beginning/ending treatment	85.4%	9.3%	3.8%	0.9%	0.6%	14.6%	411	1,069	3,885
outpatient, all persons receiving treatment	84.7%	10.0%	3.8%	0.9%	0.6%	15.3%	713	1,813	6,484
inpatient, all persons ending treatment	86.7%	8.5%	4.2%	0.2%	0.5%	13.3%	80	80	680
Hallucinogenics									
outpatient, all persons beginning/ending treatment	89.5%	8.8%	1.8%	-	-	10.5%	6	28	85
outpatient, all persons receiving treatment	88.3%	10.6%	1.1%	-	-	11.7%	11	48	142
inpatient, all persons ending treatment	100.0%	-	-	-	-	0.0%	0	0	7

*) Percentage values refer to clients having provided information on the item (without unknown).

Pfeiffer-Gerschel et al. 2010a;b;c.

Table 12.5 Principal diagnosis and living situation

Main diagnosis	Living situation		Living together with*				
	Living alone	Living not alone	Partner	Child/ren	Parent	Parent person/s	Other person/s
Opioids							
ambulant, Alle Betreuungen	41.5%	58.5%	46.1%	25.0%	24.5%	6.3%	17.7%
stationaer, Beender	47.3%	52.7%	43.2%	23.7%	32.8%	7.7%	18.0%
Cannabinoids							
ambulant, Alle Betreuungen	32.7%	67.3%	21.6%	11.0%	55.0%	9.7%	15.0%
stationaer, Beender	45.4%	54.6%	25.2%	14.0%	49.8%	11.6%	17.1%
Sedatives/ Hypnotics							
ambulant, Alle Betreuungen	40.3%	59.7%	66.7%	36.9%	11.6%	3.8%	6.4%
stationaer, Beender	43.7%	56.3%	67.8%	37.4%	17.2%	10.9%	11.5%
Cocaine							
ambulant, Alle Betreuungen	39.8%	60.2%	42.3%	22.8%	21.9%	5.9%	25.6%
stationaer, Beender	51.0%	49.0%	48.1%	23.9%	26.6%	9.3%	20.8%
Stimulants							
ambulant, Alle Betreuungen	37.9%	62.1%	30.9%	18.2%	39.8%	8.7%	18.4%
stationaer, Beender	41.7%	58.3%	28.2%	17.6%	41.1%	9.2%	22.6%
Hallucinogenics							
ambulant, Alle Betreuungen	39.7%	60.3%	26.0%	9.6%	43.8%	9.6%	17.8%
stationaer, Beender	71.4%	28.6%			100.0%		

*Multiple responses possible

Pfeiffer-Gerschel et al. 2010a;b;c.

12.1.2 Regional documentation and results of studies

Hamburger Basisdokumentation 2001 (Hamburg Basic Documentation 2001)

Hamburg Basisdokumentation (BADO) has devoted a special chapter in its annual report (data year 2001) to the topic of “Mothers and fathers dependent on addictive substances, where the children stay” since as far back as 2003. Ten years ago it assessed how many children live in families with addiction problems, how many clients receiving treatment have children of their own and how many of them live together with children. According to these

statistics, 44.0% (2,134) of the clients have children. This statistic from Hamburg is above the national average. A comparison is only valid to a certain extent, however, as this data does not provide any information on percentages accounted for by individual principal diagnoses and the period of time between these surveys is quite large. Nevertheless, one can infer that drug consumers with children tend to live more in urban areas like Hamburg than rural areas.

In Hamburg clients with children were of an average age of 35 in 2001. Between 46% of the children were no longer living with the parent under supervision or undergoing treatment, however, instead usually living with the other (separated) parent. This was particularly the case when the father had the addiction problem: in these cases three-fourths of the children lived with their single mother (76.6%). When the mother was a client of an addiction-treatment facility, the children lived more frequently in foster families (45.2%), with their grandparents (27.4%) or at child-raising facilities (13.4%). Most single parents in cases where the children live together with the parent receiving treatment were single mothers (62.4%). Basisdokumentation explored sociodemographic aspects and the socioeconomic status of clients, in particular mothers undergoing treatment. Although mothers undergoing treatment have a lower educational level than women without children undergoing treatment, they just as frequently had completed occupational training. Clients with children were more frequently dependent on social aid than clients without children, however. This figure was even higher among single mothers (Martens et al. 2003).

Fuchs et al. (2008) carried out a study on parents dependent on opioids with children of minority age with the framework of the Basisdokumentation for Hamburg Ambulatory Treatment Centres. This study examines the empirical relationship between parenthood and addiction with respect to the well-being of the children. The clients (n=4,971) were split up into the groups "parents who live together with their children", "parents who do not live together with their children" and "childless persons". Approximately one-third (30.3%) of clients had children, with roughly more than one-third of these living together with the children (35.9%). The results of the study show that the situation of parents raising children is much better with regard to the selected risk factors (drug consumption, traumatic experiences, social situation, health condition) than for those parents who do not live together with their children. Nothing can be surmised on the basis of this study as to whether the presence of children in the household is the reason that these clients are in a better situation or whether clients who were previously in a better situation tend more to keep their own children (Fuchs et al. 2008; see 2009 REITOX Report).

Results from the PREMOS study

The PREMOS Study¹³⁹ (Predictors, Moderators and Outcomes of Substitution Treatment) looked at the long-term effects of opioid-supported substitution therapy using a prospective-longitudinal, epidemiologically based 6-year study of patients receiving routine health care in Germany (see chapter 5).

¹³⁹ <http://www.premos-studie.de/>

Sociodemographic aspects examined in the study show that 40.7% of the population in the study (n=1,624) had at least one child of their own (23.4% one child; 11.8% two children; 5.5% three or more children). A comparison between male and female patients shows that this percentage is greater among female patients: a total of 50.7% of women (n=524) had children, while among male patients (n=1100) this figure was only 36.0% (Wittchen et al. 2011).

A query as to whether and which type of facilities offer special services for risk groups (a total of approximately 30% of all facilities) showed that only 8.4% could demonstrate that they specialise in pregnant and/or women with children. This statistic shows a deficit in the health-care situation, as more than one-third of all substitution patients are women, and the majority of them have children. Moreover, specialised facilities are very unequally distributed in Germany. Generally it is large, staff-intensive facilities in urban centres which are able to offer specialised services in the first place (Wittchen et al. 2011).

The specific situation and problems of women dependent on opioids who have children and pregnant women has been examined in a supplemental, more detailed study using a separately developed interview of women.¹⁴⁰ The initial reports in the final report of the study indicates that comprehensive care was provided to female patients in particular during pregnancy, which is also reflected in the fact that a disproportionate number of women studied stated that they had become abstinent at least temporarily during their pregnancy. In the following period there were frequently relapses, phases of massive social disintegration and psychosocial stress and usually several new starts with substitution treatments, however (Wittchen et al. 2011).

The authors therefore saw a considerable need to expand and improve the coordination of the various services in particular for the period following birth to support women undergoing substitution who have children and to remove regional deficits in specialised services.

12.1.3 Risk factors for pregnant women and parents who consume drugs and their children

A substance disorder is often not just a burden on the person with the disorder. The illness also has an impact on other family members. Children are especially burdened by a parent having a substance disorder, as they are dependent on their parents. They require parents to rear them, protect and care for them, attend to their health, feed them and provide love and affection as well as financially support them. In many respects children are vulnerable and helpless if parents are not able to perform the tasks of parenthood. Substance disorders among parents thus constitute a particularly great risk.

Findings relating to risk factors and health hazards for pregnant women, parents and children which arise through the consumption of drugs are usually not based on systematically collected data or more recent national studies carried out in Germany. The level of knowledge, e.g. pertaining to the risks of drugs for unborn children or dependency problems

¹⁴⁰ Additional results of these more detailed studies had not yet been analysed at the point in time of this report. The authors will be publishing additional works on these results in the future (Wittchen et al. 2011).

in families recurring across generations are for the most part based on studies conducted in the United States in the 1980s and 1990s. The following sections contain a summarising description of known risk factors and hazards discussed in the literature.

Multi-generational addiction problems in families

Alcohol and drug dependency are frequently a recurring problem in families. Dependency-related disorders constitute an increased risk for children in the family context, as they are more likely to develop a dependency-related illness themselves later on (see, for example, Klein 2003; Sack & Thomasius 2009b).

Impact of problematic life situations and circumstances

For the most part a distinction can be made between two types of negative influences on the life situation and circumstances of mother and child which are generally present at the same time. The literature first of all describes the living situation of the mother, which is marked by social disadvantage. Secondly, it addresses limitations on the ability of mothers to raise their children as a result of drug dependency.

In comparison to the normal population, drug addicts generally have a lower level of education and occupational training, which is as a whole associated with a higher risk of poverty and unemployment (Klein 2006). As a consequence it is not surprising that mothers who are dependent on drugs have a lower social status than mothers who are not dependent on drugs as well as higher levels of stress in their lives; they also tend to be more socially isolated (Klein 2008). In the case of mothers who are dependent on drugs, usually uncertain living circumstances and poor nutrition, poor housing conditions and a socially constrained environment have a negative impact on the physical, psychological and social development of the child. Discontinuities and disruptions in the lives of children of drug addicts such as changes and interruptions in their lives together are considered to be risk factors in connection with behavioural disorders. Children in families with addiction problems experience emergencies and stays in hospitals, the arrest of parents, attempts at suicide all the way to successful suicides more frequently, for instance, than other children. Mothers have often had traumatic childhoods themselves which continue to have an impact on their psychological health (Klein 2006). In families with addictions in which there is an addiction problem as a result of the consumption of illegal drugs, both partners in a relationship are frequently affected by the dependency when the mother is not raising the children alone (usually the case). In comparison to persons dependent on alcohol, among whom frequently only one partner is dependent, drug addicts also have partners who are dependent on drugs disproportionately often (Klein 2006).

Dependency-related disorders and possible additional psychological illnesses, the pressure to obtain drugs, criminality in connection with the acquisition of drugs and prostitution by mothers can place considerable constraints on the ability of mothers to raise their children

(Rasenack 2004, Klein 2008, fdr 2009)¹⁴¹. Drug-dependent parents are more prone to neglecting and not attending to their children. Children of drug consumers thus more frequently exhibit symptoms of neglect (Klein 2008). Among children who grow up in families with addiction disorders, it can frequently be observed that they assume (or have to assume) responsibility and perform tasks such as running the household and taking care of younger sisters (BMFSFJ 2009).

In a study conducted among 58 mothers undergoing substitution carried out within the framework of the development of a programme to promote the child-raising abilities of mothers who were dependent on drugs, Kroeger et al. (2006), in addition to establishing that these persons are frequently disadvantaged (see above), also conclude that these mothers perceive deficits in their child-raising competencies themselves. The authors note that the low level of self-confidence these mothers have also results in inconsistencies in their child-raising.

On the whole, it becomes clear that in addition to the many services available focusing on the needs of children from families with addiction disorders (see chapter 12.3), there is also a considerable need for aid services for these parents. It is for this reason that one of the key objectives or elements in various aid services for drug-consuming or substituting parents is to foster their child-raising abilities and to support them in exercising their right to raise their own children (on this see, for example, the sections on “early aid” in chapters 12.2 and 12.3).

Impact of heroin and cocaine on unborn children

Alcohol and illegal drugs have a teratogeneous effect on unborn children. Acute intoxication, withdrawal, the impact of substances at the cellular level and their organotoxic effect can cause deformities and developmental disorders. Moreover, substances cause passive dependency and neonatal withdrawal syndrome (Bevot & Kraegeloh-Mann 1999; fdr 2009). A woman finding out that she is pregnant and few preliminary examinations as well as comorbidity, especially with infections (HIV, hepatitis B and C), polytoxicomania and psychiatric disorders are frequent (Rasenack 2004).

The dangers posed by the effects of heroin on unborn children are more related to the aspect of it causing dependency; the teratogeneous effect is weaker than with e.g. cocaine or alcohol (Bevot & Kraegeloh-Mann 1999; Rasenack 2004). That is why the dangers posed by withdrawal for pregnant mothers are particularly great; this can lead to intrauterine death and neonatal withdrawal syndrome, (Rasenack 2004). The danger of crib death is also increased during the first year of life (Bevot & Kraegeloh-Mann 1999). Further complications in pregnancy which frequently occur among heroin consumers include insufficient intrauterine development of the hip bones, premature births and later neurological damage (Rasenack 2004).

¹⁴¹ The position paper “Drugs – Pregnancy – Child” cited in this chapter examines the debates and discussions which took place within the framework of a hearing of experts from the fields of medicine, addiction treatment and youth welfare which took place under the same title in Berlin on 29 January 2007 and was then explored in more depth at the 31st Federal Drug Congress “Children are our future – addiction treatment takes a position” in April 2008.

The teratogeneous effect of cocaine (and amphetamines) comprises a general vasoconstriction (constriction of the blood vessels) and a resulting decrease in the blood supply in the area of the placenta as well. This can lead to premature births and intrauterine death. Moreover, consumption can raise the rate of underdeveloped newborn babies with microphelia (dysplasia of the brain) and postnatal the occurrence of acute toxic symptoms and crib death (Rasenack 2004).

With regard to problems in the further development of children of mothers consuming drugs, the authors of the position paper “Drugs – Pregnancy – Child” (fdr 2009) have established a need for additional research on whether certain deficits can be attributed to the impact of drugs during pregnancy or whether psychosocial stress through parents consuming drugs is the cause (fdr 2009). The current state of the art in research in Germany has been described in the work of Stachowske (2008).

12.2 Strategies, laws and legislation

12.2.1 Statutory framework conditions: the Social Codes (SGB)

Drug-consuming parents with children have the same rights to obtain aid as other consumers, e.g. to treatment of their dependency or basic social security and other support services and benefits. The Social Codes (SGB) provide the legal foundations for the right of drug addicts to treatment and stipulate what institutions are to fund the treatment (see chapter 5). With regard to the treatment of parents, above all SGB V (statutory health insurance schemes) and SGB VI (statutory pension insurance schemes), in some cases SGB XII (social aid) are of relevance. With regard to the rights and obligations of parents towards their children, SGB VIII (children and youth welfare) provides the statutory foundations which are of key importance in the context of drug consumers.

12.2.2 Statutory framework conditions: SGB VIII – children and youth welfare

The United Nations’ Convention on the Rights of the Child lays out foundations in Articles 24¹⁴² and 33¹⁴³ which have been implemented in Germany in various statutory provisions.

The German Social Code (SGB) – Eighth Book (VIII) – child and youth welfare stipulates in § 1 that “every young person is entitled to be promoted in his or her development to become a responsible person in the community”¹⁴⁴. The services, benefits and tasks of statutory and non-statutory agencies and organisations on behalf of young people and their families is subsumed under the term “children and youth welfare” (“Kinder- und Jugendhilfe“). Welfare for drug consumers with children hence consists of complex interaction between various actors. Parties involved include *inter alia* addiction treatment centres, youth welfare

¹⁴² “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. [...]“

¹⁴³ “States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties [...]“

¹⁴⁴ http://bundesrecht.juris.de/sgb_8/___1.html

organisations, health care and the education system. Interface problems between different administrative and legal systems require cooperation and networking in order to be able to ensure optimum care (fdr 2009).

It emanates from Article 6(2) of the German Constitution that parents have the right to care for and raise their children, but that this is also related to obligations. Jeopardisation of the well-being of children resulting from the lifestyle of their parents¹⁴⁵ can lead to a conflict with the right of parents to raise their children. When the well-being of children is in danger, youth welfare offices (Jugendaemter) are assigned the task of offering suitable and necessary aid to preclude any jeopardisation of young people. The youth welfare office is an organisational unit within the community administration and under Social Code VIII (SGB VIII) must be set up by each county or urban municipality. The youth welfare offices are responsible for awarding benefits under SGB VIII; they can also act as the public agencies funding youth welfare. If the welfare of minors is at risk, for example because their parents are addicted to drugs, these offices are in charge of tasks involving cooperation with agencies providing services and benefits and institutions in the educational, health and social systems. It is expressly laid down in the law that the risk must be assessed by several experts; the parents are also to be included in this process. It is furthermore to be ensured that suitable and required aid is offered by the agencies responsible for facilities and services and that services and benefits are made use of by the parents. The objective is to jointly act to preclude dangers to the well-being of children while involving all actors required. Impingements on the rights of parents are only possible under § 1666 of the German Civil Code if the aid which is offered does not suffice to preclude dangers because the parents are not willing or are unable to cooperate. In such a case the youth welfare office petitions a family court. A host of measures can be initiated by the family court, ranging from issuing orders for services and benefits to be accepted all the way to the partial or complete removal of custody. In cases of acute risks, the youth welfare office must “take custody” of the child or adolescent under §42 of Social Code VIII.

12.2.3 Federal Child-Protection Act (Bundeskinderschutzgesetz - BKiSchG)

To achieve comprehensive protection of children and youth, it is necessary to involve different actors with different specialisations from different welfare systems with different purposes set out in law and different funding. The Federal Ministry for Family Affairs, Senior Citizens, Women and Youth has drafted a Law to Strengthen Active Protection of Children and Youth (Bundeskinderschutzgesetz - BKiSchG) in order to create uniform framework conditions for regional cooperation structures in the area of protection of children and youth (Bundesrat Drucksache 202/11). The Federal Government endorsed the Draft Act on 16 March 2011 and it is scheduled to go into force on 1 January 2012. One key element in the Federal Child-Protection Act is Article 1, the “Act on Cooperation and Information in the area of Child Protection (“Gesetz zur Kooperation und Information im Kinderschutz – KKG)”. The

¹⁴⁵ The Convention cites “persons having the care and custody over the child”. This term takes into account constellations in which children do not live with their biological parents. This section means persons having custody in the meaning of the law; for the sake of simplicity, these are referred to as “parents”.

framework conditions for binding network structures in the area of protection of children are laid down in this as are provisions on information to parents on support services. The Act on Cooperation and Information in the area of Child Protection furthermore sets out the disclosure of sensitive data among actors by laying down a standard on powers for actors possessing confidential knowledge by virtue of their profession. Legal conflicts have occurred here in the past, e.g. when actors become aware that parents have a dependency disorder which might be associated with jeopardisation of the well-being of the child, there is a conflict with physicians' confidentiality obligations. The Bundesrat debated the Government's draft bill on 27 May 2011. Although the Bundesrat generally speaking welcomed the initiative in the guise of the Draft Act and supported its general aim, it continues to see a considerable need for improvement in its statement of position. In particular it argues that the health-care system must be more closely integrated in planned cooperative structures (Bundesrat Drucksache 202/11B).

In a public hearing conducted by the Committee for Family Affairs, Senior Citizens, Women and Youth of the German Bundestag on 26 September 2011, statements made by experts pursuant to the draft bill submitted by the government were discussed (Bundestag Drucksache 17/6256). The legislative bill was generally speaking welcomed by the experts who were heard. The lack of involvement of the health-care system was criticised, however. On the other hand, the experts also stated that the draft bill ran the danger of providing too little funding and too little resources at the local level for the planned cooperation structures. The experts considered the success of the law to depend upon sufficient funding and cost-sharing by the Federal, *Laender* and local governments.¹⁴⁶

On 28 September 2011 the Federal Government also adopted the "Action Plan 2011 for the Protection of Children and Adolescents against Sexual Violence and Exploitation" (BMFSFJ 2011). Action Plan 2011 links into the "Round Table on Sexual Abuse of Children" initiated on 24 March and institutes specific measures in an overall strategy. The focal points of the Action Plan include the areas of "prevention" and "intervention". The comprehensive protection of children and adolescents on the one hand begins at the level of victims. Here increased efforts are needed to protect children in families with different neglect and abuse problems. The Action Plan also sees a need for action in informing and raising awareness (prevention) as well as counselling and housing services (intervention) to protect children from families with addiction and abuse problems.

12.2.4 National Centre for Early Aid (Nationales Zentrum fruehe Hilfen - NZFH)

The German social system offers comprehensive aid and support services for needy persons. This includes people with an addiction disorder, and these often meet other criteria entitling them to receive support as well. Poverty, illness and limited opportunities for participation are additional criteria, for example. Germany often pursues an integrative approach in strategies and action plans which aim at a more general target group in measures for needy persons. Thus drug addicts are not the primary target group, but these

¹⁴⁶ <http://www.bundestag.de/bundestag/ausschuesse17/a13/anhoerungen/Kinderschutzgesetz/index.htm>

persons nevertheless frequently meet requirements and are part of the target group receiving support services.

One example of this is “Early Aid” (“Fruehe Hilfe”) which is described in the following. Early Aid is the term used to designate support and aid services which parents are offered beginning with pregnancy up until, for instance, the child turns three years old. The aim of Early Aid is to improve protection of children against neglect and abuse as early on as possible through prevention. Strengthening child-raising skills of (soon-to-be) parents is another focal point. Early Aid addresses parents in difficult living situations with limited resources to cope with their situation, e.g. parents with addictions and their children (Die Drogenbeauftragte der Bundesregierung 2011).

The Government Coalition in the 16th electoral period agreed in its 2005 Coalition Agreement to develop a social early-warning system in a project to offer early promotion of children at risk. Services offered by the health-care system and child and youth welfare offices are to cooperate more effectively. The National Centre for Early Aid (Nationales Zentrum Fruehe Hilfen – NZFH)¹⁴⁷ was established in 2007 within the framework of the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth’s action programme entitled “Early Aid for parents and children and social early warning systems”. The Federal Centre for Health Education (BZgA) and the German Youth Institute (Deutsche Jugendinstitut - DJI) are the joint sponsors of the NZFH. Their joint sponsorship underscores the approach of multi-professional cooperation in the field of Early Aid¹⁴⁸.

12.3 Reactions

A non-intact family environment is considered to be one of the biggest causes of an increased risk that children will suffer addiction-related disorders later. The causes of increased addiction risk include inter alia experience of domestic violence, separations and divorces, physical and emotional abuse or even sexual abuse. These problems occur in varying degrees in households where there are addiction problems.

In Germany there are various services offering treatment and counselling for parents and pregnant women with drug dependencies. A large portion of services directly address children. Information offered by associations and facilities which address e.g. social workers and staff from youth welfare centres frequently focuses on work with children from families with addiction problems. In work with parents who consume drugs, the role of parents and perception of parental duties are less often the focus. Many services address the problems and difficulties of children who live with addicts.

¹⁴⁷ The National Centre for Early Aid (NZFH) is the central information platform in the area of “Early Aid”. Results from model projects are prepared on the Internet site and recommendations for action are offered for implementation at the local community level. The work of the NZFH is based on three columns: a knowledge platform (e.g. recording examples from the field of practice, model projects, scholarly findings), public-relations work and communication (e.g. sensitisation of decision-makers in the German *Laender* and local communities on the further construction and establishment of early aid) and development and transfer (support by public and non-public actors, networking of actors from different disciplines in the field of Early Aid) (NZFH 2010).

¹⁴⁸ www.fruehehilfen.de

There is no uniform, comprehensive documentation on services and activities. The projects, cooperative ventures and events listed in chapter 12.3 provide a description of selected activities with different actors and institutions involved with the issue and related problems.

12.3.1 Treatment of parents who consume drugs and pregnant consumers

Treatment, counselling and assistance for drug consumers with children

In addition to the treatment of dependency-related disorders, there are various services offering counselling and assistance to families, parents and/or children both at ambulatory and in-patient facilities. Services which facilities offer include, for example, groups where children can be cared for during therapy meetings (to take an example of services which focus on the children of addicts). There are services offering family therapy at in-patient addiction-rehabilitation centres (to take an example of services which include the family). Moreover, seminars promoting the child-rearing competence of parents are offered (to take an example of services focusing on parents).

Treatment and assistance for pregnant consumers

The general goal of assisting pregnant consumers of drugs is to make the pregnancy as low-risk as possible. The desire to change one's own consumptive behaviour so that the unborn child suffers as little damage as possible is usually high among pregnant drug consumers. In the case of pregnant consumers of opiates, stable substitution is the best way to reduce risks emanating from consumption of other substances, withdrawal and relapse (Siedentopf & Nagel 2005). German guidelines on treatment for opioid-related disorders¹⁴⁹ are the same as the guidelines of the WHO¹⁵⁰ with regard to recommendations on substitution treatment for pregnant women. Methadone is considered to be a suitable substitution. It is also possible to offer treatment with levorphanol and buprenorphine in Germany¹⁵¹. Treatment with diamorphine has also been possible in substitution treatment in Germany since 2009; strict access criteria limit this form of treatment, however, to the group of "severely addicted". Taking into account these restrictions on access, pregnant persons who otherwise meet the preconditions for treatment with diamorphine could also be treated with this substitution substance at licensed facilities. In addition to medical treatment of addictions, psychosocial and birthing-aid assistance is also important. The identification of somatic and psychological disorders as well as information on *inter alia* risks (of infection), furthermore regular care and beyond this information on infections, complications with pregnancies, deformities and growth disorders are supposed to be provided within the framework of medical and birthing-aid assistance. It is supposed to be determined within the framework of psychosocial care

¹⁴⁹ See the German treatment guideline "Opioidbezogene Störungen. Postakutbehandlung" ("Opioid-related disorders. Post-acute treatment") (Havemann-Reinicke et al. 2006).

¹⁵⁰ See the guidelines of the World Health Organization (WHO 2009).

¹⁵¹ At present the AQWMF guidelines on treatment of disorders in connection with opioids are being revised (see 2010 REITOX report, chapter 11). The previous version did not make any statements regarding diamorphine, as it was not yet licensed as a substitution substance.

what influential factors which could have an effect on the development of the child during pregnancy can be expected (Siedentopf & Nagel 2005; fdr 2009).

12.3.2 Services: examples of treatment and counselling in the field of practice and projects

It is scarcely possible to provide a complete overview of services offered in Germany, as there is no system to record the scope, type and quality of services. The services which exist at the local or regional levels are in some cases very specific services offered by facilities and initiatives. The German statistical report on treatment centres for substance use disorders most recently documented that in 1999 11% of ambulatory facilities had services of some type for children of persons with substance-abuse disorders. What type of services these are is not explained (Tuerk & Welsch 2000). No systematic data whatsoever is recorded for services outside addiction-treatment centres. With regard to the development of standards and quality features for work with drug-dependent pregnant women and mothers and the need for continuing training of specialised staff, Toedte (2010) believes there is a need for action to be taken. This applies to the establishment of networks in the area of medical care, drug and youth welfare offices.

The following sections present several services on offer, some of which have been working with drug-consuming pregnant women and mothers for many years.

Berlin Out-Patient Infection Clinic (Infektionsambulanz Berlin) and WIGWAM Reach-Out Social Work (WIGWAM aufsuchende Sozialarbeit)

One example of interdisciplinary cooperation in the field of treatment practice is the work of the Berlin Out-Patient Infection Clinic for Birth Medicine at Charité University Clinic in Berlin. Pregnant women addicted to controlled substances, consuming narcotics and undergoing substitution have been provided counselling in an inter-disciplinary team since as far back as 1987. The treatment strategy includes medical birthing, neonatal, addiction medicine, infectology and psychosocial assistance. Patients who go to meetings are offered wide-ranging services, e.g. possible in-patient treatment of newborn withdrawal syndrome is part of this¹⁵². The Institute's out-patient clinic works together with "WIGWAM Connect – competent assistance in pregnancy and early years of parenthood"¹⁵³. Pregnant patients who consume drugs are assisted and supported by WIGWAM Connect social workers at the birthing clinic. The work includes, for example, referral to offices for substitution treatment and psychosocial assistance, home visits and assessment of living circumstances and cooperation with youth welfare offices in Berlin to optimise services offered by youth welfare offices. In addition, WIGWAM cooperates with Berlin addiction-treatment facilities, providing contact to the Out-Patient Infection Clinic so that pregnant clients can make use of the medical care offered for birthing medicine at the clinic.

¹⁵² <http://geburtsmedizin.charite.de/schwangere/sprechstunden/spezialsprechstunden/suchtsprechstunde/>

¹⁵³ <http://www.vistaberlin.de/index.php?id=58>

Bella Donna, a drug counselling office for girls and women

The issue of pregnancy and motherhood among women dependent on drugs has been conceptually integrated into the work performed by the drug-counselling office for girls and women "Bella Donna" in Essen since as far back as 1992. The counselling office offers the training program MUT! (Muetter-Unterstuetzungs-Training) for addicted mothers or mothers undergoing substitution and their children. The training includes support, suggestions and practical help in the everyday chore of raising children, information on physical and psychological development stages of children and their basic needs. Child care is offered when the mothers attend group meetings in the course¹⁵⁴.

“Liliput – Mutter + Kind” counselling service

“Liliput – Mutter + Kind” is a service offered by Lilith e.V.¹⁵⁵, a non-profit funding organisation for several social facilities in Nuremberg. Individual counselling is offered for mothers and children in individual meetings, group meetings, child care, leisure time possibilities for mothers and children, consulting times for mothers and referral to facilities in the area of child and youth welfare and health services. The funding organisation Lilith among other things also addresses the target group through outpatient counselling services, reach-out work, street work and crisis intervention.

The “Eltern-Kind-Haus” at Boeddiger Berg Special Clinic

Boeddiger Berg Special Clinic¹⁵⁶ maintains a targeted service for parents consuming drugs. This offers the possibility for in-patient rehabilitation in a treatment area especially set up for the target group. The “Eltern-Kind-Haus” (“parent-child house”) is a special service offered to mothers and fathers who have substance addictions or are at risk of such, but also pregnant women and soon-to-be parents. During their treatment they can live together with their children under one roof and receive advice and help regarding child-raising questions and support in organising everyday family life. An information meeting takes place at the facility in advance. It is possible to be admitted to the facility if costs are assumed for the parents (for example, by the statutory pension insurance scheme or health insurance scheme) as well as for the children (by the youth welfare office in charge).

Regenbogen – parent-child aftercare in a shared-living situation

One service offered in the area of in-patient aftercare following successful rehabilitation of young mothers or also families is the aftercare shared-living facility “Regenbogen”¹⁵⁷ in Kassel. This facility for addicted parents over 18 years of age who want to be abstinent offers to help structure parenthood for the parents with their children and for them to establish their

¹⁵⁴ www.belladonna-essen.de/index.htm

¹⁵⁵ www.lilith-ev.de

¹⁵⁶ www.drogenhilfe.com/boeddiger_berg

¹⁵⁷ www.drogenhilfe.com/regenbogen

own existence together with their children. The aftercare comprises further assistance and counselling following ambulatory or in-patient therapy.

FachAmbulanz Kiel – HiKiDra

FachAmbulanz Kiel addresses the topic of “parents and children” and offers a broad variety of counselling services to parents with drug dependencies and their children in the project “Hi-Ki-Dra – Hilfen fuer Kinder von Drogenabhaengigen” (“Aid for Children of Drug Addicts”). HiKiDra Kinderberatungsstelle (Child Counselling Centre) has maintained its own offices focusing on comprehensive social counselling for parents, child-raising and mothers-support courses in different age groups, counselling for pregnant women, groups for children and adolescents with parents who are addicts, family leisure time and holiday programmes as well as network and lobbying work, specialised counselling and continuing education.¹⁵⁸

FachAmbulanz Keil also drafted an aid manual for the *Land* capital of Kiel (Schleswig Holstein) in 2005. The “Aid Manual for the *Land* Capital of Kiel: HiKiDr – Aid for Children of Parents Addicted to Drugs” seeks to examine the problems faced by children of parents who are drug addicts from different perspectives in order to inform all persons or persons/facilities/institutions involved with parents addicted to drugs about the problem. The manual describes the aid required for children of parents addicted to drugs and categorises these according to the type of services in charge. The manual moreover provides tips on the recognition of problems, assessment of risks and regarding legal issues, for example legal claims of the parents, but also the legal foundations for aid services under the Social Codes and with respect to financing issues. (FachAmbulanz Kiel, 2005).

Projects

The projects presented here are in some cases national model projects and in some cases projects funded at the regional and community level. The program “addiction prevention with children of parents with addiction disorders”, funded by the “Kinderland Foundation”, was carried out in Baden-Wuerttemberg over the period 2002 to 2006, for example. 23 model projects have been supported in Baden-Wuerttemberg, within the framework of which children learn positive behavioural models and self-confidence, interpersonal and decision-making skills in groups receiving therapy assistance in Baden-Wuerttemberg. This was followed by the programme entitled “support services for children of psychologically ill parents or parents with addiction disorders”, which helps fund 16 projects in Baden-Wuerttemberg.

In a review Arenz-Greiving and Kober (2007) have studied “work with children and their parents with addiction disorders” by analysing the conception, documentation and evaluation of 35 projects and initiatives on the said topic¹⁵⁹. An element of the study was among other things questions relating to the type of services and supporting measures in the projects. In particular, with regard to the aspect of parents consuming addictive substances, it was

¹⁵⁸ <http://fachambulanz-kiel.de/index.php/2010/projekt-eltern-kind-hikidra/>

¹⁵⁹ A list showing the projects which were examined in the review can be found on pp. 63 ff. of Arenz-Greiving and Kober (2007).

explored which access paths to dependent parents have proven effective and how parents can be included in work with children. The authors identified a systematic family-oriented approach as an important conceptual element in work with families with addiction problems. Approximately 3/4 of the projects analysed by the authors pursue a family-oriented approach. Other elements which the authors cited include group services and services for parents (for example open meetings, parent groups, individual counselling, case counselling, weekend seminars, crisis intervention and parent training courses. Moreover, public-relations work (this especially involves awareness of services on the part of people affected and experts), administration (planning of resources) and services within the framework of self-help for addicts (for example services for children while parents take part in group meetings or family seminars for parents and their children). With respect to the access avenues of parents to the different services, the authors note that the initiation of contact often is a very difficult step for the parents themselves to take. Feelings of embarrassment and shame with respect to their own behaviour, but also fear of losing their children pose barriers to parents taking the initiative in establishing contact. Reach-out work (actively approaching people, house visits or presence in low-threshold facilities) and referral through other actors in the help system are stated as strategies with which to reach parents who consume drugs (Arenz-Greiving & Kober 2007).

Projects: examples at the local, regional and national levels

The "Kidkit"¹⁶⁰ project is a low-threshold, Internet-based service for children from families with addiction problems. A key element in the project is the website. This is a cooperative project between the Association KOALA e.V. (Kinder ohne den schaedlichen Einfluss von Alkohol und anderen Drogen e.V.), Drogenhilfe Koeln e.V. and the German Institute for Research on Addiction and Prevention at the Catholic University, Cologne section. This project aims at informing children and adolescents who grow up in dysfunctional families and/or experience domestic violence on the topics of "addiction and family" and "violence and family" in a manner commensurate with their age through the Internet. The project also offers online counselling on these topics free of charge and anonymously. The website was set up within the framework of the project in 2002.

The national model project "Trampolin"¹⁶¹ is also a program which focuses on children from families with addiction problems. It seeks to strengthen children's self-image and ability to solve problems. For example, group work teaches participants strategies to cope with stress, removes taboos from the topic of "addiction" and informs people about drugs and alcohol. Programmes are offered to parents parallel to this. These aim at sensitizing parents to the needs of children and the effects of addiction on the children, at strengthening their abilities as parents and motivating them to make use of help. The project is supported by the German Centre for Addiction Problems of Children and Youth (Deutsches Zentrum fuer Suchtfragen des Kindes- und Jugendalters - DZSKJ) and the German Institute for Research on Addiction and Prevention (Deutsches Institut fuer Sucht- und Praeventionsforschung - DISuP) and

¹⁶⁰ www.kidkit.de

¹⁶¹ www.projekt-trampolin.de

reviewed by these to determine its effectiveness. The project is being carried out at sites in all 16 German *Laender*.

KiSEL¹⁶² (Kinder Suchtkranker Eltern – “Children of Parents with Addiction-Related Disorders”) is a project of the Drogen- und Jugendberatungsstelle Arbeitskreis Rauschmittel e.V. Loerrach which essentially focuses on children and adolescents from families with addiction problems, but also offers services to parents themselves. Services for parents include counselling on questions relating to child-raising, school or childcare centres. Moreover, the abilities of parents raising children are strengthened and feedback is obtained on the development of their children.

The project Lichtblick der Integrative Drogenhilfe e.V.¹⁶³ in Frankfurt is an ambulatory counselling and support service for parents with substance addictions and undergoing substitution. Lichtblick’s work is based on the realisation that it is in the interest of children to avoid removal of custody from the parents if possible. The immediate objective of Lichtblick is to minimise damage, while the long-term goal is to get the parents out of the drug scene. The primary goal, however, is the healthy physical and mental development of the children. Parents are offered counselling on child-raising questions and other family-related topics as well as practical aid in coping with everyday problems, although another goal is empowerment of the parents to do as much as possible themselves.

Early Intervention for Pregnant Women with Substance Addictions (Fruehintervention fuer suchtmittelabhaengige Schwangere - KIDS)¹⁶⁴ was initiated in 2007 as a joint project by the youth welfare office of the city of Kassel and Drogenhilfe Nordhessen e.V.. KIDS’ objective is to reach pregnant women with substance addictions as early as possible in pregnancy and to create the foundation for a close-knit, tailored planning of help between the soon-to-be mother, general social services (ASD) and KIDS, and to create the prerequisites for intensive individual support which is necessary to ensure a positive common future for mother and child through “KIDS”. Support services for parents consuming drugs include strengthening their ability to raise their children, referral to additional help and prevention of pre-natal damage to children and preventing children from turning to drugs by establishing a more stable emotional and social environment.

In Thuringia sabit e.V. has been carrying out the project “Jonathan-a project for the promotion of children and youth from families with addiction problems” (“Jonathan – Ein Projekt zur Foerderung von Kindern und Jugendlichen aus suchtblasteten Familien”)¹⁶⁵ in Erfurt since 2006. Campaigns and measures include inter alia leisure-time pedagogical assistance services for children with at least one parent with a substance addiction, but also stabilisation and strengthening of social skills as well as informing different age groups about specific topics relating to addiction problems. In some cases services are also provided for

¹⁶² www.kisel.de

¹⁶³ www.idh-frankfurt.de/index.php?option=com_content&task=view&id=36&Itemid=84

¹⁶⁴ www.drogenhilfe.com/case

¹⁶⁵ www.projekt-jonathan.de

parents – for example in the form of a fixed consultation day for parents, children and institutions, which has been offered since 2011.

The mission of the NZFH (see 0) includes the promotion and coordination of support of model projects by researchers and scholars in all of the German *Laender*. These model projects test measures and strategies to provide early support for families facing severe problems, such as for instance cooperation and networking of relevant actors in the field of Early Aid. Examples of model projects within the framework of NZFH which have a direct link to the topic of families with addiction problems include "family midwives in Saxony-Anhalt (Intervention)" and "family midwives in County Osnabruck (Intervention)". The strategy of family midwives is to offer support for families with severe problems and reduce the risk of infants and small children being hurt by their own parents. Willingness to accept this form of Early Aid is great.

12.3.3 Networks and cooperative ventures

Cooperation between public and non-public institutions involved

In work with families with addiction problems it is necessary to provide multi-professional assistance to families in order to offer support in various areas of life. Experts in addiction treatment have arrived at the opinion in a position paper that cooperative networks still need to be established or existing ones expanded (fdr 2009). Services on offer go beyond the area of addiction treatment, which is why the following are named inter alia as possible partners in regional cooperative networks: addiction counselling offices, AIDS-Hilfe, positions with various specialties (for example, family physicians, psychiatrists, paediatricians, gynaecologists), midwives, youth welfare offices, health offices, social-paediatric centres, early training offices, social offices, child-raising counselling offices, courts of law and additional offices. As described in chapter 12.2, cooperation structures are not yet regulated by binding laws and regulations; this is to be changed by the new Federal Child Protection Act¹⁶⁶.

Community cooperative agreements

One example for cooperation between different actors at the community level is the "Cooperation Agreement between institutions involved in assisting mothers/fathers/parents who consume drugs and their children to coordinate aid and assistance for these target groups within the municipality of Essen"¹⁶⁷. The 2002 agreement between drug treatment centres, youth welfare offices and clinics sets out joint objectives, with the aim being to make it possible for mothers/fathers/parents (including soon-to-be) who consume drugs to live together on a permanent basis and work constructively with the target group and lay down binding cooperation with the partners to the agreement in three areas. One specific example of cooperation on the basis of the Agreement is the "Helpers Conference". Depending on the

¹⁶⁶ www.fruehehilfen.de/projekte/modellprojekte-fruehe-hilfen/

¹⁶⁷ www.nacoa.de/images/stories/pdfs/kooperationsvereinbarung%20essen.pdf

individual case, experts from the eight areas and the people affected themselves regularly discuss the situation and their needs as well as health services and objectives¹⁶⁸.

The multi-institution Cooperation Agreement in Essen was the first of its kind in Germany. In the meantime there are comparable agreements at the community level in a large number of German cities. Thus, for example, in Mecklenburg-Western Pomerania there are now three functioning networks for children from families with addiction problems in Rostock, Greifswald and Wolgast. Coordination is in the hands of the Mecklenburg-Western Pomeranian Office for Addiction Issues¹⁶⁹.

In Hamburg there are two framework agreements on cooperation (“pregnancy – child – addiction” and “family – child – addiction”); the signatories wanted to underscore the need for cooperation between different professions and institutions. Actors from the areas of medical care, youth welfare and addiction treatment or the General Social Services (ASD) and addiction treatment jointly agree on standards in support of the persons affected through respective professional groups and their domains of responsibility. Standards for cooperation, for example with regard to initiating contact to offices in charge, exchange between experts and exchange of information, possible waiver of confidentiality obligations and the composition of lists of cooperation partners for particular cases, are elements of the framework agreements (BSG 2008; BSG 2010).

Cooperation structures in the area of Early Aid (Fruehe Hilfe)

A national stock-taking on forms of cooperation in the area of Early Aid (see chapter 12.2) has been carried out by the German Institute for Urban Studies (Deutsche Institut fuer Urbanistik). The cooperation structures cover approximately 50% of all youth and health offices in Germany (Landua et al. 2009). In particular, the number of offices with their own activities in the area of Early Aid is high among youth welfare offices, and networking with other professions has proceeded quite far. On the whole, the focal areas of Early Aid are, as described in the foregoing, strengthening the child-raising abilities of parents, although networking with drug-counselling offices also plays a role in the area of cooperation with other institutions (Landua et al. 2009).

In some cases, networks are also supported at the *Laender* level. Baden-Wuerttemberg, for example, provides financial support and 18 urban and rural counties are currently carrying out a programme entitled "Seal of Approval Network Early Aid and Protection of Children" („Guetesiegel Netzwerk Fruehe Hilfen und Kinderschutz“). Counties receive technical support in establishing and expanding a structure for improved cooperation between youth welfare offices and the health system and for improved Early Aid services.

12.3.4 Associations

Several examples of networks and associations which are active as actors in the field of "families with addiction problems" are provided in the following. They carry out projects,

¹⁶⁸ http://essen.de/de/Rathaus/Aemter/Ordner_50/Sucht/Sucht_Startseite_Abhaengigkeit_und_Sucht.html

¹⁶⁹ http://ismv.de/index.php?option=com_content&task=view&id=55&Itemid=31

perform information and public-relations work, help network facilities and experts or act as interest representatives. In particular, it is difficult to make a distinction between "illegal" and "legal" narcotic substances in connection with families with addiction problems.

"NACOA Deutschland - Interessenvertretung fuer Kinder aus Suchtfamilien e. V."¹⁷⁰ is an official partner organisation of the National Association for Children of Alcoholics (NACOA) in the United States. NACOA promotes the interests of children who are affected by alcoholism or other types of addiction disorders in their families. The most important tasks to be performed in the view of NACOA are to inform the public and remove taboos surrounding the topic of "children from families with addiction problems". The more general objective is to improve opportunities for children of parents with addiction disorders to receive help in order to improve their lives. The Association provides background information, facts and figures from studies and other sources as well as help services on its home page. NACOA offers information for staff working at youth welfare offices, for example recommendations on how to deal with families with addiction problems or it provides examples of community cooperation agreements with offices which work with families having addiction problems in target group-oriented parts of its website.

The "European Network for Children Affected by Risky Environments within the Family (ENCARE)"¹⁷¹ networks, informs and supports experts who work with children and young people from families with addiction problems. Primarily projects relating to the topic of "families with alcohol problems" are carried out in the network, which are for the most part funded by the Daphne Programme of DG Justice. The focus is by the same token, for example, on surveys of risky environments in which children live, violence in the family in connection with alcohol or recommendations for action and compendiums of good practice to limit damage and promote health.

12.3.5 Conferences and events

The Brandenburg Land Centre for Addiction Problems (Brandenburgische Landesstelle fuer Suchtfragen, BLS), AG Suchtpraevention Potsdam and AK Sucht/Erwachsene Potsdam staged a joint conference on the topic of children in families with addictions on 13 December 2010. Presentations addressed issues relating to support for families with addiction disorders and networking of youth welfare services and addiction offices as well as a presentation of the national project "Trampolin". The workshops addressed issues relating to networking and cooperation between actors and facilities in Potsdam und Brandenburg which work with families with addiction problems.¹⁷²

The "Action Week for Children from Families with Addictions" took place from 13 to 19 February 2011. The three associations "Kunst gegen Sucht" (Duesseldorf), "NACOA Deutschland" (Berlin) und "Such(t)- und Wendepunkt" (Hamburg) initiated the Action Week. This took place at the same time as the "Children of Alcoholics Week (COA Week)" was

¹⁷⁰ www.nacoa.de

¹⁷¹ www.encare.de

¹⁷² <http://www.spf.chillout-pdm.de/content/view/396/233/>

taking place in the United States and Great Britain and is carried out every year. The aim of the Action Week is to raise the awareness of the public and media for the situation of up to 2.65 million children who grow up in families with addiction problems in Germany. Events and campaigns are carried out throughout Germany at institutions, facilities, associations and initiatives from different social areas. Different types of activities are performed – for example, conferences, informational evenings, continuing education seminars or theatre and film presentations.¹⁷³

The Baden-Wuerttemberg Office for Addiction-Related Issues held its 31st conference on the topic of "Father-Mother-Child – Family Orientation in Addiction Treatment" on 23 May 2011. Presentations addressed the dimensions of families with addiction problems in Germany and the repercussions of addiction problems in families for the persons with addictions and family members as well as possible solutions and information on specific help services. The high number of children affected is being assigned too little attention at addiction-treatment facilities at present. On the other hand, in particular many children are in jeopardy in families whose father/mother/parents abuse alcohol or are dependent on it and cannot be reached at all by addiction treatment organisations and facilities at present, which is why the need for work with families and family members was emphasised. The conference also offered a host of projects and facilities the possibility to present their work and methods in dealing with families with addiction problems.¹⁷⁴

The German Centre for Addiction Research in Childhood and Adolescence (DZSKJ) staged a conference on the topic "When parents are addicted ... assistance for children from families with addiction problems on 9 September 2011."¹⁷⁵ The conference addressed the increased danger faced by children from families with drug addictions of developing an addiction-related disorder or another psychological disorder later. Experts from the fields of science and practice discussed the causes of the problematic development of such children, covering both genetic factors as well as internal family stress factors. The DZSKJ staged the conference to draw attention to the various problems faced by children in families with addiction disorders and provided an overview of the various aspects of the topic.

¹⁷³ <http://www.coa-aktionswoche.de/>

¹⁷⁴ <http://www.suchtfragen.de/landestagung/beitraege.html>

¹⁷⁵ <http://www.uke.de/zentren/suchtfragen-kinder-jugend/index.php>

PART C: BIBLIOGRAPHY AND ANNEXES

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13.2 Laws

- Betaeubungsmittelgesetz (BtMG) in der Fassung der Bekanntmachung vom 01.03.1994 (BGBl. I S. 358), zuletzt geaendert durch Artikel 1 der Verordnung vom 11. Mai 2011 (BGBl. I S. 821)
- Betaeubungsmittel-Verschreibungsverordnung (BtMVV) vom 20.01.1998 (BGBl. I S. 74, 80), zuletzt geaendert durch Artikel 2 der Verordnung vom 11.05.2011 (BGBl. I S. 821)
- Buergerliches Gesetzbuch (BGB) in der Fassung der Bekanntmachung vom 02.01.2002 (BGBl. I S. 42, 2909; 2003 I S. 738), zuletzt geaendert durch Artikel 1 des Gesetzes vom 27.07.2011 (BGBl. I S. 1600)
- Fahrerlaubnis-Verordnung (FeV) vom 13.12.2010 (BGBl. I S. 1980), zuletzt geaendert durch Artikel 1 der Verordnung vom 07.01.2011 (BGBl. I S. 3)
- Fuenfundzwanzigste Verordnung zur Aenderung betaeubungsmittelrechtlicher Vorschriften (25. BtMAendV) vom 11.05.2011 (BGBl. I S. 821)
- Gesetz ueber den Justizvollzug in Baden-Wuerttemberg (JVollzGB) vom 10.11.2009 (GBl. 2009, 545)
- Gesetz ueber den Vollzug der Freiheitsstrafe und der Sicherheitsverwahrung (Hamburgisches Strafvollzugsgesetz - HmbStVollzG) in der Fassung vom 14.07.2009 (HmbGVBl. 2009, S. 257)
- Gesetz ueber den Vollzug der Freiheitsstrafe, der Jugendstrafe und der Sicherheitsverwahrung (Bayerisches Strafvollzugsgesetz - BayStVollzG) vom 10.12.2007 (GVBl. S. 866, BayRS 312-2-1-J), zuletzt geaendert durch § 3 G zur Aend. des Bayerischen DatenschutzG, des PolizeiaufgabenG und des Bayerischen StrafvollzugsG vom 10.06.2008 (GVBl. S. 315)
- Gesetz zur diamorphingestuetzten Substitutionsbehandlung (BtMGuaAendG) vom 15.07.2009 (BGBl. I S. 1801)
- Gesetz zur Neuordnung des Arzneimittelmarktes in der gesetzlichen Krankenversicherung (Arzneimittelmarktneuordnungsgesetz – AMNOG) vom 22.12.2010 (BGBl. I S. 2262)
- Gesetz zur Verbesserung der Bekaempfung des Dopings im Sport in der Fassung vom 24.10.2007 (BGBl. I S. 2510)
- Grundgesetz (GG) fuer die Bundesrepublik Deutschland in der im Bundesgesetzblatt Teil III, Gliederungsnummer 100-1, veroeffentlichten bereinigten Fassung, zuletzt geaendert durch Artikel 1 des Gesetzes vom 21.07.2010 (BGBl. I S. 944)
- Hessisches Gesetz ueber den Vollzug der Freiheitsstrafe und der Sicherheitsverwahrung (HStVollzG) in der Fassung vom 28.06.2010 (GVBl. I S. 185)
- Infektionsschutzgesetz (IfSG) in der Fassung vom 20. Juli 2000 (BGBl. I S. 1045), zuletzt geaendert durch Artikel 2a des Gesetzes vom 17. Juli 2009 (BGBl. I S. 2091)
- Jugendgerichtsgesetz (JGG) in der Fassung der Bekanntmachung vom 11.12.1974 (BGBl. I S. 3427), zuletzt geaendert durch Artikel 3 Absatz 2 des Gesetzes vom 22.12.2010 (BGBl. I S. 2300)
- Niedersaechsisches Justizvollzugsgesetz (NJVollzG) in der Fassung vom 14.12.2007 (Nds. GVBl 2007, S. 720)
- Sozialgesetzbuch (SGB) Aechtes Buch (VIII) – Kinder- und Jugendhilfe (Artikel 1 des Gesetzes vom 26.06.1990, BGBl. I S. 1163) in der Fassung der Bekanntmachung vom

- 14.12.2006 (BGBl. I S. 3134), zuletzt geändert durch Artikel 2 des Gesetzes vom 29.06.2011 (BGBl. I S. 1306)
- Sozialgesetzbuch (SGB) Drittes Buch (III) – Arbeitsförderung (Artikel 1 des Gesetzes vom 24.03.1997, BGBl. I S. 594), zuletzt geändert durch Artikel 2 des Gesetzes vom 22.06.2011 (BGBl. I S. 1202)
- Sozialgesetzbuch (SGB) Fünftes Buch (V) – Gesetzliche Krankenversicherung – (Artikel 1 des Gesetzes vom 20.12.1988, BGBl. I S. 2477), zuletzt geändert durch Artikel 3 des Gesetzes vom 28.07.2011 (BGBl. I S. 1622)
- Sozialgesetzbuch (SGB) Zweites Buch (II) – Grundsicherung für Arbeitslose – (Artikel 1 des Gesetzes vom 24.12.2003, BGBl. I S. 2954) in der Fassung der Bekanntmachung vom 13.05.2011 (BGBl. I S. 850), geändert durch Artikel 3a des Gesetzes vom 20.06.2011 (BGBl. I S. 1114)
- Sozialgesetzbuch (SGB) Zwölftes Buch (XII)– Sozialhilfe (Artikel 1 des Gesetzes vom 27.12.2003, BGBl. I S. 3022), zuletzt geändert durch Artikel 3b des Gesetzes vom 20.06.2011 (BGBl. I S. 1114)
- Strafgesetzbuch (StGB) in der Fassung der Bekanntmachung vom 13.11.1998 (BGBl. I S. 3322), zuletzt geändert durch Artikel 4 des Gesetzes vom 23.06.2011 (BGBl. I S. 1266)
- Strafvollzugsgesetz (StVollzG) in der Fassung vom 16.03.1976 (BGBl. S. 581, 2088), zuletzt geändert durch Artikel 2 des Gesetzes vom 29.07.2009 (BGBl. I S. 2274)
- Straßenverkehrsgesetz (StVG) in der Fassung der Bekanntmachung vom 05.03.2003 (BGBl. I S. 310, 919), zuletzt geändert durch Artikel 2 des Gesetzes vom 12.07.2011 (BGBl. I S. 1378)
- Straßenverkehrs-Ordnung (StVO) vom 16.11.1970 (BGBl. I S. 1565), zuletzt geändert durch Artikel 1 der Verordnung vom 01.12.2010 (BGBl. I S. 1737)
- Verordnung zur Festlegung der nicht geringen Menge von Dopingmitteln (Dopingmittel-Mengen-Verordnungen - DmMV) in der Fassung vom 29.11.2010 (BGBl. I S. 1752)
- Vorgaben der Vollzugsgeschäftsordnung (VGO) vom 01.07.1965, AV d. JuM vom 09.12.1991 (1464-IV/179) (Die Justiz 1992 S. 41), zuletzt geändert durch AV d. JuM vom 15.11.1996 (1464-IV/179) (Die Justiz 1997 S. 6)

13.3 Websites

Apart from the websites of the most important bodies and organizations, the table contains a selection of some innovative initiatives carried out in the area of demand reduction. The list is an extract of the myriad of addresses that exist in this field.

Important institutions

Website	Content
www.bmg.bund.de	Bundesministerium fuer Gesundheit (BMG) Federal Ministry for Health
www.bzga.de	Bundeszentrale fuer gesundheitliche Aufklaerung (BZgA) Federal Centre for Health Education (FCHE)
www.dbdd.de	Deutsche Beobachtungsstelle fuer Drogen und Drogensucht (DBDD) German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction
www.dhs.de	Deutsche Hauptstelle fuer Suchtfragen (DHS) German Centre for Addiction Issues
www.drogenbeauftragte.de	Drogenbeauftragte der Bundesregierung Commissioner of the Federal Government on Narcotic Drugs
www.drugcom.de	BZgA Informationen fuer junge Leute und Partygaenger FCHE information for young people and party goers
www.drugscouts.de	Landesprojekt in Sachsen fuer junge Leute Land project in Saxony for young people
www.emcdda.europa.eu	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Europaeische Beobachtungsstelle fuer Drogen und Drogensucht (EBDD)
www.prevnet.de	Das Fachportal „PrevNet“ dient der Vernetzung zwischen den Beteiligten im Feld Praevention und erleichtert den Zugang zu vielen Informationen und Materialien “PrevNet“ serves as a network between persons involved in drug prevention and facilitates access to information and material
www.rki.de	Robert Koch-Institute (RKI), Berlin

Websites of research institutions

Further information on individual research projects, network structures and cooperation partners as well as research reports and literature references can be found at the websites of the research associations:

Website	Content
www.suchtforschungsverbund-nrw.de	Suchtforschungsverbund Nordrhein-Westfalen Addiction Research Association of North Rhine-Westphalia
www.medizin.uni-greifswald.de/epidem/forschung/intervention/earlint.html	Suchtforschungsverbund Nord-Ost ("Fruehintervention bei substanzbezogenen Stoerungen" (EARLINT)) Addiction Research Association North-East, "Early intervention on substance-related disorders" (EARLINT)
www.dg-sucht.de	Deutsche Gesellschaft fuer Sucht German Association for Addiction
www.heroinstudie.de	Deutsche Heroinstudie German Heroin Study
www.premos-studie.de	Premos-Studie Premos-Study
www.gesundheitsforschung-bmbf.de/de/137.php	Suchtforschung gefoerdert vom Bundesministerium fuer Bildung und Forschung Addiction research funded by the Ministry for Education and Research
www.uni-frankfurt.de/fb/fb04/forschung/cdr/index.html	Goethe Universitaet Frankfurt am Main Centre For Drug Research (CDR)
www.psychologie.tu-dresden.de	Technische Universitaet Dresden Institut fuer Klinische Psychologie und Psychotherapie Technical University Dresden Institute for Clinical Psychology and Psychotherapy
www.uke.de/zentren/suchtfragen-kinder-jugend/index.php	Universitaetsklinikum Hamburg Eppendorf Deutsches Zentrum fuer Suchtfragen des Kindes- und Jugendalters (DZSKJ) University Clinic Hamburg Eppendorf German Centre for Addiction Problems among Children and Adolescents
www.zis-hamburg.de	Zentrum fuer interdisziplinaere Suchtforschung Hamburg Centre for Interdisciplinary Addiction Research
www.zi-mannheim.de	Zentralinstitut fuer seelische Gesundheit Mannheim Central Institute for Mental Health Mannheim
www.fh-frankfurt.de/de/forschung_transfer/institute/isff.html	Institut fuer Suchtforschung der Fachhochschule Frankfurt/Main Institute for Addiction Research of the Technical College Frankfurt/Main

Website	Content
www.addiction.de	Kompetenzplattform Suchtforschung an der katholischen Fachhochschule NRW Competence Platform for Addiction Research at the Catholic University of Applied Sciences in North Rhine-Westphalia
www.suchtforschungsverbund.de	Suchtforschungsverbund an Fachhochschulen (SFFH) mit den Standorten Frankfurt/M., Koeln, Aachen und Mainz Addiction Research Association at Universities of Applied Sciences in Frankfurt/Main, Cologne, Aachen and Mainz
www.ift.de	Institut fuer Therapieforchung Muenchen Institute for Therapy Research Munich

Websites of other relevant institutions/working groups

Website	Content
www.fachstelle-faire.de	Fachstelle fuer Arbeitsmarktintegration und Reintegration Suchtkranker Department for Labour Market Integration and Reintegration of Addicts
www.indro-online.de	Institut zur Foerderung qualitativer Drogenforschung, akzeptierender Drogenarbeit und rationaler Drogenpolitik Muenster Institute for the Promotion of High Quality Drug Research, Addiction Work and Rational Drug Policy in Muenster
www.iss-ffm.de	Institut fuer Sozialarbeit und Sozialpaedagogik Frankfurt/M. Institute for Social Work and Social Education in Frankfurt/Main
www.500Fragen.de	Forum fuer Substitution und Recht mit dem Ziel, die rechtlichen Aspekte der Behandlung unter rein praktischen Gesichtspunkten aufzuarbeiten und den taeglich in der Substitution taetigen Therapeuten eine Hilfe an die Hand zu geben, damit sie sich in Kenntnis der Begebenheiten auf das reine therapeutische Verhaeltnis konzentrieren koennen Forum for substitution and law dealing with legal aspects of treatment from a practical point of view. Therapists working in substitution therapy receive valuable information on the legal situation that forms the background for their daily work
www.suchthh.de	Hamburgische Landesstelle fuer Suchtfragen e.V. Buero fuer Suchtpraevention Hamburg Land Centre for Addiction Problems Department for Addiction Prevention
www.gangway.de	Transit - Projekt fuer transkulturelle Suchtarbeit Transit – Project for transcultural addiction work

Cannabis-specific projects

Website	Content
www.dhs.de/projekte/abgeschlossene-projekte/cannabis.html	Projekt „AVerCa“, das sich den Aufbau einer effektiven Versorgungsstruktur zur Frueherkennung und Fruehintervention jugendlichen Cannabismissbrauchs zum Ziel gesetzt hat The goal of the project “AVerCa” is to set up an effective care service for the early detection and intervention in cannabis misuse among young people
www.candis-projekt.de/	Modulare Therapie von cannabisbedingten Stoerungen Modular therapy of cannabis-related disorders
www.canstop.med.uni-rostock.de	Gruppentraining „Can Stop“ wurde im Auftrag des BMG vom Deutschen Zentrum fuer Suchtfragen des Kindes- und Jugendalters (DZSKJ) entwickelt. Hierbei handelt es sich um ein manualisiertes Behandlungsprogramm fuer junge Menschen mit Cannabiskonsum. The group training programme “Can Stop” was developed on behalf of the German Ministry of Health by the German Centre for Addiction among Children and Young People (DZSKJ). “Can stop” is a manual treatment programme for young people with cannabis disorders.
www.quit-the-shit.net	Das Cannabisausstiegsprogramm „Quit the Shit“ ist seit 2004 online unter www.drugcom.de . nutzbar und richtet sich an Menschen mit regelmaeßigem Cannabiskonsum Available since 2004 at www.drugcom.de , the cannabis cessation programme “Quit the Shit” addresses people with regular cannabis use
www.incant.eu	International Cannabis Need of Treatment Study
www.realize-it.org	Beratungsobjekt bei Cannabiskonsum, durchgefuehrt in Deutschland und der Schweiz Counselling service for cannabis use, offered in Germany and Switzerland
www.be-u-online.de	Cannabiskampagne der Stadt Frankfurt Cannabis campaign of the city of Frankfurt

Party projects

Website	Content
www.partypack.de	Drogenhilfe Koeln e.V. Drug Aid Cologne
www.drugscouts.de	SZL Suchtzentrum gGmbH Leipzig Addiction Centre Leipzig
www.eve-rave.net	Verein zur Foerderung der Partykultur und Minderung der Drogenproblematik e.V. Berlin Association for the promotion of party culture and the reduction of drug problems in Berlin
www.party-project.de	Party Project e.V. Bremen

Website	Content
	Party Project in Bremen
www.chill-out.de	Chill-Out – Gemeinnuetziger Verein zur Foerderung der Kommunikationskultur e.V. Aachen chill-out – non-profit association for the promotion of communication culture in Aachen
www.alice-project.de	Alice Project - Frankfurt
www.drobs-hannover.de	Centre for young people with addiction problems / psychosocial counselling and treatment centre in Hannover

Safer Use/Harm Reduction

Website	Content
www.konsumraum.de	Informationsplattform fuer Personal in drogen-therapeutischen Ambulanzen und Konsumraeumen Information platform for staff working in drug therapeutic ambulatories and consumption rooms
www.spritzenautomaten.de	Deutsche AIDS-Hilfe e.V. – Projekt Spritzenautomaten JETZT German Aids Help Organisation AIDS-Hilfe – Project Syringe dispensing machines NOW
www.saferuse-nrw.de	Safer-Use-Seiten der AIDS-Hilfe NRW e.V. Safer use pages of the AIDS-Hilfe NRW

Drug-related health policy and health promotion in prison

Website	Content
www.wiad.de	Wissenschaftliches Institut der Aerzte Deutschlands gem. e.V. Scientific Institute of the German Medical Association
www.akzept.org	Bundesverband fuer akzeptierende Drogenarbeit und humane Drogenpolitik Federal association for accepting drug work and humane drug policy
www.gesundinhaft.eu	Forum zur Gesundheitsfoerderung in Haft Forum for health promotion in prison
www.aidshilfe.de	Deutsche AIDS-Hilfe German AIDS Help Organisation
www.who.int/topics/prisons/en	World Health Organization – Health Topics: Prisons
ec.europa.eu/health/ph_projects/2003/action3/action3_2003_07_en.htm	ENDIPP – European Network on Drugs and Infections Prevention in Prison
hpyp.eu	HPYP – Health Promotion for Young Prisoners

Drug users with children

Website	Content
www.projekt-jonathan.de	Projekt Jonathan – Betreuungsangebot in Erfurt, welches sich vor allem den Kindern und Jugendlichen aus suchtbelasteten Familien widmet Project Jonathan – assistance services offered in Erfurt especially to children and teenagers of addiction-stricken families
www.fruehehilfen.de/projekte/modellprojekte-fruehe-hilfen	Projekte auf Basis des Programms "Fruehe Hilfen fuer Eltern und Kinder und soziale Fruehwarnsysteme" Projects on the basis of the programme "Early Aids for parents and children and social early warning systems"
www.drogenhilfe.com/case	Fruehintervention fuer suchtmittelabhaengige Schwangere Early intervention in addicted pregnant females
www.nacoa.de	NACOA Deutschland - Interessenvertretung fuer Kinder aus Suchtfamilien e.V. NACOA Germany – National association for children of families with addiction problems
www.vistaberlin.de/index.php?id=58	WIGWAM Connect – Kompetente Begleitung in der Schwangerschaft und fruehen Elternzeit WIGWAM Connect – competent assistance during pregnancy and early parenthood
www.belladonna-essen.de	Drogenberatung fuer Maedchen und Frauen Drug counselling for girls and women
www.lilith-ev.de	Lilith e.V. – Zielgruppe u.a. Kinder von DrogenkonsumentInnen Lilith – target group among others children of drug users
ismv.de/index.php?option=com_content&task=view&id=55&Itemid=31	Netzwerke fuer Kinder aus suchtbelasteten Familien in Mecklenburg-Vorpommern Networks for children from families with addiction problems in Mecklenburg-Western Pomerania
www.encare.de	European Network for Children Affected by Risky Environments Within the Family
www.kidkit.de	KIDKIT – Hilfe fuer Kinder & Jugendliche KIDKIT – Help for children and teenagers
www.projekt-trampolin.de	Trampolin – Kinder aus suchtbelasteten Familien entdecken ihre Staerken Trampolin - children from families with addiction problems discover their strenghts
www.kisel.de	Kisel – Hilfe fuer Kinder und Jugendliche suchtkranker Eltern Kisel – Help for children and teenagers of addicted parents

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