



European Monitoring Centre  
for Drugs and Drug Addiction



Tim Pfeiffer-Gerschel & Ingo Kipke, IFT Institute for Therapy Research

Peter Lang & Peter Spahlinger, Federal Centre for Health Education

Gabriele Bartsch, German Centre for Addiction Issues

In cooperation with: Krystallia Karachaliou, IFT Institute for Therapy Research

## **2008 National Report to the EMCDDA by the REITOX National Focal Point**

# **Germany**

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

**Drug Situation 2007/2008**

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**Institute for Therapy Research (Institut für Therapieforschung, IFT) (Epidemiology and Coordination)**

Tim Pfeiffer-Gerschel (Dr. Dipl.-Psych., Head of the DBDD)

Kristallia Karachaliou

Ingo Kipke

Parzivalstr. 25

D - 80804 Munich

Tel.: +49 (0) 89 – 360804-40

Fax: +49 (0) 89 – 360804-49

Email: pfeiffer-gerschel@ift.de

**Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA) (Prevention)**

Peter Lang

Ostmerheimer Str. 220

D - 51109 Cologne

Tel.: +49 (0) 221-8992 - 364

Fax: +49 (0) 221-8992 - 300

Email: peter.lang@bzga.de

**German Centre for Addiction Issues (Deutsche Hauptstelle für Suchtfragen, DHS) (Therapy)**

Gabriele Bartsch

Westring 2

D - 59065 Hamm

Tel.: +49 (0) 2381-901521

Fax: +49 (0) 2381-901530

Email: bartsch@dhs.de

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

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## Table of contents

### Introduction

### Summary

<b>PART A: NEW DEVELOPMENTS AND TRENDS</b>	<b>1</b>
<b>1 NATIONAL POLICIES AND CONTEXT</b>	<b>1</b>
1.1 OVERVIEW	1
1.1.1 Political framework	1
1.1.2 Legal Framework	3
1.1.3 Objectives and focal points of national “drug and addiction policy“	4
1.1.4 Coordination	5
1.2 LEGAL ASPECTS	6
1.2.1 Laws	6
1.2.2 Laws implementation	7
1.3 INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES	8
1.3.1 Coordination	8
1.3.2 National plans and strategies	8
1.3.3 Implementation of policies and strategies	9
1.3.4 Effects of policies and strategies	19
1.4 BUDGETS AND PUBLIC EXPENDITURES	19
1.5 SOCIAL AND CULTURAL CONTEXT	22
<b>2 DRUG USE IN THE GENERAL POPULATION AND SPECIFIC SUB-GROUPS</b>	<b>25</b>
2.1 OVERVIEW	25
2.2 DRUG USE IN THE GENERAL POPULATION	27
2.2.1 Overview of the use of various drugs	27
2.2.2 Comparison of the consumption of individual drugs	28
2.3 DRUG USE IN SCHOOL AND IN THE YOUTH POPULATION	32
2.4 DRUG USE IN SPECIFIC GROUPS	41
<b>3 PREVENTION</b>	<b>45</b>
3.1 OVERVIEW	45
3.2 UNIVERSAL PREVENTION	48
3.2.1 School	49
3.2.2 Family	50
3.2.3 Community	51
3.2.4 Driving school	51
3.3 SELECTIVE / INDICATIVE PREVENTION	52
3.3.1 Organized leisure time	52
3.3.2 Non-organized leisure time	54
3.3.3 At-risk groups	54
3.3.4 At-risk families	58
3.4 INDICATIVE PREVENTION	60

---

<b>4</b>	<b>PROBLEM DRUG USE</b>	<b>63</b>
4.1	OVERVIEW	63
4.2	PREVALENCE AND INCIDENCE ESTIMATES	64
4.2.1	Estimate methods of the EMCDDA	64
4.2.2	Other approaches to collect data on problem drug use	66
4.3	PROFILES OF CLIENTS IN TREATMENT	67
4.3.1	Outpatient treatment	69
4.3.2	Inpatient treatment	75
4.3.3	Diagnostic data from other areas	78
<b>5</b>	<b>DRUG-RELATED TREATMENT</b>	<b>79</b>
5.1	OVERVIEW	79
5.2	TREATMENT SYSTEM	83
5.3	DRUG-FREE TREATMENT	85
5.4	PHARMACOLOGICALLY ASSISTED THERAPY	90
5.5	QUALITY ASSURANCE	94
5.6	RESEARCH	95
<b>6</b>	<b>HEALTH CORRELATES AND CONSEQUENCES</b>	<b>99</b>
6.1	OVERVIEW	99
6.2	DRUG-RELATED DEATHS AND MORTALITY OF DRUG-USERS	101
6.2.1	Drug-related deaths	101
6.2.2	Overall mortality and causes of death in drug users	107
6.3	DRUG-RELATED INFECTIOUS DISEASES	108
6.3.1	HIV	108
6.3.2	Viral hepatitis	110
6.3.3	Sexually transmissible diseases, Tbc and others	111
6.4	PSYCHIATRIC COMORBIDITY	112
6.5	OTHER DRUG-RELATED HEALTH CORRELATES AND HEALTH CONSEQUENCES	112
<b>7</b>	<b>RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES</b>	<b>115</b>
7.1	OVERVIEW	115
7.2	PREVENTION OF DRUG-RELATED DEATHS	115
7.3	PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES	116
7.4	INTERVENTIONS RELATED TO PSYCHIATRIC COMORBIDITY	118
7.5	INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES	119
<b>8</b>	<b>SOCIAL CORRELATES AND CONSEQUENCES</b>	<b>121</b>
8.1	OVERVIEW	121
8.2	SOCIAL EXCLUSION	121
8.3	DRUG-RELATED CRIME	124
8.3.1	Direct economic compulsive crimes	124
8.3.2	Trafficking crimes	124
8.3.3	Consumption-related offences	125
8.3.4	Drug-users who have come to the notice of police for the first time	126
8.3.5	Convictions under the Narcotics Act and custody sentences	127

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8.3.6	Drug use and road accidents	129
8.4	DRUG USE IN PRISON	130
8.5	SOCIAL COSTS	132
<b>9</b>	<b>RESPONSES TO SOCIAL CORRELATES AND CONSEQUENCES</b>	<b>133</b>
9.1	OVERVIEW	133
9.2	SOCIAL REINTEGRATION	133
9.2.1	General changes to the legal framework conditions and their impact on people with substance-related problems	133
9.2.2	Housing	134
9.2.3	Education and training	134
9.2.4	Employment	134
9.2.5	Social assistance and welfare benefits	136
9.3	PREVENTION OF DRUG-RELATED CRIME	136
9.3.1	Assistance to drug users in prison	136
9.3.2	Other interventions to prevent drug-related crime	138
<b>10</b>	<b>DRUG MARKETS</b>	<b>139</b>
10.1	OVERVIEW	139
10.2	AVAILABILITY AND SUPPLY	140
10.2.1	Availability	140
10.2.2	Production, distribution sources and supply	140
10.3	SEIZURES OF NARCOTIC DRUGS	142
10.4	PRICE AND PURITY OF DRUGS	145
10.4.1	Price	145
10.4.2	Purity	145
	<b>PART B: SELECTED ISSUE</b>	<b>151</b>
<b>11</b>	<b>SENTENCING STATISTICS</b>	<b>151</b>
11.1	SUMMARY	151
11.2	OPTIONS AVAILABLE IN THE COUNTRY	151
11.2.1	Legislative framework	151
11.2.2	Types of response at the police stage	154
11.2.3	Types of response at the prosecution stage	156
11.2.4	Types of response at the court stage	158
11.3	DATA COLLECTION SYSTEMS	159
11.3.1	Data collection system at the police stage	160
11.3.2	Data collection system at the prosecution stage	162
11.3.3	Data collection system at the court stage	162
11.4	DATA COLLECTED	163
11.5	RESULTS AVAILABLE	164

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<b>PART C: BIBLIOGRAPHY AND ANNEXES</b>	<b>171</b>
<b>12 BIBLIOGRAPHY</b>	<b>171</b>
12.1 LITERATURE ON THE REPORT	171
12.2 WEBSITES	185
<b>PART D: LISTS OF TABLES AND FIGURES</b>	<b>189</b>
<b>13 TABLES</b>	<b>189</b>
<b>14 FIGURES</b>	<b>191</b>

## ABBREVIATIONS

Abbreviation	German	English
AMG	Arzneimittelgesetz	Medical preparations act
BÄK	Bundesärztekammer	German Medical Association
BfArM	Bundesinstitut für Arzneimittel und Medizinprodukte	Federal Centre for Drugs and Medical Devices
BMI	Bundesministerium des Inneren	Federal Ministry of the Interior
BMJ	Bundesministerium der Justiz	Federal Ministry of Justice
BMG	Bundesministerium für Gesundheit	Federal Ministry for Health
BtM	Betäubungsmittel	Narcotic drugs
BtM-ÄndV	Betäubungsmittelrechts-Änderungsverordnung	Amending regulation on narcotic law
BtMG	Betäubungsmittelgesetz	Narcotics Act
BtMG-ÄndG	Gesetz zur Änderung des Betäubungsmittelgesetzes	Amending Narcotics Act
BtMVV	Betäubungsmittelveränderungsverordnung	Amending regulation on narcotic drugs
BUB-Richtlinien	Richtlinien über die Bewertung von ärztlichen Untersuchungs- und Behandlungsmethoden	Guidelines on the evaluation of medical examination and treatment methods
BZgA	Bundeszentrale für gesundheitliche Aufklärung	Federal Centre for Health Education
DBDD	Deutsche Referenzstelle für die Europäische Beobachtungsstelle für Drogen und Drogensucht	German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction
DGVS	Deutsche Gesellschaft für Verdauungs- und Stoffwechselkrankheiten	German Society for Digestive and metabolic diseases
DHS	Deutsche Hauptstelle für Suchtfragen	German Centre for Addiction Issues
DND	Drogennotdienst	Drug Emergency Service
DRV Bund	Deutsche Rentenversicherung Bund	German National Statutory Pension Insurance
EBDD	Europäische Beobachtungsstelle für Drogen und Drogensucht	EMCDDA - European Monitoring Centre for Drugs and Drug Addiction
ECDP		European Cities on Drug Policy
EDDRA	Austausch über Aktivitäten zur Reduzierung der Drogennachfrage	Exchange on Drug Demand Reduction Action
ESA	Europäische Suchtstudie (früher Bundesstudie)	Epidemiological Survey on Addiction
EU	Europäische Union	European Union
G-BA	Gemeinsamer Bundesausschuss	Common Federal Committee
GKV	Gesetzliche Krankenversicherung	Statutory Health Insurance Scheme
GRV	Gesetzliche Rentenversicherungen	Statutory Social and Pension Insurances
HAART		Highly Activating Antiretroviral Treatment
HBV	Hepatitis B Virus	Hepatitis B Virus
HCV	Hepatitis C Virus	Hepatitis C Virus
IFT	Institut für Therapieforschung	Institute of Therapy Research
IVU	Intravenös applizierender Drogenkonsument	IDU – Injecting drug user
KJHG	Kinder- und Jugendhilfegesetz	Law on children and youth welfare
LAAM	Levoalphaacetylmethadol	Levomethadyl acetate hydrochloride
MoSyD	Frankfurter Monitoring System Drogen	Frankfurt Monitoring System Drugs
NGO	Nicht-staatliche Organisation	Non-governmental organization
REITOX	Europäisches Informationsnetzwerk zu Drogen und Sucht	European Information Network on Drugs and Addiction
RKI	Robert Koch Institut	Robert Koch Institute
SGB	Sozialgesetzbuch	Social Codes
StBA	Statistisches Bundesamt (DESTATIS)	Federal Statistics Office

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## ABBREVIATIONS

StGB	Strafgesetzbuch	Penal Code
THC	Tetrahydrocannabinol	Tetrahydrocannabinol
UN	Vereinte Nationen	United Nations
WHO	Weltgesundheitsorganisation	World Health Organization
ZI	Zentrales Institut der Kassenärztlichen Versorgungen	Central Institute of SHI-accredited care services

<b>Abbre- viation</b>	<b>Bundesland</b>	<b>Land</b>
BW	Baden-Württemberg	Baden-Württemberg
BY	Bayern	Bavaria
BE	Berlin	Berlin
BB	Brandenburg	Brandenburg
HB	Bremen	Bremen
HH	Hamburg	Hamburg
HE	Hessen	Hesse
MV	Mecklenburg-Vorpommern	Mecklenburg-Western Pomerania
NI	Niedersachsen	Lower Saxony
NW	Nordrhein-Westfalen	North Rhine-Westphalia
RP	Rheinland-Pfalz	Rhineland-Palatinate
SL	Saarland	Saarland
SN	Sachsen	Saxony
AT	Sachsen-Anhalt	Saxony-Anhalt
SH	Schleswig-Holstein	Schleswig-Holstein
TH	Thüringen	Thuringia

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## Introduction

The German REITOX-Report 2007/2008 has been written in accordance with the guidelines issued by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) taking into account the quality report's feedback on previous reports.

Each chapter of the report has an introductory passage presenting the most important and up-dated background information – e.g. on the structure of the health care system or the available data sources used for surveys of drug use in the population. These parts describe the most important fundamentals and have only been revised according to requirements. The introductory passages are to help to see the up-dated information on the drug situation in context and comprehend it without having to resort to supplementary literature.

The other sections of the individual chapters provide exclusively new data and results found for 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 which contain a multitude of information. They are electronically available over the statistical bulletin released by the EMCDDA, but can, of course, also be electronically supplied by the German Reitox Reference Centre (Deutsche Referenzstelle für die Europäische Beobachtungsstelle für Drogen und Drogensucht, DBDD) on request.

More information on the national report can be found at [www.dbdd.de](http://www.dbdd.de) and on the European Report at [www.emcdda.europa.eu](http://www.emcdda.europa.eu).

On behalf of the German Reitox Reference Centre I would like to thank all experts who have supported us through their work and provided us again with a host of valuable information in the reporting year for their cooperation. It is only thanks to this extensive network that cross-sectional reporting within the framework of the Reitox-Report is made possible.

Tim Pfeiffer-Gerschel

Head of the DBDD

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## 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 between the German Reference Centre (DBDD), the Institute for Therapy Research (IFT), the Federal Centre for Health Education (BZgA) and the German Centre for Addiction Issues (DHS). The German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction is funded by the Federal Ministry for Health and Social Affairs and the EMCDDA. The overall report is structured according to EMCDDA guidelines and is available for download at [www.dbdd.de](http://www.dbdd.de).

### National policy in context

Isolated “drug“ concepts have meanwhile been replaced by a cross-substance “addiction<sup>1</sup>“ policy which increasingly sets the focus on common aspects of the whole range of psychotropic substances. The current “Action Plan for Fighting Drugs and Addiction” is the mainstay of the overall policy concept in which various activities are embedded. The national “Board on Drugs and Addiction“ which is to accompany and evaluate the goals and measures laid down in the action plan, introduced its work programme in September 2005. The programme focuses on reducing smoking and alcohol consumption among teenagers as well as on bringing down experimental and regular use of cannabis. In the field of illicit substances, national policy-making continued in the reporting year to focus on the improvement of care offers for persons with cannabis problems, the research of the effects of abusive cannabis use as well as the initiation of further research work on the long-term results of substitution treatment.

### Drug use: prevalence

The results of the last epidemiological survey on substance abuse (ESA) carried out in 2006 corroborate the findings of earlier surveys, showing that about a quarter of the adult population in Germany has had experience with drugs. The portion of adults who took drugs in the last 12 months fell to 5%; only about 3% used drugs in the last 30 days. Prevalences among teenagers and young adults continue to be higher, but have also decreased compared to studies of previous years. Only 13% of the 14- to 17-year-olds stated in a representative national survey carried out in 2007 to have smoked cannabis at least once in their lifetime compared to 22% in 2004. According to the most recent results, cannabis consumption among teenagers in the age group from 11 to 17 years lies below 10% in the 12-month-category. Unchanged however appears to be the portion of young adults who regularly use cannabis. A recent survey carried out in 2007/2008 at schools in Hamburg

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<sup>1</sup> The term “addiction“ no longer refers to a narrow target group, but comprises risky, harmful and addictive consumption.

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(“Hamburger Schulbus“), provides indications of a marked decline in the consumption of narcotic drugs (mainly cannabis among the illicit substances) by adolescents. Recent findings of a survey carried out at schools within the framework of the “Frankfurt Drug Monitoring System (MoSyD)“ also show a repeated decline in the reported lifetime-prevalences of cannabis consumption following the continually declining trend since 2002. In 2007, the results of European School Survey Project on Alcohol and Other Drugs (ESPAD) were presented. 28% of the school children reported in the survey to have tried any illicit drug (cannabis, amphetamine, ecstasy, LSD, cocaine, crack or heroin) in their lifetime. From 2003 to 2007, lifetime-prevalences for cannabis consumption fell from 31% to 25% among the students interviewed within the framework of ESPAD; the 12-month-prevalence dropped from 25% to 17% and the 30-day-prevalence from 14% to 8%. The lifetime-prevalence for the consumption of illicit drugs (apart from cannabis) however, has hardly changed since 2003 (10.0% vs. 10.2%).

## **Prevention**

The guidelines spelled out by the EU-drug strategy 2005-2012 for supply and demand reduction continue to be implemented with resolution in Germany. In this, priority is given to health protection and prevention. Alongside measures of behavioural prevention, a series of structural approaches (measures of condition prevention) (Piontek et al. 2007) for example in tobacco prevention (coming into effect of the non-smoker-protection-act at national and regional level, raising the age limit for smoking in the public and the sale of tobacco products) were successfully realized in particular in the field of licit addictive substances in 2007. In addition to addiction prevention projects carried out in the field of licit and illicit drugs, also measures targeting behavioural addictions have been developed and put into practice. The fight against “pathological gambling<sup>2</sup>“ in particular, was continued in 2007.

In order to guarantee quality and target orientation of preventive measures, documentation and evaluation – often based on computer- or Internet-assisted documentation systems – assume an important role.

Schools are still the most important setting for addiction prevention in Germany. In addition to prevention projects with the general population as target group, there have been increasing efforts undertaken to develop and realize measures for specific risk groups like for example “children from families with addiction problems“ or “adolescents with (problem) cannabis use“. Using strategies of early recognition and early intervention, young people are taught to critically deal with psychoactive substances (risk competence). A large number of preventive measures are addressed to multipliers.

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<sup>2</sup> 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.

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## **Problem drugs use: extent and treatment**

Based on the figures from treatment, police contacts and records of drug-related fatalities, estimates venturing the prevalence of problem (i.e. risky, harmful or dependent) drug use make the number of problematic users of heroin range between 82,000 and 162,000 persons (0.2-0.3%) in the age group 15-64 years. For problem use in a broader sense, the following figures were found: "regular consumption" of cannabis in the 18-19-year-olds: 4.3%, in the 14-17-year-olds 2.3%. The portion of regular users among young males is with 7% markedly higher than among young females (about 2%). In a young age group of students (14-18 years) in Hamburg "risky consumption" of cannabis was found in 4.0% of the interviewees. The portion of this group of persons has thus been on a continual decline in the surveys carried out since 2004.

About half (49.6%) of the clients who seek help from outpatient drug counselling facilities in connection with illicit drugs, have primary opiate-related problems; about a third (32.5%) suffer primarily from cannabis-related disorders. Cannabis-related cases account for 51.2% (opiates: 27.7%) of the first-time clients in addiction treatment. Opiates continue to play a predominant role in the category of illicit drugs in the inpatient setting. But the number of cannabis-related cases is on the rise here as well.

## **Health correlates and consequences of drug use**

1,394 people died of drugs in Germany in 2007. With this, the number of drug-related deaths has been up on the previous year for the first time since the year 2000. However, compared to the last peak of 2,030 death-cases in 2000, this figure is still down by more than 30%. The deaths were mostly caused by opiates which were frequently used in combination with other psychotropic substances including alcohol.

## **Social correlates and consequences of drug use**

In the year 2007, about 171,000 offences in connection with drug use (excluding drug dealing) were recorded. This corresponds to a repeated decrease (-4.1%) relative to the previous year, which can be explained by the declining figures found for cannabis (-7.0%), heroin (-2.0%) ecstasy (-2.9%), cocaine (-6.0%) and other drug offences (-5.1%). Only amphetamine-related offences (+11.7%) increased in the same period of time.

Unemployment, low education and low income are still commonly found problems among drug users. Special measures undertaken by social security agencies and offers made by the second labour market are geared to tackle these problems, which play a decisive role for the outcome of the therapy, but which are hard to solve under current labour market conditions.

## **Drug market**

There was little change in the development of drug prices between 2006 and 2007. The wholesale price for marijuana markedly dropped relative to the previous year, while at street level the decrease was only marginal. After a slight increase in the previous year, the price for heroin fell by about 3% below the price of the previous year at street level. This

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development is in contrast with the increase in heroin prices at wholesale level by 9%. Street prices for amphetamines and cannabis resin (which had slightly gone up from 2005 to 2006), slightly decreased in comparison with 2006. While in 2007 the wholesale price for cocaine was somewhat below the one of the previous year, the price increased at street level by 7%.

Despite some variations, the level of active substance in amphetamines has been on a continual decline since 1997 similar to street cocaine whose level of active substance was above the one of the year 2006, but reached the second lowest value since 1997. The concentration of active ingredient of heroin markedly increased in 2007 both at wholesale and street level compared to 2006. As in the previous year, the mean THC-content of cannabis resin and marijuana declined again between 2006 and 2007. The mean THC-content of marijuana did increase from 2006 to 2007, but still ranged clearly below the values found between 2003 and 2005. Since 2006 all participating laboratories have been reporting their data differentiating between cannabis leaves and flowering tops which have a higher concentration of active substance. In 2007, the content of active substances found in the flowering tops was with 10.0% somewhat lower than in 2006.

### **Selected issue: Sentencing statistics**

The Narcotics Act (Betäubungsmittelgesetz, hereinafter BtMG), the basic legal instrument regulating the institutional response to drug related offences in Germany, foresees a variety of sanctions according to the severity and the type of the act ranging from administrative fines to custodial sentences. Mere consumption of substances, which fall under the narcotics act, is not subject to sanctions following the principle of the German criminal law, which states impunity for self-injury. Moreover, the German law following the principle “treatment instead of punishment” (Therapie statt Strafe) allows for a deferment of the punishment if the (drug addict) offender undergoes treatment instead of imprisonment.

The main data sources regarding drug criminality and the respective responses are the Police Criminal Statistics (Polizeiliche Kriminalstatistik, PKS) and the nationwide data network Drugs Data File (Falldatei Rauschgift, FDR), as well as the Criminal Prosecution Statistics of Justice. All aforementioned data sources refer to federal and federal state (Länder) level. There seems to be a variety of data available referring to the various stages of the justice system, nonetheless there is a lack of connection between the different statistics. The main obstacles in sequencing and comparative analysis are the different procedures of data recording and classification (i.e., different variables), as well as the differentiation in the level of the detail provided (Paoli 2008). By way of illustration, the police statistics provide information also on the substance type, whereas the prosecution statistics do not.

## **PART A: NEW DEVELOPMENTS AND TRENDS**

### **1 National Policies and Context**

#### **1.1 Overview**

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 which were at the centre of the political interest. There was no comparable conception for an alcohol or tobacco policy nor for an ‘addiction<sup>3</sup>policy’, comprising the whole range of addictive substances. For 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 addictions<sup>4</sup> (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 (unsatisfactory) 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.

##### **1.1.1 Political framework**

#### **Responsibilities of the Federal Government and the Länder**

The Federal Government and the Länder 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

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<sup>3</sup> The term “addiction” no longer refers to a narrow target group, but comprises risky, harmful and addictive consumption.

<sup>4</sup> 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.

welfare law. On this basis, it has defined a legal framework for its drug policy and has formulated specific standards. However, the execution of these federal laws mainly falls under the responsibility of the Länder. In addition, the Länder 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 Länder 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 Länder are working on shifting competences especially with regard to counselling, care and general prevention activities to the municipalities (z.B. Hessisches Sozialministerium, 2006), 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, Länder- 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 (SGB VIII).

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

## 1.1.2 Legal Framework

### Narcotics Act

The Narcotics Act (BtMG) contains all important regulations on as how to deal with these substances taking into account the respective UN-conventions on addictive substances. Substances which 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 prescription (e.g. MDMA, heroin, cannabis).
- Schedule II: narcotics eligible for trade but not for medical prescription (e.g. Delta-9-tetrahydrocannabinol (THC), dexamphetamine).
- Schedule III: narcotics eligible for trade and medical prescription (e.g. amphetamines, codeine, dihydrocodeine, cocaine, methadone, LAAM, morphine and opium).

The prescription of narcotics (schedule III) as part of a medical therapy is subject to the special regulations on the prescription of narcotic drugs (BtMVV) 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 in which the possible legal consequences of the consumption of psychoactive substances are defined, 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,
- the 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,
- the Criminal Code (Strafgesetzbuch, StGB), which also goes into the consequences of the consumption of alcohol and other intoxicating substances in road traffic and
- the 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.

### 1.1.3 Objectives and focal points of national “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 cornerstones:

- 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 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, continues to set the framework for current addiction policy. More details can be found in the REITOX report 2004.

From the second half of last year onwards, drug/addiction-related issues have been picked up in a comprehensive and intense debate focusing on the protection of non-smokers. Both at federal and Land level, acts were passed to protect non-smokers and the age limit for the sale of tobacco goods was raised from 16 to 18 years on 1<sup>st</sup> September 2007. Alcohol prevention - in particular amongst youth - (e.g. the nationwide project “Hart am Limit – HaLt“)

and the nationwide action week on the topic of alcohol staging over 2,000 events (with the motto: alcohol – responsibility sets the limit) were important areas of concentration in 2007. In addition, the continuation of heroin-assisted therapy remained a topic for discussion. Increased attention continued to be given to non-substance-related forms of addiction (especially pathological gambling).

#### **1.1.4 Coordination**

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 are 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 Länder. However, the Länder 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 5.5). Therefore, a multitude of different approaches and methods or instruments are currently used in the individual Länder and municipalities. Furthermore, large differences with regard to the availability of resources are to be found between the Länder.

Coordination between the Federal Government and the Länder takes place in the conferences of government departments and their working groups. The new national Board on Drugs and Addiction (Drogen- und Suchtrat, DSR) as well as its steering group play also an important role in this field. As part of the steering group the working group ‘German Annual Statistical Report on Addiction Therapy’ 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 helps for addicted people from treatment to work, from prison to treatment within and outside of prison walls or, generally to improve early-intervention in counselling and treatment of people suffering from addiction. In addition, Länder and Federal Government also cooperate in various projects.

On a national level, the Federal Centre for Health Education (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 Pharmaceutics and Medical Devices (BfArM) is responsible for the admission of pharmaceuticals. Affiliated with the BfArM is the Federal Opium Monitoring Centre which monitors the quantity of delivered narcotics and has been keeping the National Substitution Register since its inception in 2003.

## 1.2 Legal Aspects

### 1.2.1 Laws

The following presentation is solely devoted to legal changes undertaken in the reporting year.

#### **Act on the introduction of the prohibition of the consumption of alcoholic beverages for novice drivers (FAAlkVerbotG)**

Entered into effect as of 1<sup>st</sup> August 2007, the act on the introduction of the prohibition of the consumption of alcoholic beverages for novice drivers who are under the age of 21 years or who are still in the trial period represents a legal measure undertaken to promote abstinence in road traffic and to reduce alcohol-related road accidents. Offences can carry fines up to 1,000 Euro and can be punished by an entry of two points in the Central Register for Traffic Offenders. Offences committed by driving novices who are still in the trial period can also lead to a prolongation of the trial period by 2 years and an order to follow a continuation course entailing costs up to Euro 200.

#### **The Narcotics Act**

With the 21<sup>st</sup> Amending Regulation on Narcotic Drugs (21. BtMÄndV) changes have been made to the schedules of the Narcotics Act (BtMG) entering into effect as of 1 March 2008 ([www.gesetze-im-internet.de](http://www.gesetze-im-internet.de)). In schedule I (narcotics not eligible for trade) salvia divinorum (Aztec sage/magic mint) has been newly entered. The plant contains some of the most potent psychoactive substances known in the vegetable kingdom (diterpenes). Its consumption can lead to severe disturbances of consciousness, psychoses and other health disorders. Based on the assessment report of the scientific committee of the EMCDDA, benzylpiperazine (BZP) was put on the list of controlled substances. Oripavin was placed under the Narcotics Act following a recommendation (binding under international law) made by the Commission on Narcotic Drugs of the United Nations. The substance meta-chlorphenylpiperazin (m-CPP) which had already been temporarily put on the list of controlled substances by the 20<sup>th</sup> amending regulation, has been permanently entered into schedule II. Oxymorphon has been moved from schedule I to schedule II (narcotics eligible for trade, but not for medical prescription) in order to make it available for industrial use.

The substances amfetaminil, butobarbital, cyclobarbital, fencamfamin, mazindol, mefenorex, meprobamat, metamfetamin, methaqualon, methyprylon, phenmetrazin, secbutabarbital and vinylbital have been moved from schedule III (narcotic substances eligible for medical prescription) to schedule II since there have been no licences issued any more in Germany for pharmaceuticals containing these substances and because its therapeutic use is not justifiable any more due to a negative benefit-risk-assessment within the German risk management procedure and its misuse potential. With the removal of modafinil from schedule III the substance does not fall any more under the Narcotics Act (BtMG ) since its dependence potential is rated as low ([www.bfarm.de](http://www.bfarm.de)).

### **Legal aspects of heroin prescription**

No final decision has been taken yet on the assessment of the results yielded by the demonstration project and the continuance of the diamorphine-assisted therapy in Germany. On 19 September 2007, a public hearing of the health committee of the German Bundestag (lower house of the German Federal Parliament) took place on the bill to amend the Narcotics Act and other regulations. Some Federal States have meanwhile also introduced a bill with the Bundesrat (upper house of the German Federal Parliament) on the diamorphine-assisted substitution treatment (Bundesratsdrucksache 434/07). On 21 September, the Bundesrat decided in a clear majority vote to table a corresponding initiative over the Federal Government in the German Bundestag. The Federal Government decided on 21 November 2007 to issue a statement on this matter, in which it is assumed that various questions will be looked into more deeply during the parliamentary debate on the bill. It is however still not clear when this bill will be debated in the Bundestag.

### **Penal Code (placement under a hospital order)**

In connection with the diverging practices applied by the Länder with respect to the placement of offenders in psychiatric hospitals or withdrawal clinics, Heinz (2007) points to the fact that the number of hospital orders issued by criminal courts has markedly increased in recent years (in particular placements in respect of § 64 StGB, i.e. placements in institutions for curing alcoholics and drug addicts). In 2005, an order under § 64 StGB was imposed in 0.6% of the persons convicted for offences committed against the Narcotics Act (by way of comparison, an order in respect of § 63 StGB, placement in a psychiatric hospital, was only imposed in 0.005%). There are considerable divergences to be found between the Länder both with regard to the number of hospital orders imposed and the number of convicted offenders treated under a placement order. These differences may not be explained by the type of offences committed nor by offender profiles but are interpreted by Heinz as a consequence of diverging regional sanctioning practices.

#### **1.2.2 Laws implementation**

The Federal High Court of Justice (BGH) rendered a ruling in April 2007 defining the “non-small amount“ for buprenorphine. With that, the Federal High Court of Justice adds another ruling to the series of basic rulings on “non-small amounts“ in which it deals for the first time with a substance used in substitution therapy which 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.

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 Länder have regulated details of the application of § 31a BtMG through recommendations or guidelines. However, these regulations still diverge in crucial points (cf. Schäfer & Paoli 2006).

In the meantime, most of the Länder have introduced comparable threshold values for “small amounts“ (upper/lower limit) for cannabis. The limits set by the individual Länder 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).

Further information on legal practice and prosecution can be found in the chapter selected issue “Sentencing Statistics” from page 155 onwards.

### **1.3 Institutional framework, strategies and policies**

#### **1.3.1 Coordination**

Cooperation between the different players in the fields of health care, drugs and addiction, is supported by a host of information offers. In cooperation with the Land Commissioners for the Prevention of Addictions, the BZgA has created a national platform called “Prevnet“ enabling the exchange of information and opinion on prevention between experts and institutions. Currently, the expert network is used by 850 members from 560 facilities. More than 350 projects and materials as well as over 80 studies can be found on the portal. In PrevNet’s interactive area more than 60 (cross-Land) internet working groups have been set up by numerous experts. As part of a network extension, it is planned for 2008 to implement a comprehensive e-learning area to train PrevNet-members.

#### **1.3.2 National plans and strategies**

The yearly Drug and Addiction Report was presented to the public by the Federal Government Commissioner on Narcotic Drugs in May 2008. As one of its continued central tasks it lists the improvement of the protection of non-smokers through regulations for a better protection against the dangers of passive smoking both at federal government and regional level. According to its legislative responsibility conferred by the German Basic Law (Grundgesetz), the Federal Government passed a law in 2007 on the protection of non-smokers at federal level which prohibits smoking in all public federal government buildings and in public transport. At the same time, the age limit for smoking in public places and the sale of tobacco goods to adolescents was raised from 16 to 18 years. With the introduction of an age-verifying chip card system at all cigarette vending machines in Germany, it was attempted to prevent the sale of cigarettes to adolescents under the age of 16 years. The Act entered into force on 1 September 2007. Manufactures of cigarette vending machines were granted a transition period to retrofit their machines until 01.01.2009. The Länder likewise

passed laws on the protection of non-smokers at Land-level in the course of the year 2007. However, with the laws passed by the Länder diverging in some points, there is currently no uniform legal practice across the board. Problems are also caused by the different special regulations granted by the individual Federal Länder to the catering business. In most of the Länder, restaurant owners were granted the possibility to provide separate rooms for smokers. The competitive distortions resulting therefrom led to a judgement rendered by the Federal Constitutional Court in summer 2008 which requires the revision of some laws passed by the Länder entailing some transitional regulations.

The action week “Alcohol – responsibility sets the limit“ was reported on by the last year’s REITOX-report.

In the area of abuse of and dependence on medical drugs, initiatives have been undertaken to improve the possibilities of doctors and chemists and especially also patients to better inform themselves. In January 2008, the expert committee on narcotics advocated the inclusion of conditions for the license of benzodiazepine. Expert circles and users receive target-oriented information including information on the addiction potential based on these recommendations.

With regard to help offers and prevention activities undertaken in the field of illicit drugs, the Federal Ministry for Health and the Federal Government Commissioner on Narcotic Drugs started a cooperation between the BMG and a known early-evening TV-series which did not only include expert support for the makers of the TV-programme in presenting a drug story but also offered the opportunity to advertise the national addiction and drug hotline ([www.sucht-und-drogen-hotline.de](http://www.sucht-und-drogen-hotline.de)) free of charge in front of a broad TV audience.

In summer 2008, the National Board on Drugs and Addiction (Drogen- und Suchtrat, DSR) passed recommendations for the draft of national action programmes aiming at alcohol and tobacco prevention. In these recommendations, the Board made suggestions to the Federal Government Commissioner on Narcotic Drugs on numerous preventive and structural measures to further curb tobacco consumption and promote responsible and cautious consumption of alcohol. The recommendations form a basis for the further coordination of necessary measures to be undertaken within the Federal Government and are currently under close examination. Additional expert hearings are planned for autumn 2008 to engage in an expert discussion involving all interest groups (Die Drogenbeauftragte der Bundesregierung 2008).

The framework for the current drug and addiction policy is set by the Action Plan for fighting Drugs and Addiction passed in the year 2003. The national Board on Drugs and Addiction (see 1.3.3) is the most important body to support and steer the implementation of the plan.

### **1.3.3 Implementation of policies and strategies**

#### **Implementation of the Action Plan for fighting Drugs and Addiction**

On 25 June 2003, the Federal Cabinet passed the “Action Plan for fighting Drugs and Addiction“. To implement the plan, a national “Board on Drugs and Addiction” (Drogen- und

Suchtrat, DSR) was set up to accompany measures, evaluate results and make suggestions for further developments. It is composed of representatives of the respective government and Länder departments as well as funding organs, associations, research and self-help organizations.

Following its reconstitution after the elections of the German parliament in autumn 2005, the Board reconfirmed the primordial goal of the “Action Plan for fighting Drugs and Addiction“ which is to reduce the consumption of licit and illicit psychoactive substances as well as non-substance-related forms of addiction. The following focal areas were defined:

- The quota of smokers among teenagers (12-17 years) is to fall below 17% by 2008. It sank already from 28% to 18% between 2001 and 2005.
- The quota of teenage consumers of alcoholic beverages is to be reduced from currently 20% to below 18% by 2008.
- The quota of experimental cannabis users among the 12- to 25-year-olds is to be brought down from 31% in 2004 to below 28 % by 2008.
- The quota of regular cannabis users among the 12- to 25-year-olds is to fall below 3 % by the year 2008.

In order to implement these goals, a wide range of offers and support by the Länder and service providers are considered imperative. Research results of the Federal Ministry of Education and Research and the heroin study are also to be taken into account.

First reports of representative surveys conducted on the consumption of alcohol and cannabis among 12-19-year-olds were published already in 2007 (and presented in the last REITOX-report). The results found by the surveys indicate that the goals set for the reduction of cannabis consumption are attainable. Alcohol consumption among adolescents however, possibly requires a more differentiated approach (BZgA 2007a, b). The most recent results of the drug affinity study (DAS) conducted by the BZgA on the consumption amongst 12-25-year-olds, have however not been available as of summer 2008.

### **Demonstration programmes and research projects with central government funding**

Since 2001, one focal area of Germany’s drug and addiction policy has been addiction research which was continued in the second funding period until November 2007. 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 if 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.

- **Transfer of the cannabis cessation programme “Quit the Shit“**  
Available since 2004 at [www.drugcom.de](http://www.drugcom.de), the cannabis cessation programme “Quit the Shit“ addresses people with regular cannabis use. The programme is based on an Internet-assisted log book and counselling over the Internet with the primary goal to substantially decrease the individual consumption of cannabis within a period of 50 days. This effective approach has been successfully integrated into the municipal structures of outpatient addiction treatment within the framework of a demonstration project. The evaluation of the outcome reveals a significant reduction of the consumption of the participants.
- **Transfer of the project “Realize it“**  
As a result of the positive outcome yielded by the project “Realize it“, which has already been reported about in the last REITOX-reports, the Federal Ministry for Health has tasked the “Villa Schöpflin“ (Lörrach) and the delphi-Institute for Research, Consulting and Project Development (Berlin) to transfer “Realize it“ into 60-80 counselling facilities in Germany in order to make the programme also available to other addiction and drug counselling facilities. Thanks to additional funding by the Länder, a nationwide transfer of “Realize it“ can be effected in a few individual Länder so that more than 150 addiction and drug counselling facilities are expected to be integrated into the national network “Realize it“ till the end of the year 2008. The transfer of “Realize it“ will be carried out in three phases in the years 2008 und 2009: In a first phase, the personnel of the drug counselling facilities will be qualified. In spring 2009, the current status of the implementation of the transfer project and practical problems encountered in counselling work will be discussed within the framework of regional network meetings. The third component of the transfer is quality assurance: the acceptance of the programme will be verified among the clients by means of two follow-up surveys carried out centrally 3 and 6 months after the start of the programme. The question will be examined whether and to what extent the participants were able to profit from the programme. The results of the scientific evaluation of the transfer of “Realize it“ are expected to be published at the beginning of the year 2010.
- **Transfer of the CANDIS-Therapy**  
Within the framework of the CANDIS-study (modular therapy of cannabis-related disorders) which has already been presented in the last REITOX-report, a modular, behavioral therapy treatment programme for cannabis-related disorders (for clients from 16 years onwards) has been developed and evaluated for the first time with funding by the Ministry for Education and Research. The most important results reveal a high retention rate (86%) and significantly higher abstinence rates of the treated group in comparison with the control group (13%,  $p < .0001$ ). The treatment effects remained stable in the follow-ups carried out three and six months after the end of the therapy (51% and respectively 45%) (Die Drogenbeauftragte der Bundesregierung 2008b; Hoch et al. 2008b; Hoch et al. 2008a). A new two-year demonstration project funded by the BMG is to implement the CANDIS-therapy into outpatient addiction care and to evaluate the

therapy under real treatment conditions. The project comprises 3 phases. In the preparation phase (until April 2008) 10 participating facilities (plus one additional reserve facility) were selected and a two-day training held. The training served to provide participants with disorder-specific knowledge, explain the course and contents of the CANDIS-therapy and introduce them into the CANDIS-treatment manual. Practical exercises, case examples, role play and video recordings as well as training in all aspects of the scientific evaluation and the logistics of the study made the preparation phase complete. 30 patients are to be recruited and treated by the addiction aid facilities during the implementation phase and results documented. All 22 study therapists will be interviewed on the current status of the practical transfer of the CANDIS-therapy as part of a prospective process evaluation. In August 2008, it was begun to develop a group therapy version of the CANDIS-manual. The group programme is tested for its effectiveness in a pilot study and compared to the standardized CANDIS individual therapy (N=12 per therapy). It is planned to start with the evaluation and the communication of the results from May 2009 onwards.

- Project “AVerCa“  
Devoted to setting up an effective care structure for the early recognition of and intervention in youth cannabis abuse, the project “AVerCa“ has gone on from the results of an expert report published in 2007 (LWL Koordinationsstelle Sucht 2007) setting itself the goal to sustainably expand drug care services across the board by means of effective and efficient interventions geared both to cannabis users and their adult parents or relatives (see also: <http://www.dhs.de/web/projekte/cannabis.php>). “AVerCa“ focuses on providing differentiated qualification both at the level of the supporting organs of the facilities and at the level of the facility personnel. The supporting organs and the specialized institutions are provided with “tools” to (further) develop prevention and support services for the target group of the young cannabis consumers. Having identified “good practice“, it is planned within the framework of the project to bundle practical experience and transfer it into practical work aides together with training and further education measures. Another important area is the work with the parents of consuming children and adolescents. To this purpose, an analysis is carried out on well proven parents programmes complete with data on the number and quality of the concepts. The project also tries to investigate in how far parental work is a suitable means to access the target group. “AVerCa“ is jointly carried out by the German Centre for Addiction Issues (Deutsche Hauptstelle gegen Suchtgefahren, DHS) and the LWL-Addiction Coordination Centre (LWL-Koordinationszentrum Sucht).
- International Cannabis Need of Treatment Study (INCANT)  
Funded by the Federal Ministry for Health, the three-year main study of the multi-staged project INCANT (International Cannabis Need of Treatment Study) was started on 1 September 2006. The project, which is carried out in parallel in the Netherlands, France, Belgium, Switzerland and Germany, is addressed to 15-20-year-old cannabis addicts who are treated using the evidence-based treatment method Multidimensional Family

Therapy (MDFT). The German “Therapieladen”, a counselling centre in Berlin which has been specializing on care for clients with primary cannabis problems for a long time, is participating in INCANT (<http://www.incant.de/>). Until the end of March 2008, the Berlin “Therapieladen” succeeded in recruiting 75 adolescents/families to participate in the study. The age average was 16.3 years and the portion of female clients 20%. The initial examination at the beginning of the treatment revealed – apart from the necessary eligibility criterion cannabis disorder, a high percentage of additional alcohol-related disorders and psychological co-morbidity, especially externalized behavioural disorders. Almost half of the adolescents are already in professional youth care and do not live with their families any more. The number of adolescents/families participating in the study has increased to 90 by the middle of August 2008. First trends indicate a higher effectiveness of MDFT in terms of a reduction of drug consumption and retention quota. It is planned to have the treatment phase completed by July 2009; final scientific results are expected for summer 2010.

- **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 für Suchtfragen des Kindes- und Jugendalters, DZSKJ) analyses and evaluates from February 2008 until 2011 a manualized treatment programme called “CAN Stop” which is addressed to young people with problematic cannabis use. The group training “CAN Stop“ which focuses on psychological education and prevention of relapses of young users, has been developed with the condition that it should be easy and economical to implement and usable as an early intervention measure. “CAN Stop“ is the first scientifically evaluated group training for young people with problem cannabis use in a manualized form which is also to be used in low-threshold facilities. The programme is to investigate the effects of the group programme on cannabis consumption, self-efficacy and the influence of the peer-group. The evaluation of “CAN Stop“ is done within the framework of a multi-staged study with a controlled pre-post-design. The study is evaluated in the respective settings (outpatient youth aid, in- and outpatient medical care, youth detention centres) (Feldmann et al. 2008).
- **Longterm effects of substitution treatment: PREMOS**  
Based on the results of the COBRA-Study (Cost Benefit and Risk Appraisal of Substitution Treatments), which set the framework for a comprehensive empirical, clinically differentiated evaluation of the substitution and care situation of opiate addicts in Germany (Wittchen et al. 2005; 2008a), the Federal Ministry for Health commissioned a research project in 2007, in order to gain insight into the long-term (i.e. several years) effects of substitution treatment. It is planned under the acronym PREMOS (Predictors, Moderators and Outcomes of Substitution Treatment) to analyze the 3-4-year-course of substitution treatments, to describe long-term effects and identify predictors and moderators of the therapy outcome ([www.premos-studie.de](http://www.premos-studie.de)).

- Estimates of governments' expenses for drugs

In German-speaking territory there have only been scattered recent studies on the health-economic aspects of addiction-related illnesses. The goal of the project is to venture for the first time a comprehensive estimate and description of the direct funds expended by German governments for the misuse of and dependence on illicit drugs. The project orients itself as far as possible to already available standards (EBDD, COFOG, Pompidou group), in order to allow for later comparability at European and international level. The project is carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in cooperation with the chair of medical management at the university Duisburg-Essen).

- Government agency for labour market integration and reintegration of addicts  
The government agency for labour market integration and reintegration of addicts FAIRE ([www.fachstelle-faire.de](http://www.fachstelle-faire.de)) has been set up at the end of the year 2006 as a demonstration project by the Federal Ministry for Health and the Land Rhineland-Palatinate (Ministry for employment, social affairs, health, family and women) to promote the integration of drug patients undergoing rehabilitation on the job market. The agency is tasked to strengthen the cooperation between the addiction support system and the bodies responsible for the vocational reintegration and to contribute - through networking, further education programmes and project development - to a smooth transfer from inpatient facilities to work, training and qualification settings or counselling and support measures. Due to the positive experience made within the framework of the demonstration project, it is currently planned to expand the project to other Länder; in autumn 2008, a pilot phase of the project will be funded by the BMG in Mecklenburg-West Pomerania.

At the suggestion made by the National Board on Drugs and Addiction in November 2007 to complement the measures undertaken within the framework of FAIRE, the BMG has tendered a scientific study which is to collect, evaluate and process for further usage the approaches of good practice made over the last years in the integration of addicted persons in the job market. Within the framework of this research project, the measures, initiatives and co-operations undertaken by the working groups formed between the municipalities and the National Employment Agency (Arbeitsgemeinschaften zwischen Kommunen und der Agentur für Arbeit, ARGEn), the respective institutions in the opting municipalities and the job agencies – all assuming different tasks and responsibilities – are to be analyzed for this target group in a first step.

- EU-Project DRUID

The German Federal Highway Research Institute (Bundesanstalt für Straßenwesen, BAST, [www.bast.de](http://www.bast.de)) takes the chair in the project of the European Commission, in which 37 partners are working together on "Alcohol, Drugs, Medicines and Driving" (duration: 2006-2010). The topic of psychoactive substances in road traffic is treated in seven units. The results of this interdisciplinary research project are expected to offer important information on how often psychoactive substances appear in road traffic (individually or in combination with others) as well as their risk potential. In addition, as part of experimental

studies on these psychoactive substances, proposals are to be expected on currently non-existing danger limits which are to be defined in analogy to the limits for alcohol blood levels. Methods and requirements for the detection, prosecution and punishment for those driving under the influence of alcohol, drugs or medicines, and their rehabilitation will be evaluated. Information for professionals and for the general public will be developed and also disseminated (for more information see [www.druid-project.eu](http://www.druid-project.eu)).

### **Activities undertaken by the Länder**

The Länder 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 Länder are also presented under the respective topics of the chapters.

There are numerous projects carried out in the Federal Länder 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 police for the first time.

Cooperation between the different help settings is given increasing importance in particular with regard to support offers made to young users. Set against this background, the Agency for Social Affairs, Family, Health and Consumer Protection Hamburg has published a manual for a successful cooperation between youth welfare and child and youth psychiatry which is the product of the working group "Youth Welfare Child and Youth Psychiatry 2006-2007" (Jugendhilfe Kinder- und Jugendpsychiatrie 2006-2007) (Behörde für Soziales, Familie, Gesundheit und Verbraucherschutz Hamburg 2008).

In 2005, 203 persons aged between 18 and 24 years were killed in road accidents in Bavaria. This was the reason for launching the campaign "Disco fever". The goal of the project is to prevent road accidents among the target group of adolescents by addressing them in an age-appropriate way and teaching them how to responsibly use alcohol (<http://www.wirbrauchendichauchmorgen.de>). The addiction prevention project "Mindzone" has been active in the Bavarian party scene since 1996. It addresses young visitors of clubs aged between 15 and 29 years in the techno and house scene. Mindzone is positioned close to the scene and is based on a peer-to-peer approach ([www.mindzone.info](http://www.mindzone.info)).

The experience made and the concepts and materials used within the framework of the project "FreD" (early intervention in drug users coming to the notice of police for the first time) are transferred and expanded to the project Projekt "FreD<sup>plus</sup>" which specifically targets alcohol-consuming adolescents in Brandenburg. A peer project developed for driving novices (cf. also chapter 3.2.4, page 52) in Saxony-Anhalt and introduced also in other Länder, is currently implemented in five selected regions in Brandenburg. A further extension of the project is planned. Following a first survey conducted in 2004, it is planned to carry out

another survey in the school year 2008/2009 among students of grade 10 to find out about their drug use and addictive behaviour.

The project “Drogerie” ([www.drogerie-projekt.de](http://www.drogerie-projekt.de)) is still running in Thuringia. It offers prevention and help at music scenes, outreach social work at music events, information and counselling as well as referrals to help services. The project “Hart am Limit – HaLt” (“Close to the limit – STOP”) ([www.bueroimpuls](http://www.bueroimpuls)) which is also carried out in other Federal States, tackles problem drug use among adolescents who are provided with information on the topic and referred to help service. Another project ([www.projekt-jonathan.de](http://www.projekt-jonathan.de)) is dedicated to the promotion of children and adolescents from families with addiction problems and/or psychological disorders using a flexible and multifold care approach ([www.projekt-jonathan.de](http://www.projekt-jonathan.de)).

Saxony-Anhalt too is home to a host of initiatives and measures such as: projects dedicated to the specific target group of girls (project “MIA”), projects to promote socially disadvantaged families (project “ELAN”), the provision of safer use cards, school prevention projects (project “Blue”), media projects (project “Szene zeigen“), various sport events, talk rounds for consuming adolescents, information material and recommendations on how to deal with addictive substances. Several facilities in Saxony-Anhalt also participate in the aforementioned projects “HaLt” and “FreD”).

### **Activities undertaken by the Federal Centre for Health Education (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 establish less risky forms of consumption. Apart from illicit drugs, in particular the licit and socially accepted drugs nicotine and alcohol are in the centre of attention. In 2006, the BZgA added a new focus on its list of activities: the fight against ‘pathological gambling’. When developing new measures and media, the BzGA attaches specific importance at systematically addressing target groups in their living environment. In the following, three innovative measures carried out in 2007 will be presented:

- Action week 2007 – “Alcohol – responsibility sets the limit”

“Alcohol – responsibility sets the limit” was the motto of a nationwide action week organized by the German Centre for Addiction Issues (Deutsche Hauptstelle gegen die Suchtgefahren, DHS) together with the Federal Centre for Health Education (Bundeszentrale für Gesundheitliche Aufklärung, BzGA) and many other partners in June 2007. At the suggestion of the DHS, the German Olympic Sports Federation (Deutscher Olympischer Sportbund, DOSB) set a focus in the youth work of its clubs on the prevention of addiction. 475 sports associations participated in the “alcohol-free sports weekend“, a sports event which took place completely without alcohol at one weekend in June 2007. Numerous social groups were reached by the imaginative activities undertaken by a host of experts in addiction within the frame of this initiative. The action week was already reported on in the last REITOX-report.

- National campaign to prevent pathological gambling

Based on a cooperation agreement made between the German Lotto- und Totoblock and the Federal Centre for Health Education, a national umbrella campaign to prevent gambling addiction was developed and launched under the responsibility of the BZgA in 2007. The agreement is to fulfil the stipulations laid down in the state treaty on gambling which entered into force on 31 December 2007 (cf. also chapter 3).

The goal pursued by the national campaign is to guarantee a nationwide equally high quality in the prevention of gambling addiction or problem gambling behaviour. The campaign is complemented by measures undertaken at Länder-level (e.g. training of personnel in Lotto-betting offices and setting-up regional facilities offering counselling for pathological gambling).

The measures undertaken at national level comprise the development of a monitoring system to observe trends in gambling-related addiction risks and evaluate measures, counselling and information provided over the Internet as well as countrywide telephone counselling on pathological gambling. Furthermore, information print material is provided and a mass media campaign developed and implemented to communicate messages related to the prevention of pathological gambling.

- Internet platform [www.drugcom.de](http://www.drugcom.de)

Set-up as a substance abuse prevention measure, the Internet portal [www.drugcom.de](http://www.drugcom.de) resorts to the multifold possibilities provided by the Internet to allow the users to interactively deal with the contents of addiction prevention. The platform offers interactive self-tests, personal counselling via email and chats. [www.drugcom.de](http://www.drugcom.de) informs on effects and risks of drugs and drug use and tries to stimulate users to develop a (self-) critical attitude towards substance use. It furthermore promotes low-risk consumption behaviour with regard to psychoactive substances (situational abstinence) and to motivate users to completely abstain from certain substances. [www.drugcom.de](http://www.drugcom.de) is to contribute to decrease the number of cannabis users.

The Internet platform offers the cannabis cessation programme “Quit the shit” as a substance-specific module and the self-test “Check your drinking” complete with the supplementary programme “Change your drinking”. “Quit the Shit” is described in more detail in chapter 3. The following section will therefore present the modules “check your drinking” and “change your drinking”.

The self-test “check your drinking” suggests to users with risky alcohol consumption to reduce frequency and quantity of consumption. Completed in 2007, the supplementary programme “change your drinking” is a fully automated short-term module aimed at reducing alcohol consumption. The programme’s target group are adolescents and young adults with risky alcohol consumption. The programme is based on an Internet-assisted log book which is kept for 10 days as well as on specific information on how to reduce alcohol consumption. An evaluation of the programme is carried out in 2007/ 2008 by means of a randomized control study which is to find out about acceptance and effects of the intervention.

## **Conferences and working groups**

As in the previous years, a host of conferences and working sessions were also held in the reporting year. Due to the multitude of events dealing with administrative, organisational, technical or scientific aspects, the following chapters represent only a small and random selection of events which are to serve as examples for the wide array of offers.

In April 2008, an addiction self-help conference was held on the topic "From competition to cooperation – addiction self-help on the path into the future". The conference was about future challenges faced by professional addiction support and self-help groups and the practical cooperation and partnership between self-help groups and professional addiction support.

In November 2007, the German Centre on Addiction Issues held an experts conference in Mannheim on the topic "Alcohol – new strategies for an old problem?" The conference was to take a practical approach to the topic "alcohol" and to facilitate the transfer of research results of the last years into the practical field.

Placed under the motto "High as a kite – new forms of adolescent alcohol consumption" a conference was held by the Federal Government Commissioner in cooperation with the DHS in October in Berlin.

Cannabis use and misuse was also the topic of the 11th scientific meeting held by the German Society for Addiction Research and Addiction Therapy (Deutsche Gesellschaft für Suchtforschung und Therapie, DG-Sucht) in the German Centre for Addiction Problems among children and adolescents (Deutsches Zentrum für Suchtfragen des Kindes- und Jugendalters DZSKJ) in Hamburg. Both more recent epidemiological research results on the effects of cannabis use and older data on the psychological concomitant disorders were viewed from new angles at the conference.

## **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. Bilateral cooperation on the subject of drugs took place with Latvia, Rumania, Poland and Croatia (twinning projects) as well as with numerous other countries (DRUID, exchange on the programme "FreD goes Net"). Furthermore, it was decided in 2008 that Germany would carry out a two-year twinning project with Turkey starting in 2009.

The Federal Government Commissioner on Narcotic Drugs assumes an important coordinating function in representing Germany in the European and other international bodies dealing with drug policy (Die Drogenbeauftragte der Bundesregierung 2008b). Apart from the Federal Government Commissioner on Narcotic Drugs, the competent special agencies of the ministries (Ministry of the Interior, Ministry of Health, Ministry of Foreign

Affaires) and experts from other areas represent Germany in bodies at European and international level.

### **1.3.4 Effects of policies and strategies**

The alcohol industry reacted to policy measures such as the surtax on so-called alcopops (cf. Previous REITOX-reports), among others by introducing mixed drinks on the basis of beer and wine. First indications of the effects of these developments were gained from the presentation of the most recent results of representative survey carried out in 2007 on the consumption of alcohol among adolescents. Compared to the results of the surveys carried out in the years 2004 and 2005, it was found that— after a decline between 2004 and 2005 — alcohol consumption among teenagers is clearly on the rise again (details of this survey were already presented in the last REITOX-report). The increase in alcohol consumption is mainly attributable to the increase of the consumption of beer, mixed drinks with beer and spirits. No major changes were found in the last years with respect to the consumption of illicit drugs apart from cannabis. There are however indications that, with regard to cannabis consumption in the population, consumption has stabilized or even decreased after the temporarily considerable increases in the 90ies of the last century. Details on drug use in the population can be found in chapter 2.

## **1.4 Budgets and public expenditures**

A detailed overview of the data sources available in Germany and a presentation of the problems linked to the collection and analysis were given in one of the “selected issues” of last year’s REITOX-report which is available in German and English on the website of the DBDD. Furthermore, the EMCDDA published a summary of the information available on this subject from the member states which can be obtained from the EBDD.

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, Länder and local levels along with social insurance schemes with respect to the funding and execution of tasks. Especially information on financial resources which the Länder 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. Therefore,

it is only possible to present a few (*labelled*) costs which by no means even come close to providing complete information on the overall funds devoted to dealing with the drug problem. A recent research project (see below) is investigating the topic to provide a better overview of the public expenditures.

### **Federal budget**

Expenditures connected with the problems of addiction can also be expected to be included in the budgets of a series of federal ministries. These include for example the Ministry for Development Aid and Economic Cooperation (e.g. activities undertaken in countries producing drugs), the Ministry of the Interior (e.g. the Federal Office of Criminal Investigation), the Federal Ministry of Finance (e.g. customs), the Federal Ministry of Justice (e.g. Federal courts), the Federal Ministry of Education and Research (e.g. funding of the network associations conducting research on addiction) or the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (e.g. prevention programmes). A summarizing overview does not exist at present. In the following solely the budget of the Federal Ministry for Health will be presented in a discriminating manner since it contains the only budget information directly available at federal level (without any further analyses and estimates) which can be explicitly assigned to the area “addiction” and “substance abuse”. Contrary to the REITOX-reports of previous years, which reported the budgeted expenditures, the data presented hereinafter reflect the amounts actually spent in the year 2006.

According to the Federal budget, expenditures by the Federal Ministry for Health (BMG) on “measures carried out in the area of drug and addictive substance abuse” in 2006 amounted to € 12.7 million (2005: € 12,1 million). In the distribution of funds, € 6.7 million (2005: € 6.7 million) were devoted to information; central institutions and associations received grants of € 1.0 million (2005: € 1.0 million), demonstration measures € 2.8 million (2005: € 3.1 million), € 1.5 million went to expenditures for research and development projects ((2005: € 604 thousand) and to the promotion of national information nodes in the area of addiction € 642 thousand (2005: € 630 thousand). The portion which was specifically devoted to illicit drugs amounted to, according to the Ministry, about € 3.3 million (personal communication). On top of this there were the operating expenditures of the business office of the Federal Government Commissioner on Narcotic Drugs to the amount of € 79 thousand (2005: € 76 thousand), out of which about € 25 thousand were in connection with illicit drugs (personal communication of the BMG). The total costs of the business office of the Federal Commissioner on Narcotic Drugs and the technical departments of the Federal Ministry of Health taking into account all staff and material costs are not specified in the budget. The expenditures by the Federal Centre for Health education for the prevention of the abuse of illicit drugs amounted to € 690 thousand ([www.drugcom.de](http://www.drugcom.de); personal communication).

### **Statutory pension insurance**

Outpatient and inpatient rehabilitation with the aim of “restoring the capacity to work” are funded with payments from statutory pension insurance schemes. At € 496.6 million, expenditures by the statutory pension insurance (Deutsche Rentenversicherung Bund (DRV)

2007) on medical rehabilitation and supplementary services for dependence-related illnesses (alcohol, pharmaceuticals, drugs) were slightly higher in 2006 than in the previous year (2005: € 494.0 million), but remained below the amounts for previous years (2004: 524.6; 2003: 527.0). Budgets for inpatient services showed a similar trend (2006: 400.0; 2005: 390.6; 2004: 409.6; 2003: 415.2). After a strong increase till 2005, funding for outpatient services declined for the first time again in 2006 (2006: 25.2; 2005: 30.0; 2004: 26.9; 2003: 22.2). The budget for transitional payments has continuously decreased since 2003 (2006: 60.4; 2005: 62.7; 2004: 77.1; 2003: 78.8), while the budget for other supplementary services has remained stable over the years (2006: 11.0; 2005: 10.6; 2004: 11.0; 2003: 10.8). The portion of persons dependent on one or several drugs among total patients who completed withdrawal treatments amounted to 27.5% in 2006 (2005: 28.2 %). If one estimates the budget for this group of persons, one arrives at an amount of about € 136.5 million.

In addition, the National German Pension Insurance (Deutsche Rentenversicherung Bund) has provided funds for years (in respect of § 31 paragraph 1, alinea 1 no. 5 SGB VI) both to the regional self-help system for addictions and the work of the commissioners for addiction of the help organisations who are members of the DHS. In 2007, regional self-help received grants to an amount of € 792,664 which were primarily allocated to self-help groups represented countrywide. The work of the commissioners on narcotic drugs who work in self-help were supported by financial funds amounting to approx. € 1.4 million in 2007 (Die Drogenbeauftragte der Bundesregierung 2008b).

### **German statistical report on treatment centres for substance use disorders**

The German statistical report on treatment centres for substance use disorders (Deutsche Suchthilfestatistik, DSHS) provides an overview of funding for outpatient addiction therapy. Even if only less than half (2007: 39.9 %; 2006: 46.2 %) of the facilities affiliated with the DSHS supplied data on their individual budgets, it is possible to infer funding structures which in turn provide an overview of the type and composition of the funds available. Work performed by outpatient addiction-counselling facilities continues to be largely funded by local governments and the Federal Länder (together accounting for almost three-fourths of total funding)<sup>5</sup>. The budget for 2007 breaks down as follows: local governments 56.0 %, Länder 17.5 %, Federal Government 0.4 %, social security administration 7.3 %, health insurance schemes 1.4 %, premiums paid by clients 0.7 %, personnel expenses of labour administration 1.1 %, non-governmental organizations' own funds 10.0 % and various other funding resources 5.6 % (Sonntag, Bauer & Eichmann 2008). Comparisons with the data from previous years can only be drawn to a limited extent since the introduction of the revised Core Data Set has led to changes both in the categories grouped under the item "funding of the facilities" and in the definition of the group of "outpatient facilities".

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<sup>5</sup> The majority of facilities and services funded mainly address users of licit and illicit substances or offer support for additionally existing problem fields like for example pathological gambling or eating disorders.

An extrapolation of the average annual budget per facility of € 309,637 to all facilities existing in Germany according to the short reports of the Länder (n = 934) (Simon 2005) leads to an approximate amount of € 289 million spent for the outpatient addiction support system in 2007. It needs however to be taken into account that the extrapolation is not based on a sound data basis.

### **Current project on the estimate of public expenditure in the area of illicit drugs**

The dissatisfying data situation was the reason for the Federal Ministry for Health to commission a project in February 2008 which is to venture for the first time an overall estimate of the direct public funds provided for the dependence on and misuse of illicit drugs. The project is carried out by the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction in cooperation with the chair of medical management at the university Duisburg-Essen. As for the methodology, the project orients itself as far as possible to already available standards (EBDD, COFOG, Pompidou group), in order to allow for later comparability at European and international level. In a first step, a literature research is to identify already existing relevant studies and to analyze the methodology and references to data sources or already existing estimates of funds. In a second step, an analysis is carried out at the institutional level to identify government authorities and institutions which provide funds related to the combat against illicit drugs. Various approaches are combined in the data collection: the budgets and statistics open to the public are analyzed, the ministries, associations and social insurance agencies or their representatives respectively are interviewed and – starting from the activities undertaken “in the field” (e.g. in addiction support facilities) – the flows of money traced back to the funding institutions. The individual expenses are allocated to various political areas to allow for an international comparability of the expenditures (Reuter 2006). The results are to be presented in the form of a modular “building block system” to allow the overall expenditures to be broken down by players or by political areas. First results are expected at the beginning of the year 2009.

### **1.5 Social and cultural context**

In the reporting year, public discussion in Germany was dominated by the topics of economy, unemployment, health and fiscal policy. In public discussions and in reporting about addictive behaviour a large interest was shown for the passing of the Protection of Non-Smokers Act and the draft of the acts at Länder-level. Among the illicit drugs, cannabis, which has made its entry into all social strata, and sporadically also cocaine (e.g. after the presentation of the annual report of the EMCDDA) were a frequent subject of discussion. A few cases of cannabis contaminated with lead which made its appearance in the region of Leipzig were intensely reported on by the media. The heroin study and the uncertain future of the project and of the participating patients continued to receive quite some press coverage.

### **Public opinion on drug-related issues**

There have been no new studies presented on this topic during the reporting period.

### **Parliamentary initiatives and civil society**

Members of parliament actively participated in the discussion on current topics (e.g. diamorphine-based therapy, implementation of substitution therapy, driving under the influence of cannabis, spread of methamphetamine). However, besides the activities deployed by the Federal Government within the framework of its drug policy, no further specific initiatives were launched.

Based on the principle of subsidiarity, the German Centre for Addiction Issues (Deutsche Hauptstelle für Suchtfragen, DHS) plays an important role as an umbrella organisation for the charity organisations in the German civil society. It currently works within the framework of the project “Building Capacity“ together with partners from 30 European countries and international partner organizations on a network for alcohol policy with a goal to promote the development of a comprehensive strategy to reduce alcohol induced disorders in Europe. The project is funded by the European Union and the Federal Ministry for Health. Furthermore, the DHS participates for Germany in the “Civil Society Forum“ set up in 2007 by the EU.

### **Media coverage of drug-related issues**

Reporting on drug-related issues is closely linked to the social and cultural context. It has a considerable influence on the public discussion. Therefore, reporting on addiction and (illicit) drugs is practically identical in terms of contents to the subjects already referred to in chapter 1.5. The annual report of the EMCDDA met with quite some response. In the centre of interest were especially the development of cocaine consumption in Europe and the comparison with the situation in Germany.



## 2 Drug use in the General Population and specific sub-groups

### 2.1 Overview

#### 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. An even more up-to-date picture is provided by surveys on drug use 30 days prior to the survey. The clear difference which 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.

#### Data sources

In Germany, epidemiological sources for drug consumption data are mainly available through regular national representative surveys and prevalence studies which are complemented by regional quantitative and qualitative studies.

- The Drug Affinity Study (DAS) carried out by the Federal Centre for Health Education investigates the consumption, the motives for consumption 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 very 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 2004 (BZgA 2004). In 2007, the BZgA additionally published first results of a representative survey conducted on cannabis use among 3,602 interviewees in the age group from 12 to 19 years (BZgA 2007b). A summary of the results was already presented in the last REITOX-report.
- The Epidemiological Survey on Substance Abuse (ESA) (Federal Study on the abuse of psychoactive substances among adults in Germany) is a paper-based nationwide 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 Länder have provided additional funding for a regional expansion of the sample to create a statistical basis for regional evaluations. The Epidemiological Survey on Substance Abuse 2006 (ESA 2006; Kraus & Baumeister 2008) used a random sample of 21,463 persons as a

data basis. Out of these, 7,912 aged between 18 and 64 years took part in the survey. The response rate was estimated at 45%. The results of the non-response-analyses show that the response behaviour (early/late/non-responder), correlate negatively with the data on the consumption of illicit drugs. Summarizing, Kraus and Baumeister (2008) conclude that the used data collection method based on telephone contact and telephone interviews with people who are not reachable in writing, has generally led to an improvement of the response rate.

- 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 Länder participated for the second time in the survey after 2003. The participants of 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 CAN 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. Some of the evaluations of own surveys carried out in individual Länder were included in ESPAD.
- 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 Federal Länder (North Rhine-Westphalia, Berlin, Hamburg, Saxony, Hesse) participated in the survey on health behaviour in 2005/2006. The survey carried out in 2006 also collected data on the consumption of illicit drugs. First results have been available since the summer of 2007 (Settertobulte & Richter 2007). Furthermore, there are also data available in the reporting year from an own HBSC study carried out for the Federal Land North Rhine- Westphalia.
- 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 results 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 consumption, the data from the interviews conducted among the 11 to 17 year old boys and girls and their parents were used. Schleswig-Holstein contributed to the national health survey by publishing a report on the health state of children and adolescents in Schleswig-Holstein (Ministerium für Soziales, Gesundheit, Familie, Jugend und Senioren des Landes Schleswig-Holstein 2007; Robert Koch Institut 2007b). This contribution is based on the evaluation of the Health Interview and Examination Survey for Children and Adolescents at land level. The overall results of the evaluation have already been presented in the last Reitox-report.

Apart from these surveys, most of which are conducted on a regular basis, various studies commissioned by some individual Länder are carried out irregularly at regional and local

level focusing among others on the extent and effects of the consumption of a specific substance, consumption patterns or characteristics of a specific group of users

These studies are based in part on individual evaluations carried out within the frame of larger national studies (see above, HBSC North Rhine-Westphalia, ESA 2006 and ESPAD-data for Berlin or KiGGS Schleswig-Holstein).

- As part of the Local Monitoring System (LMS), a survey was conducted for the third time in 2007/2008 (the last one dates back to the year 2005) under the title “Hamburger Schulbus” among 14-18 year old students at schools in Hamburg providing general education or vocational training. The results of 2005 were already presented in the last REITOX-report (Baumgärtner 2006). The data of the “Hamburger Schulbus” collected in the reporting year 2007/08 were based on a sample of 1,287 adolescents and young adults in the age group 14 -18 years (Baumgärtner 2008).
- Another source which has been supplying data on drug trends at local level for many years is the Monitoring System Drug Trends from Frankfurt on the Main. One module of the monitoring system is a school survey. In the reporting period 2007, N=1,182 students aged between 15 and 18 years at schools providing general and vocational training were interviewed (Werse et al. 2008; Werse & Müller 2008b). In addition, there are also results available from interviews carried out among drug experts within the frame of MoSyD.

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). Insofar as no new data were published in the period under review, this report confines itself to presenting only a few basic data. The most important results of ESA 2006 on substance abuse among the adult population and of the two studies on cannabis and alcohol consumption among adolescents and young adults published by the Federal Centre for Health Education were already presented in the REITOX-report 2007.

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 persons with a high consumption of illegal drugs are more difficult to reach by such studies and often have a tendency to underreport the frequency and quantity of their consumption. Therefore, especially in the case of heroin addicts, estimation methods tapping other data sources (e.g. police files) are used. In addition to quantitative data, also qualitative studies, if available, were 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 ESA (2006) the most recent DAS (2004) results. The data of the two studies were already presented in the last years, new results are expected from DAS

in the course of 2008. Therefore, this year's overview restricts itself to only a few items (table 2.1).

**Table 2.1** Prevalence of illicit drugs in Germany

	Source	Age	Prevalence	Total <sup>1)</sup>
Lifetime	ESA '06	18-64	23.7%	12,396,000
	DAS '04	12-17	15.7%	892,000
12 Months	ESA '06	18-64	5.0%	2,615,000
	DAS '04	12-17	10.4%	591,000
30 Days <sup>2)</sup>	ESA '06	18-64	2.5%	1,308,000
	DAS '04	12-17	2.5%	142,000

1) Figures were rounded. Population figures used: 18-64 years: 52,305,000; 12-17 years: 5,684,349 (Statistisches Bundesamt 2006).

2) DAS: "current consumption" instead of "30-day-prevalence".

(Kraus et al. 2007), special calculations; (Bundeszentrale für gesundheitliche Aufklärung (BZgA) 2004)

The table shows that the lifetime-prevalence of illicit drugs has practically remained unchanged between 2003 and 2006 (2006: 25.4%; 2003: 25.2%). However, the most recent figures of the year 2006 are markedly lower than the ones found by ESA 2003 both for the consumption of illicit drugs in the 12-month-category (2006: 5.4%; 2003: 7.3%) and in the 30-day-category (2006: 2.7%; 2003: 3.9%) (details are also contained in the online standard table 1).

These declines can almost exclusively be explained by the lower prevalences of the consumption of cannabis which are possibly an indicator of a trend reversal in cannabis consumption. Taking the latest ESA findings from 2006 as a basis, the figure for current users (12 months, 30 days) in the age group 18-59 years would be markedly lower than the comparative value from 2003.

### 2.2.2 Comparison of the consumption of individual drugs

The most recent data on the prevalences of individual drugs stem from the ESA study 2006. The most important figures on prevalences of substances used in the lifetime are presented for both age groups in table 2.2. The table also shows the ESA results for the 12-month- and 30-day-prevalences in detail. Cannabis remains the by far most frequently consumed illicit drug. Values worth mentioning are furthermore only reached by cocaine (0.6%), amphetamines (0.5%), ecstasy and mushrooms (both 0.4%). The consumption of heroin, LSD and crack remained limited to specific and much smaller groups.

**Table 2.2** Lifetime-prevalences for illicit drugs

Study	DAS '04 (%)		ESA '06 (%)		
	Age group	12-17 Years	18-64 Years		
	Prevalence	Lifetime <sup>1)</sup>	Lifetime	12 Months	30 Days
Cannabis <sup>2)</sup>		9.0	23.0	4.7	2.2
Amphetamines		0.7	2.5	0.5	0.3
Ecstasy		1.0	2.0	0.4	0.2
LSD		<0.5	1.7	0.1	0.0
Heroin			0.4	0.1	0.1
Cocaine		<0.5	2.5	0.6	0.2
Crack			0.3	0.1	0.0
Mushrooms		0.8	2.4	0.4	0.1
Volatile substances		0.9			
Illicit drugs besides Cannabis		--	5.8	1.2	0.7

1) There are no detailed data available for prevalences < 0.5; in case there are no figures reported, there are no data available

2) DAS '04 „Cannabis“: Data are based on a representative survey carried out by the BZgA in 2007. (Bundeszentrale für gesundheitliche Aufklärung (BZgA) 2007), special calculation.

(Bundeszentrale für gesundheitliche Aufklärung (BZgA) 2004); (Kraus et al. 2007).

The consumption of illicit drugs is a phenomenon which occurs primarily in the younger age groups up to about 40 years. Apart from the trend data for the population group of the 18-39 year-olds, which were already reported in the last year, ESA has been providing comparative figures also for the age group of the 18-24-year-olds which can be used for trend analyses since 1990. Table 2.3 contains the results of the lifetime- and the 12-month-prevalences of individual substances and of all illicit drugs for all years of ESA data collection since 1990 (Kraus et al. 2007). It can clearly be seen that the variations in the prevalences of (all) illicit drugs, are, at any time, primarily attributable to the variations of the number of cannabis users. Striking about this more restricted age group is the marked decline of the 12-month-prevalence of cannabis in 2006 compared to 2003 and a drop below the figure of the year 2000. As for the other substances, only slight variations are to be found.

**Table 2.3** Trends in the lifetime and 12-month-prevalences of the consumption of illicit drugs broken down by substances (age group 18-24 years), 1990-2006<sup>1)</sup>

Drug		Prevalence (%)					
		1990	1995	1997	2000	2003	2006
Illicit drugs	LT <sup>2)</sup>	15.7*	25.2*	24.3*	37.1*	43.9*	40.3
	12M <sup>2)</sup>	7.9*	16.7	13.6*	21.8*	22.8*	17.5
Cannabis	LT	15.2*	23.6*	21.5	36.6*	43.0*	39.5
	12M	7.7*	15.7	11.9*	21.1*	22.1*	16.9
Ampheta- mines	LT	2.6*	5.9	2.5*	4.6	6.0	5.4
	12M	0.6*	3.1	1.8	2.7	3.1	2.4
Ecstasy	LT		5.8	4.9	5.2	6.3	5.4
	12M		4.2	2.8	2.9	2.1	1.9
LSD	LT	1.1*	2.8	1.7	3.0	3.3*	2.2
	12M	0.2	2.0	1.3	1.0	0.6	0.4
Opiates	LT	1.1	3.3*	1.2	1.5	2.0	0.9
	12M	0.2	1.5*	0.7	0.8	0.5	0.3
Cocaine/ Crack	LT	1.3*	4.3	2.1*	3.8	4.7	4.1
	12M	0.5*	2.4	1.8	2.5	2.1	1.8

1) Figures for the whole of Germany.

2) LT = lifetime-prevalence; 12M = 12-month-prevalence.

3) \* = p<.05 for a change in respect of the year 2006.

(Kraus et al. 2007).

Heroin continues to play a predominant role in the Frankfurt drug scene which, according to experts, is favoured by a relatively low price level and a high quality of the substance (Werse & Müller 2008b). It is estimated though that prevalences of heroin and crack (in Frankfurt) are still equally high. A relatively new development reported by experts is the illicit traffic with the substitution substance buprenorphine. According to the data provided by experts of the Frankfurt drug aid system within the frame of the monitoring system MoSyD, the number of treatment requests for intensive cannabis consumption remains at a high level. Experts have observed that the portion of psychiatric double diagnoses is comparatively high in these clients. GHB ("Liquid Ecstasy") in form of the legally available precursor substance GBL seems to have established itself in some circles, though the concrete extent of its spread remains unclear. Experts did not find any noteworthy changes in the (problem) consumption of cocaine and crack in the Frankfurt party scene nor of heroin and crack in the (open) scene. It seems that methamphetamine has not spread yet in Frankfurt. "Ritalin" (methylphenidate) made its appearance as a narcotic substance in a few individual cases. There were also sporadic reports on the consumption of the drugs BZP and salvia divinorum which have recently been added to the list of the controlled substances of the Narcotics Act.

The Land Berlin has drawn up own reports on the European School Survey Project on Alcohol and other Drugs 2007 (ESPAD) and the Epidemiological Survey on Substance Abuse 2006 (ESA 2006) which were presented to the public at a press conference held in March 2008 (Senatsverwaltung für Gesundheit, Umwelt und Verbraucherschutz 2008).

According to these reports, there are approx. 165,000 users of illicit drugs and 8,000 to 10,000 opiate addicts currently living in Berlin. The number of persons with risky alcohol consumption, by comparison, is reported to be at approximately 370,000 (approx. 250,000 men, 125,000 women). A total of 37% of the interviewed adult inhabitants of Berlin are reported to have experience with illicit drugs. If one extrapolates this to the 15- to 64-year-old resident population one gets almost 900,000 persons in Berlin who have experience with the consumption of illicit drugs.

About every one in ten (10.8%, approx. 260,000 persons) stated to have consumed illicit drugs in the last 12 months, about 6.9% (approx. 165,000 persons) in the last 30 days. Among the illicit drugs, cannabis, is, just like in other cities, the most common drug used in Berlin: about 10% of the interviewees reported cannabis consumption in the 12-month-category, almost every one in ten (9.7) stated to have consumed cannabis daily or almost daily in the last 12 months. These figures are markedly higher than those reported for the German overall population. About 0.6% of the 15- to 64-year-old population were estimated to be dependent on cannabis and 1.4% to abuse cannabis in respect of DSM-4.

Data show that consumption trends have stabilized since the year 2000. No significant changes were found over the last six years in the consumption of drugs among the age group of the 15- to 39-year-olds. The consumption of amphetamines, opiates and ecstasy has remained stable since 1995. The consumption of illicit drugs is definitely more common in Berlin than in the rest of Germany.

Data on the consumption of methamphetamines are not presented in a discriminating manner in the current epidemiological studies. In 2007, data on experiences made with the consumption of methamphetamines were collected for the first time by MoSyD. Both the lifetime- and 12-month-prevalences are at 1% among the surveyed students, thus ranging at the same levels as the substances opium, heroin and GHB which are also relatively seldomly consumed. All in all however, it is assumed that methamphetamines, in comparison with other substances, are still not very prevalent in Germany. Methamphetamines were mainly seized in the Bavarian and Saxon border regions close to the border with the Czech Republic where they are produced for the German markets and from where they are smuggled over the common border into the territory of the Federal Republic of Germany.

In Germany, methamphetamine is mostly seized in its crystalline form. Even if the data situation with respect to the prevalence of methamphetamines is patchy in Germany, there are scattered reports on the effects of the consumption of methamphetamines or on characteristics of the users. Furthermore, the Federal Supreme Court also dealt with the substance in summer 2008 by revising the existing limit values of the "non-small quantity" which determine the degree of punishment for various offences in respect of the Narcotics Act (Süddeutsche Zeitung 2008). Following a decision of the Federal Supreme Court in 2001, the limit value for methamphetamine base had been set at 30 grammes and for metamphetamine hydrochlorid at 35 grammes. Härtel-Petri and Kollegen (2008) report on a survey carried out among 241 persons who had undergone inpatient withdrawal treatment. About a third of the interviewees reported intravenous use of stimulants. The average age of

first-time consumption of methamphetamine was 17 years. The interviewees – most of whom meanwhile live drug-free lives, gave high ratings for the efficiency of especially the inpatient help offers for (initial) treatment. Information on the price of methamphetamine has been supplied by Thoms (2008) who gives an estimate of approx. 70 €/g, this means a single dosis costs between €7 and €10. Thoms underlines the relevance of a higher likelihood of the occurrence of persisting aggressive behaviour after the consumption of methamphetamine which poses new challenges also to the treatment facilities. Rawson and colleagues (2007) have discussed various aspects of the consumption of methamphetamines by young people emphasizing that the consumption of amphetamines by adolescents constitutes a considerable problem in some parts of the world. They also report that especially young women have a higher risk of developing methamphetamine-induced problems. Among these are depressive disorders and suicidal ideations. Risky sexual behaviour which is associated with the consumption of methamphetamine carries a higher risk of contracting sexually transmissible diseases. Knowledge, though, of the best ways of treating methamphetamine-induced problems in young people is rather limited.

### **2.3 Drug use in school and in the youth population**

With a prevalence of about 5-6%, psychological disorders connected to the consumption of illicit drugs in children and adolescents continue to be among the epidemiologically most important psychiatric disorders occurring during childhood and adolescence. The vast majority of adolescents stop using drugs again when entering adulthood (Sack et al. 2008). 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 consumption 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. For this group of persons it is particularly important to be provided with specific treatment offers as described for example by Küstner and Kollegen (2008). (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 consumption of illicit substances (Perkonigg et al. 2008).

#### **Consumption of licit psychotropic substances**

An important finding of a study recently carried out by the Federal Center for Health Educaiton (Bundeszentrale für gesundheitliche Aufklärung, BzgA), was that the portion of the 12- to 17-year-olds who regularly consume alcohol (i.e. at least one alcoholic beverage per week), increased again in the reporting period 2007 after having slightly declined between 2004 and 2005. This rise is attributable to the increased consumption of beer and mixed drinks containing beer and wine as well as spirits in particular among the male adolescents in the age of 16 and 17 years. The portion of the 12- to 17-year-old adolescents who have had five or more alcoholic drinks at least once on one day (binge drinking) in the last month, has

also considerably increased amounting now to 26% (BZgA 2007a). Recent data on alcohol consumption among the youth population has also been provided by the HBSC-study (Settertobulte & Richter 2007), which has also been reported on in last year's Report. According to this survey, only few 11-to 13-year-olds regularly drink alcohol. Alcohol consumption has however become common for many teenagers from the age of 14 years onwards. About a quarter of the 15-year-old boys drink regularly. Striking is the increase in the consumption of spirits by 15-year-olds in comparison with previous surveys.

According to the results of the Health Interview and Examination Survey for Children and Adolescents (Kinder- und Jugendgesundheitsurvey, KiGGS), 38.6% of the 11- to 17-year old boys and 22.2 % of the girls can be referred to as regular alcohol consumers (Lampert & Thamm 2007).

The results on tobacco consumption of adolescents found within the frame of the HBSC-study and KiGGS were already presented in the REITOX-report 2007.

The project "Hamburger Schulbus" corroborated again the association between intense tobacco consumption and experience with cannabis: the more intensely tobacco is consumed, the more common are experiences with cannabis: While non-smokers have hardly had any experience with cannabis products, more than two thirds (70%) of the regular smokers reported to have already had experience with cannabis. More than a quarter of the regular smokers (29%) reported cannabis consumption in the last 30 days.

### **Consumption of individual drugs**

The results of the European School Survey Project on Addiction and other Drugs (ESPAD) were presented in 2007. According to these results, 28% of the pupils surveyed reported to have tried any illicit drug (cannabis, amphetamines, ecstasy, LSD, cocaine, crack or heroin) once in their lifetime (Kraus et al. 2008). The lifetime-prevalence of the consumption of illicit drugs though, (except for cannabis) has remained almost unchanged since 2003 (10.0% vs. 10.2%).

Among the illicit drugs (excluding cannabis), amphetamines (6%) were the most commonly tried drugs (at least once in a lifetime). The lifetime-prevalences of all other illicit drugs lie below 5% with the portion of boys being larger than the one of the girls for all substances. Among other psychoactive substance which do not fall under the category of illicit drugs (inhalants, tranquilizers/sedatives, anabolic steroids), the adolescents had most frequently experience with inhalants (12%).

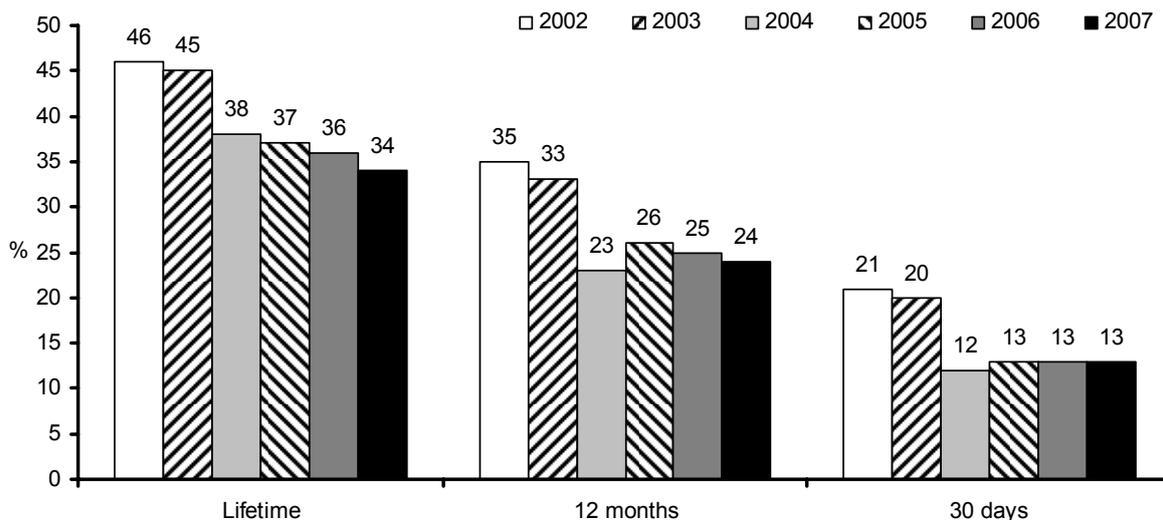
Only for the substance gamma hydroxybutyrate (GHB) a marked increase in the lifetime prevalences has been found since 2003 in all students at all types of schools and in all Länder (total: 0.3% vs. 2.2%). A significant increase in the portion of adolescents with lifetime-experience with amphetamines and cocaine was furthermore found in Brandenburg and Mecklenburg-Western Pomerania. With regard to licit psychoactive substances, the most recent study on inhalants and anabolic steroids does not report any statistically relevant changes in the portion of users in comparison with 2003. Lifetime-prevalences of

tranquilizers/sedatives used without medical prescription have almost doubled from 1.5% to 2.9% since 2003.

The most recent results of a countrywide representative survey carried out in spring 2007 by the BZgA among adolescents and young adults between 12 and 19 years, indicate a strong decline in cannabis consumption in this age group. The results of this survey were already presented in 2007 (BZgA 2007b).

ESPAD figures also speak of a significant decline of cannabis consumers compared to the last ESPAD-survey carried out in 2003. The lifetime-prevalence sank from 31% to 25%, the 12-month-prevalence from 25% to 17% and the 30-day-prevalence dropped from 14% to 8%. The portion of female cannabis users declined more strongly than the one of the male users. This declining trend in cannabis consumption can be observed in all participating Länder across all types of schools. However, there are still more boys than girls who report cannabis consumption at least once in the lifetime (30% vs. 21%), in the last 12 months (22% vs. 13%) and in the last 30 days (11% vs. 5%) before the survey. Compared to the relatively high figures found for the experience with the consumption of cannabis, frequent consumption of this substance was relatively seldom. 3% of the adolescents reported to have consumed cannabis more than once a week in the last 30 days. Data on cannabis abuse was collected by means of the Cannabis Abuse Screening Tests (CAST). According to this test, boys (1.6%) showed a four times higher abusive behaviour with regard to cannabis than girls (0,4%). In total, 1.0% of the interviewees fulfilled the CAST criteria of abusive cannabis consumption. 8% of all the 12-month-consumers reported that friends or family members had advised them very often to reduce their cannabis consumption. The adolescents expect cannabis consumption to have an effect on their social contact behaviour or hope to derive a stimulating effect from it.

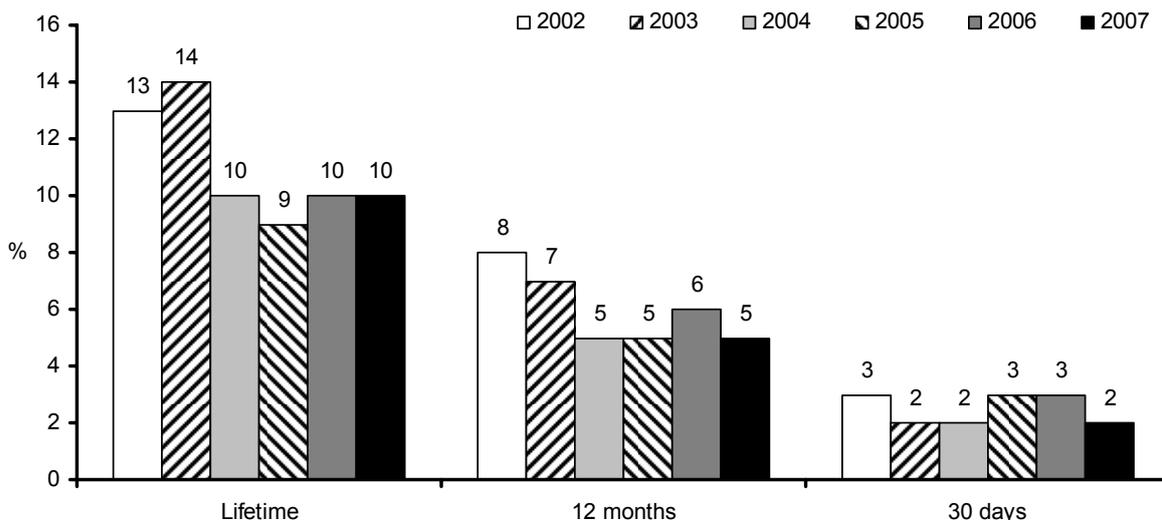
The results of the most recent school survey carried out within the framework of the MoSyD do not show any significant changes compared to the previous years. However, the reported lifetime-prevalence of the interviewees has declined again in line with the trend which has been observed since 2002. The 30-day-prevalence of cannabis consumption has basically remained unchanged since 2004 while the 12-month-prevalence has slightly decreased since 2005 (fig. 2.1).



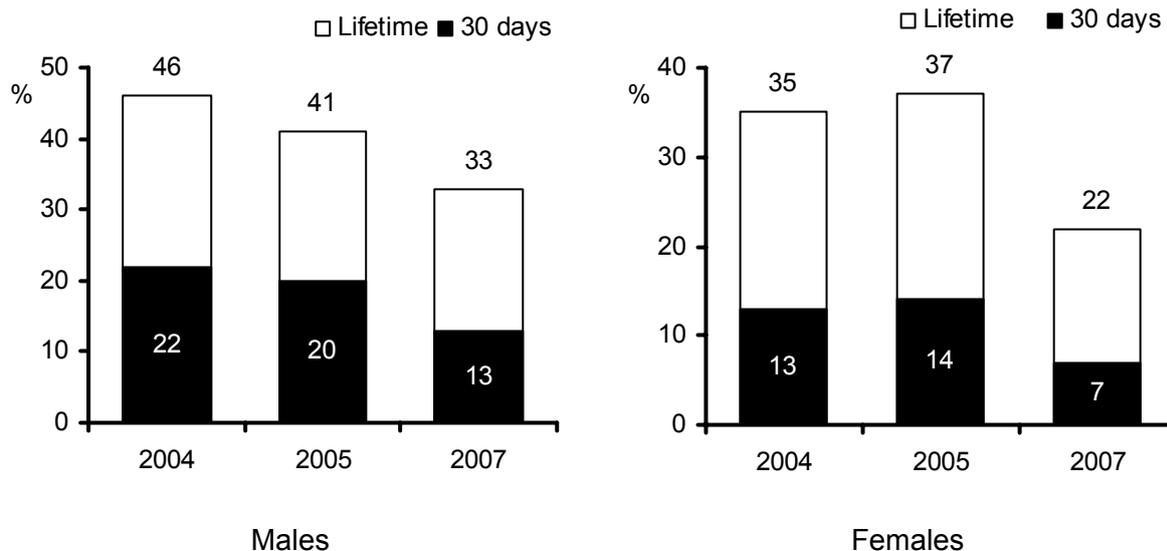
**Figure 2.1** Lifetime-, 12 month- and 30-day-prevalence of the cannabis consumption among Frankfurt students aged between 15 and 18 years - 2002-2007 (MoSyD)

The average age at initial consumption has also remained unchanged in Frankfurt. With 14.6 years, it was practically identical in the reporting year 2006/2007 to the results found by the “Hamburger Schulbus“ (see below). With regard to the prevalences of other illicit drugs (excluding cannabis), no significant changes were found in the Frankfurt students neither for the lifetime prevalences nor for the 12-month-prevalences. The 30-day-prevalence has practically not changed either since the first data collection conducted in 2002 (figure 2.2). The overall declining lifetime- and 12-month-prevalences of illicit drugs (excluding cannabis) since 2002 are mainly attributable to the decline in the consumption of psychoactive mushrooms and ecstasy.

Initial results from the “Hamburger Schulbus“ also show here that in particular the consumption of cannabis among the surveyed population has noticeably decreased in comparison with the previous years and that the age of initial consumption of cannabis is on the rise compared to the previous year. Since 2004, the 30-day-prevalence of cannabis consumption of male interviewees in Hamburg has decreased from 22% to 13%, and among girls and young women it dropped from 13% to 7% (figure 2.3). The lifetime-prevalences sank during the same period of time from 46% to 33% (boys and young men) and from 35% to 22% respectively (female interviewees) (Baumgärtner 2008).



**Figure 2.2** Lifetime-, 12-month- and 30-day-prevalence of the consumption of illicit drugs (excluding cannabis) among Frankfurt students aged 15 to 18 years - 2002-2007 (MoSyD)



**Figure 2.3** Lifetime- and 30-day-prevalence of the consumption of cannabis among adolescents in Hamburg 2004-2007

Data collected by the “Hamburger Schulbus“ seems to indicate that risky cannabis consumption<sup>6</sup> is also on the decline. However, the declining trend showing in the portion of adolescents with risky consumption (2004: 5.6%, 2007: 4.0%) falls under statistical randomness. Compared to the results of the previous year however, the age of initial consumption noticeably increased from 14.0 (2005) to 14.5 years (2007).

<sup>6</sup> Defined as: consumption more than 25 times *and* last consumption in the previous week *and* consumption also in the school context as well as alone at home *or* daily consumption.

Preventive measures specifically addressed to cannabis users should have the goal to delay the initial use of the substance as far as possible and reduce the extent of the experience made with cannabis since these factors play an important role with regard to the later development of persisting cannabis use and potential dependence (Perkonig et al. 2008).

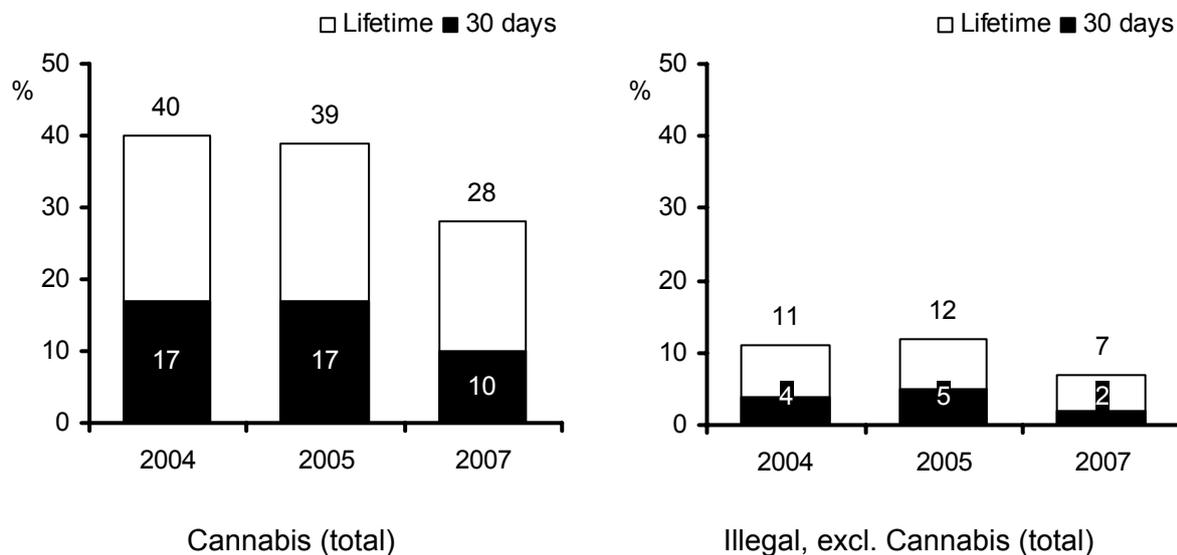
In the year 2007, a report on the health of children and adolescents was published in Schleswig-Holstein (Ministry for Social Affairs, Family, Youth and Senior Citizens of the Land Schleswig-Holstein 2007; Robert Koch Institute 2007b), which is based on an evaluation of the Health Interview and Examination Survey for Children and Adolescents (KiGGS) at Land level. All in all, almost every tenth of the interviewed children or adolescents in Schleswig-Holstein (10.6%) has consumed cannabis, ecstasy, stimulants, medical drugs or glue/solvents at least once in the last 12 months. Drug experience made a jump in particular from the 13<sup>th</sup> to the end of the 14<sup>th</sup> year of age. At this age, there is larger group of adolescents to be found who has tried drugs. Among the substances surveyed within the framework of KiGGS, cannabis is the by far most commonly used substance also in Schleswig-Holstein. 9.3% of the KiGGS interviewees in Schleswig-Holstein reported to have used cannabis at least once during the last 12 months. This value is practically identical with the average value found at federal level (Lampert & Thamm 2007). As already known from other studies, the portion of boys who “often” consumed cannabis in the last 12 months is with 1.9% significantly higher than the one of the girls (0.5%). All other substances are of comparatively little relevance. The portion of interviewees who used ecstasy or stimulants like amphetamines and “speed” at least once in the last 12 months lies below the comparative value for glue or solvents (less than 1%) and is thus in line with the results found by the national survey which was presented in the REITOX-report 2007. These low prevalences may also be connected with the relatively young age of the interviewees since - according to the results of the last drug affinity study carried out by the Federal Centre for Health Education - the age of initial consumption is 17.3 years on average (Bundeszentrale für gesundheitliche Aufklärung (BZgA) 2004).

Complementing the overall results of the HBSC-study which were already presented in the last REITOX-report, an evaluation of this study for the Land North Rhine-Westphalia has been supplied in the meantime. 19% of the surveyed boys and 12% of the girls of grade 9 reported to have smoked cannabis at least once in their lifetime. These figures are almost identical with the results found by the overall evaluation of the HBSC (which is based on the data of 5 Länder).

The picture of last year’s cannabis consumption looks similar: 14% of the boys and 9% of the girls in North Rhine-Westphalia have consumed cannabis at least once in the 12 months prior to the survey. Differences related to the type of school are not very pronounced for this indicator. (Richter et al. 2008).

## Summary and trends

An important result yielded by the recent “Hamburger Schulbus“ is that the consumption of narcotics has noticeably declined among the surveyed population (14- to 18-year-old students) in comparison with the previous years (Baumgärtner 2008) (figure 2.4).

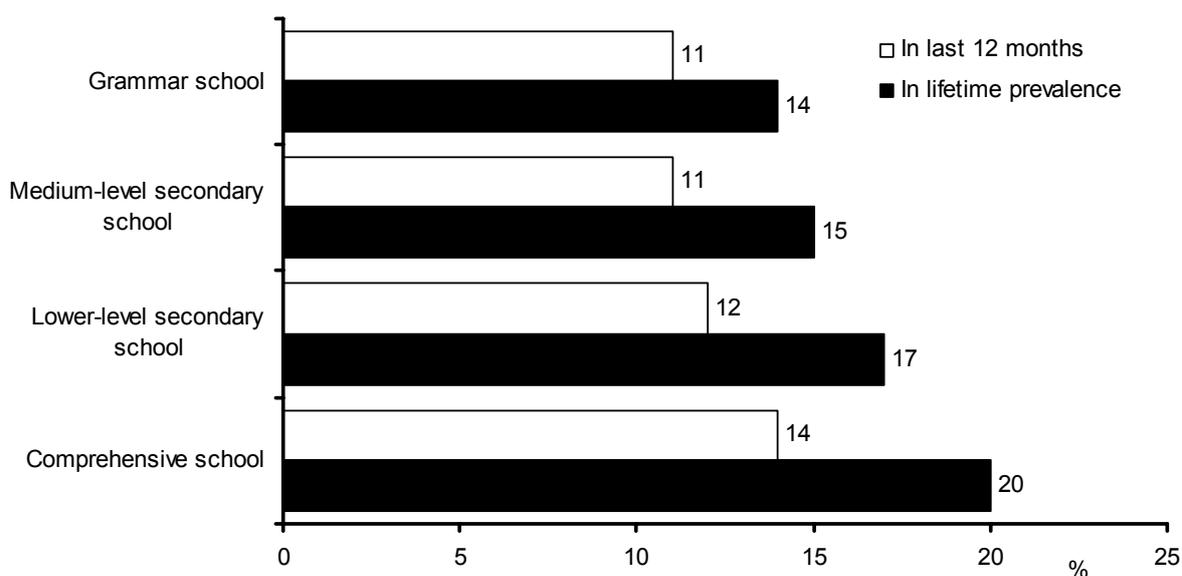


**Figure 2.4** Lifetime- and 30-day-prevalence of the consumption of cannabis and other illicit drugs (excluding cannabis) among adolescents in Hamburg 2004-2007

The relevance of peer group behaviour as a motive for cannabis consumption has significantly declined compared to the previous year. Unchanged however, is the most reported motive for the (initial) consumption of cannabis: curiosity about the effects of cannabis. The more experienced consumers of hashish and/or marijuana mainly use cannabis, by their own account, to deliberately influence their physical and psychological condition. Significant declines were also found for the consumption of illicit drugs other than cannabis, that is in all age groups.

The KiGGS conducted in Schleswig-Holstein found no significant differences relating to gender nor to social status with regard to drug experience. However, interviewees from Schleswig-Holstein families with a high social status tended to report experience with drugs more frequently than children and adolescents from families with a lower social background. When breaking down the results found by KiGGS at national level by social status, type of school, migration background and residential area, differences were merely found in a more frequent use of cannabis by boys who attended a comprehensive school in comparison with those who attended a grammar school.

The evaluation of the data for North Rhine-Westphalia collected within the framework of HBSC shows as a result that experience with cannabis is lowest among students of grammar schools (Figure 2.5).



**Figure 2.5** Cannabis consumption broken down by school type, results of HBSC, North Rhine-Westphalia

According to the ESPAD-results (Kraus et al. 2008), students attending a comprehensive school have the highest lifetime-prevalences for any illicit drug (32%). Boys and girls of lower- and medium-level secondary schools (respectively 28%) and of grammar schools (26%) had somewhat lower levels of experience with illicit drugs. The largest portion of adolescents who have consumed amphetamines (7%) and hallucinogenic mushrooms (6%) at least once in the lifetime were found among comprehensive school populations. These displayed also a significantly higher abusive behaviour with regard to cannabis than pupils from other types of schools. Pupils from lower-level secondary schools report consumption of ecstasy and cocaine (6% respectively) in the lifetime category more frequently than those from other types of schools.

Richter and Leppin (2008) investigated recent age- and gender-specific prevalences for the consumption of cannabis and presented developments in the time period between 1994 and 2006. They tapped data from from the North Rhine-Westphalian sub-surveys carried out within the frame of the HBSC-studies in the years 1994, 1998 2002 and 2006. The data of a total of 15,729 students aged 11 to 15 years could be included in the trend analyses. Apart from information on alcohol and tobacco consumption, there is also data available on the cannabis consumption of this population which is however only surveyed in the age group of the 15-year-olds. Due to missing data, trend analyses can only be made for the 12-month-prevalence because this indicator has been used by the HBSC-study since 1998. As reported also by other epidemiological studies, the prevalence of cannabis consumption of the 15-year-old boys increased significantly, in the HBSC-study by 18% to 23% from 2002 to 2006. Afterwards, figures declined again between 2002 and 2006 and dropped below the value of 1998 (14%). As for the girls, by contrast, figures continually declined from 15% in

1998 to 9% in the year 2006. A similar pattern was found for the boys also with regard to the consumption of tobacco and alcohol.

Table 2.4 and table 2.5 summarize the results of the most recent estimates of the prevalence of consumption among adolescents for the illicit drugs altogether and for cannabis separately. When comparing the figures, it needs to be taken into account that the questioned age groups are not identical. One also needs to bear in mind that ESPAD and HBSC were only conducted in a few of the 16 Federal Länder which might also have lead to distortions. Some of the differences in the prevalence estimates may also be attributable to different interviewing techniques (telephone vs. face-to-face interviews) or different wording used in the questionnaires.

**Table 2.4** Prevalences of the consumption of illicit drugs among children and adolescents – various studies

Study	Year	Agegroup	Region	Period		
				30 days <sup>1)</sup>	12 months	Lifetime
BZgA	2004	12-15	National	1.3%	5.5%	7.8%
BZgA	2004	16-17	National	5.2%	20.8%	32.2%
BZgA	2004	18-19	National	6.0%	20.0%	36.0%
ESPAD <sup>2)</sup>	2007	15-16	7 Laender			27.7%
ESPAD	2003	15-16	6 Laender	15.0%	26.0%	33.0%
MoSyD <sup>3)</sup>	2007	15-18	Frankfurt	2%	5%	10%
Schulbus <sup>3)</sup>	2007/08	14-18	Hamburg	2%		7%
Schulbus <sup>3)</sup>	2005	14-18	Hamburg	5%		12%
Schulbus <sup>3)</sup>	2004	14-18	Hamburg	4%		11%

1) BZgA ("present consumption" = 30 days); Schulbus ("current consumption" = 30 days).

2) ESPAD interviews students from grade 9 and 10, the focus therefore being on the age group 15-16 years, but also a few students aged between 14 and 17 years took part

3) All illegal drugs except for cannabis were taken into consideration

**Table 2.5** Prevalences of the consumption of cannabis among children and adolescents – various studies

Study	Year	Age group	Region	Consumption in period (%)		
				30 days <sup>1)</sup>	12 months	Lifetime
HBSC <sup>2)</sup>	2006	15	5 Laender	7.1/4.3		18.1/13.8
HBSC	2002	M=15,7	4 Laender		18.0	24.0
KiGGS <sup>2)</sup>	2003-2006	11-17	National		9.2/6.2	
BZgA	2007	12-19	National	3.4 (2.3) <sup>3)</sup>	8.0	15.1
BZgA	2004	12-19	National	(2.3) <sup>3)</sup>	12.1	21.3
ESPAD <sup>4)</sup>	2007	15-16	7 Laender	8.1	17.2	25.2
ESPAD	2003	15-16	6 Laender		24.0	31.0
MoSyD	2007	15-18	Frankfurt	13	24	34
Schulbus	2007/08	14-18	Hamburg	10 <sup>5)</sup>		28 <sup>5)</sup>
Schulbus	2005	14-18	Hamburg	17.1		39.1
Schulbus	2004	14-18	Hamburg	17.3		40.3

<sup>1)</sup> BZgA ("present consumption" = 30 days), Schulbus ("current consumption" = 30 days)

<sup>2)</sup> HBSC (2006) and KiGGS: First value: boys, second value: girls

<sup>3)</sup> In brackets: regular consumption (> 10 times in the last year)

<sup>4)</sup> ESPAD interviewed students from grades 9 and 10, the focus therefore being on the 15- to 16-year-olds, but also a few students aged 14 or 17 years respectively took part. Source: BZgA

<sup>5)</sup> Preliminary data.

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

## 2.4 Drug use in specific groups

### 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.

Härtel-Petri and colleagues (2007) report on the extremely big difficulties of motivating especially opiate addicts of the group of ethnic German immigrants to undergo regular substitution treatment. According to the authors, there is a considerable part of patients who, in the course of the treatment, give preference to substitution doctors who prescribe take-home-doses instead of insisting on a daily visual check while administering the substitution

drugs in substitution ambulatories. An amazing result of the analysis carried out by the authors was that a high percentage of the patients with migration background have never undergone any withdrawal or rehabilitation treatment although they have been receiving substitution drugs for years.

Access to migrants who only make use of care offers upon referral continues to constitute a special problem. Also Walter & colleagues (2007) underline the importance of looking more deeply into the specific health and psychological problems of people with a migration background living in Germany. They refer to a project which is currently carried out by the Federal Ministry for Education and Research with a focus on addiction-related illnesses and the costs caused by the deployment of native speakers as prevention counsellors who could find better access to the immigrants. The authors point out that 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.

In an article on the treatment prognosis for addicted delinquent repatriates, Hoffmann (2007) arrives nevertheless at the conclusion that, given the adequate framework conditions, the treatment prognosis for this group does not necessarily have to be worse at least in the course of the withdrawal treatment than the one for a comparable group of natives. These results are based on the experience made by a forensic department in which repatriates are treated through the therapeutic community in high-frequency group therapy combined with intense work and a swift orientation towards the outside world.

Apart from language barriers and potential fears of consequences for their rights of residence, also cultural reasons seem to play a role in this context. 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 also 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.

### **Children of addicted parents**

Arenz-Greiving und Kober (2007) conducted a metastudy on the work with children and their addicted parents on behalf of the Federal Ministry for Health. Based on a vast practical experience made in particular in outpatient work, they developed a series of recommendations for the keynotes of future demonstration projects. The authors point out that many of the difficulties encountered with the projects are actually more linked to the implementation of the projects and the transfer into the practical field than they would appear to require any further additional analysis. The authors gave recommendations for the scope, structural and content-related requirements as well as for the development and testing of a

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base module. In their recommendations, they also dealt with the conception, didactics and time frame for the implementation of a preventive family-oriented counselling offer.



## **3 Prevention**

### **3.1 Overview**

The guidelines spelled out by the EU-drug strategy 2005-2012 on offer and demand reduction are implemented with resolution. In this, priority continues to be given to health protection and prevention.

German “Drug and Addiction Policy“ is based on the current “Action Plan for Fighting Drugs and Addiction“ of the Federal Government Commissioner on Narcotic Drugs. The expert working group “Prevention of Addiction“ set up by the National Board on Drugs and Addiction suggests strategies and measures to implement and coordinate the goals contained in the action plan in the area of prevention. In 2007 and at the beginning of 2008, the working group was intensely occupied with the elaboration and coordination of “national action programmes” in the field of tobacco and alcohol prevention (Die Drogenbeauftragte der Bundesregierung 2008b).

Alongside measures of behavioural prevention, a series of structural approaches (of behavioural prevention) (Piontek et al. 2007) were successfully implemented in 2007, in particular in the area of licit addictive substances. Part of these approaches are also legislative measures to reduce consumption by for example influencing price and availability through the number of vending places, by setting age limits, restricting trading hours and licences and by prohibiting advertising. In 2007, structural framework conditions were developed and implemented especially in the area of tobacco prevention or respectively for the protection against the dangers of passive smoking. Examples of these are the rise of the age limit to 18 years for smoking in the public and purchasing tobacco products and the introduction of the Non-smoker Act at national and Länder level.

Besides activities undertaken in the area of “universal prevention“ for the general population, there is an increasing number of measures developed and implemented for specific risk groups like for example “children from families with addiction problems“ or “adolescents with (problem) cannabis use“.

#### **Focal areas of prevention**

Federal and Länder governments have set their focus on the prevention of tobacco, alcohol and cannabis dependence. Since 2006, another focal area has been added: the prevention of “pathological gambling“. On 28 March 2006, the Federal Constitutional Court rendered a

decision on the maintenance of the state gambling monopoly<sup>7</sup> setting conditions for a consequent and satisfactory fulfilment of the state's obligation with regard to addiction prevention. These conditions are also part of the State Treaty on gambling<sup>8</sup> which entered into force on 1 January 2008. The earmarking of the profits from state betting has been complemented in the State Treaty by binding measures to prevent addiction. The Land lottery organisations were tasked in the regulatory statutes to develop social concepts which guarantee the countrywide availability of an active addiction prevention offer within a nationwide overall concept. Three years after the State Treaty entered into force, it is evaluated by the gambling control authorities in co-operation with an advisory committee.

In order to comply with the requirements set by the Federal Constitutional Court for the maintenance of the state betting monopoly, the German Lotto- and Totoblock and the Federal Centre for Health Education made a cooperation agreement to develop and realize a national umbrella campaign in 2007 to prevent gambling addiction or abusive gambling behaviour respectively. The goal of the campaign is to guarantee countrywide consistency in the quality of the prevention of gambling addiction or problem gambling behaviour respectively (for a detailed description of the measures cf. chapter 1, page 17, activities undertaken by the Federal Centre for Health Education (BZgA)). The campaign is complemented by measures undertaken at Land level. Among them are for example the training of personnel in the Lotto-offices and the set-up of regional counselling facilities focusing on the topic of "gambling addiction".

### **Cooperation, transfer and evaluation**

As a result of the federal structure and the principle of subsidiarity, the practical implementation of addiction prevention measures is shared by a multitude of players at local, regional and national level. In order to guarantee a mutual exchange of information and experience between the different levels, appropriate interfaces and structures have been developed. The BzGÄ-Länder-cooperation group "prevention of addiction" for example was founded in the early 90's to improve the quality and coordination of prevention measures to be carried out by the responsible representatives of the Länder and the BZgÄ.

Within the framework of capacity building measures, a series of additional computer- and Internet-assisted systems have been created over the last years to improve cooperation between the players and improve conditions for addiction prevention work. One of them is the documentation system „Dot.sys“ which monitors and collects data on prevention activities

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<sup>7</sup> In general language usage, the gambling monopoly is taken as referring to as the state control on publicly accessible gambling for monetary assets. The Federal Constitutional Court laid down specifications for the state gambling monopoly in its decision of 28 March 2006 (1 BvR 1054/01). According to the Federal Constitutional Court's decision, a state monopoly for sports betting interferes with the constitutional right of the freedom of occupation of private betting operators and is only justifiable by a consequent and credible fulfilment of state addiction prevention. Therefore, the Federal Constitutional Court is critical of the exclusion of private betting and gambling operators by the state and simultaneous advertising for sports betting for example by the state-licensed operator ODDSET.

<sup>8</sup> GVBI 2007, p. 906

undertaken in Germany. The Internet platform “PrevNet“ ([www.prevnet.de](http://www.prevnet.de)) has been developed for experts in addiction prevention. Both projects, which will be outlined in the following, are cooperation projects between the Federal Centre for Health Education and the Länder.

Drug prevention professionals from counselling facilities and drug prevention agencies, government offices, associations, drug ambulatories and Land coordination agencies of all Federal Länder collect data on their activities via an electronic data collection system within the framework of Dot.sys. In the year 2007, more than 350 professionals (75% of all professionals working full-time in drug prevention) documented about 31,000 measures. The expressiveness of the data collected via the documentation system is limited due to the still in part considerably diverging participation quotas of the individual Länder. The results of the yearly data evaluations can thus not (yet) meet the requirement of giving a complete picture of the prevention activities undertaken by the full-time professionals in Germany. It is planned to continue and complete the documentation system in the following years. In doing so, a focus will be set on the harmonization of the diverging participation quotas of the individual Länder.

In the following, the most important results of the Dot.sys-survey conducted in 2007 are summarized:

- 50% of all the prevention activities documented by Dot.sys are addressed to multipliers, another 42% to final addressees and 7% fall under the category “public relations”. This distribution of main target groups has remained stable in addiction prevention practice over the years of data collection through Dot.sys (2005 bis 2007).
- The most frequently reported setting among the documented measure are schools (38 % of all entries)<sup>9</sup>. Students are correspondingly identified as the most frequently entered final addressee group. Furthermore, every third measure for multipliers is addressed to teachers. The most important working areas outside of the school setting are “health care” and “youth work”.
- The Action Plan for Fighting Drugs and Addiction identifies “children and adolescents“ as the main target group of addiction prevention. This emphasis is also reflected by the practical prevention work documented within the framework of Dot.sys. 60% of all measures undertaken for final addressees involve children and adolescents up to 17 years<sup>10</sup>. Adolescents between 14 and 17 years are reached mostly over corresponding projects (49%).
- 50% of the measures were assigned to a non-substance-related approach. Behavioural addictions formed the focal area of 7% of all documented activities. Passing on

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<sup>9</sup> Due to a change in the data collection procedure at this documentation level, figures cannot be compared to the percentage values of previous years.

<sup>10</sup> Here, measures intended for “children aged up to 13 years“ and/or “adolescents aged between 14 and 17 years) are taken into account. The category “age“ permits several entries.

information on addictive substances was the intention of 43% of all documented measures. Among the addictive substances, “alcohol” is the one most frequently mentioned (70% of all substance-related measures) followed by cannabis (43%) and tobacco (39%).

- “Passing on information” and “forming of critical opinions” are the conceptual basis of most of the measures (74% of all entries). As for the activities deployed for the target group “multipliers”, “capacity building” (55%) and “promotion of skills” (40%) are of particular relevance. Measures directly targeted at final addressees put a special emphasis on the promotion of skills (56%) as well as the formation of norms and values (36%).
- Evaluations are carried out for almost a third (29%) of the activities. Most of them are internal evaluation measures (78%).

The Internet portal “PrevNet” serves ([www.prevnet.de](http://www.prevnet.de)) to network professionals in the field of prevention and to facilitate the access to a host of information and materials. Approximately 850 professionals from 560 facilities of substance abuse prevention are members of PrevNet. More than 350 projects and material as well as more than 80 studies can be found on it. Numerous experts have linked in more than 60 (cross-country) Internet working groups in the interactive area of the forum. It is planned to further expand the portal by implementing a comprehensive E-learning-area in 2008 which is to offer training for Prev-Net-members.

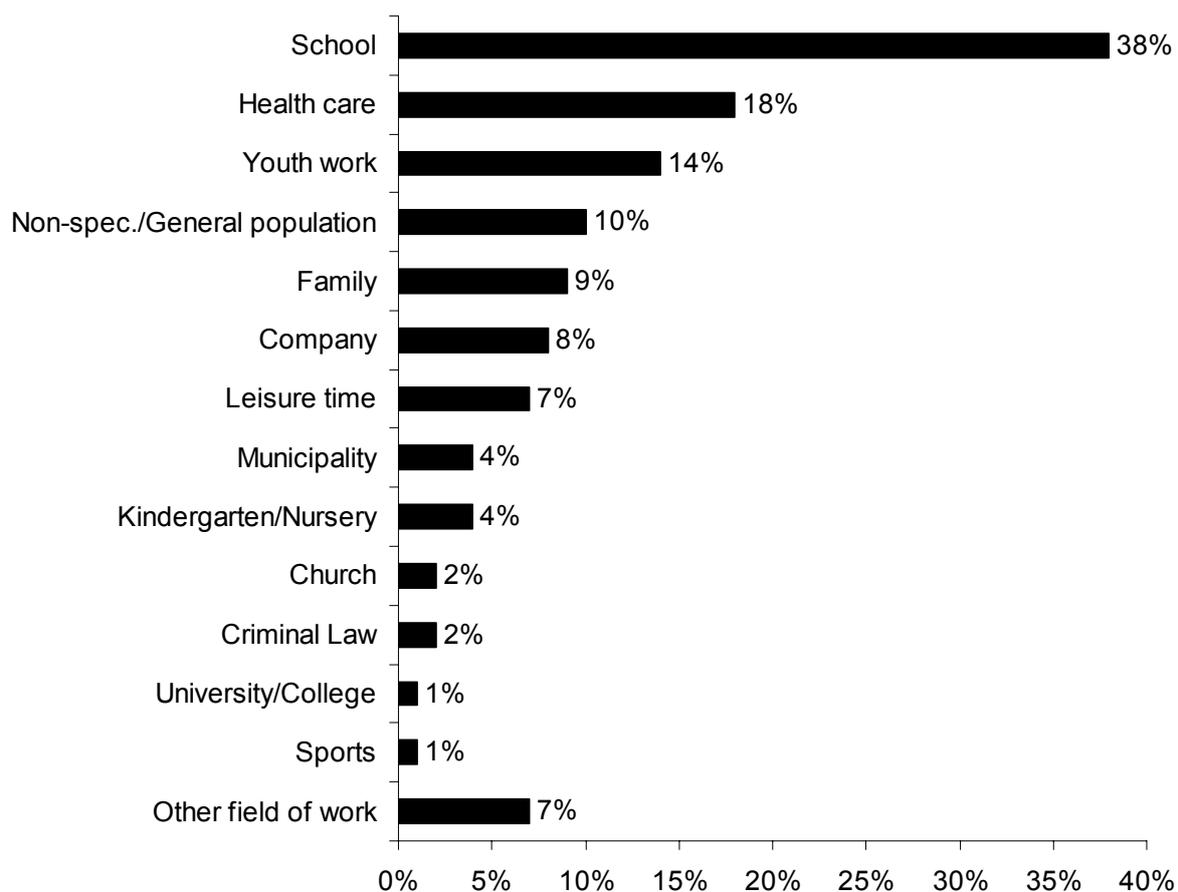
### 3.2 Universal prevention

Figure 3.1 shows the distribution of the documented prevention activities broken down by settings<sup>11</sup> in Dot.sys. It shows that “school” is most frequently mentioned working field<sup>12</sup> just like in the years 2005 and 2006. In second place are measures undertaken in the field of health care which ranked third in the previous year and were even on the last position but one in 2005. This development suggests that the importance of this working field for addiction prevention apparently has increased. 14% of all measures were assigned to the setting “youth work”.

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<sup>11</sup> Due to a change in data collection in the documentation level “setting” and the integration of new answer categories it is not possible to compare the percentages directly to last years’ values.

<sup>12</sup> Since this question category allows multiple entries, some of the measures are also related to other settings apart from the school. This means the value does not only represent solely school-related measures. The value is at 33 %.



Basis: 31.441 (2007) measures; percentages; multiple entries possible.

**Figure 3.1** Settings of prevention measures (Dot.sys)

### 3.2.1 School

In their expert report, Bühler & Kröger (2006) describe the school “as an excellent setting to reach children and adolescents and carry out programmes with them“. This working field as described above<sup>13</sup> assumes particular importance within the framework of the Dot.sys-documentation system. 38% of all prevention activities are carried out in the school setting.

Among the host of programmes which have been used for years to implement addiction prevention in schools, there are for example ALF (Prevention programme to teach general life-skills and competences to students of grade 5 and 6), Lions Quest, Class 2000, Become self-sufficient and BASS – a modular programme of addiction prevention in the school setting (Hallmann et al. 2006).

The prevention activities undertaken in the school setting comprise both behavioural and structural approaches. The programme BASS – modular programme of addiction prevention in the school setting – is cited here as an example. It uses methods to improve the social competence but also understands itself as a structural programme and involves as such the

<sup>13</sup> The most frequently mentioned setting category

whole school. Furthermore, the programme serves to give recommendations on how to link with other institutions.

Approximately every fourth school-related measure documented via Dot.sys (see above) has a structural component (24%)<sup>14</sup>. Part of this are for example the interior design of schools, the promotion of a good school atmosphere, playground activities and playground layout.

School-related measures of *behavioural prevention* mainly serve to convey information and form critical opinions (78%). They are furthermore devoted to promoting life-skills (57%) and forming values (32%).

Measures which put an emphasis on *non-substance-related* prevention approaches form the largest part (49%) of the activities<sup>15</sup>. Most of them focus on promoting life-skills. 43% of the prevention measures are mainly concerned with conveying information on specific substances. The substances most frequently dealt with are alcohol (68%), tobacco (54%) and cannabis (50%).

Comprehensive smoking prohibition laws entered into force in almost all Länder during the reporting period. These comprise smoking prohibition at schools. Most of the Länder however, passed non-smoking laws or regulations for schools already in the previous years. In order to support schools in setting up and realizing smoke-free concepts, specific programmes and measures have been developed. An example of these is the initiative undertaken by the Land North Rhine-Westphalia "Living without smoke" which contains a five-step programme to introduce a smoke-free concept in schools ([www.loq.de](http://www.loq.de)). The Federal Centre for Health Education held conferences, continuing education events and workshops also in 2007 to support schools in various Länder on their way to a smoke-free environment. It laid a focus on schools in those Länder which had only recently passed non-smoking regulations. There was quite a large demand for support from these schools. Student-teacher-seminars are a further innovative measure which was offered in 2007 for the first time.

### 3.2.2 Family

The family assumes a key role in the prevention of addiction. Here the child makes its first basic experiences which will impact later phases of life. Assigning evidence grades to various types of prevention measures, Bühler & Kröger (2006) conclude in their expert report: "Taking into account these evidence levels, it is recommended to offer comprehensive measures in the family, i.e. trainings for parents, children and families (especially alcohol, evidence grade C<sup>16</sup>)." The involvement of the family system in prevention projects offers the advantage of being able to take into account not only the problems and stress situations but also the resources coming along with the family.

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<sup>14</sup> If one only includes the activities undertaken by the multipliers here, this portion increases to 46%.

<sup>15</sup> This documentation level asks for the *main* content-related orientation. Since it is only possible to make one entry here, other additional components like "conveying information on specific substances", are not given.

<sup>16</sup> Evidence level C = The result is based on a meta-analysis or a systematic review with all studies.

9% of all measures documented via Dot.sys target the setting “family“. Breaking down the measures by target groups, one sees that parents or family members respectively can be addressed both as multipliers (10% of all multiplier measures involve parents or family members respectively) and as final addressees (15% of the activities are targeted to final addressees).

The Internet portal [www.starke-eltern.de](http://www.starke-eltern.de), which also contains projects from the settings kindergarten, school and youth work, addresses parents directly by providing information on the developmental phases and needs of children as well as on the prevention of addiction in the family.

### **3.2.3 Community**

As a direct living space for adults, teenagers and children, communities represent a suitable basis for the implementation of comprehensive prevention activities and projects. In the year 2001, the Federal Centre for Health Education organized for the first time a national competition on “Model strategies of community prevention of addiction“ followed by the competitions “tobacco prevention at ground level“ and “alcohol prevention at ground level“ with a gap of two years between each. The overall goal of the competition is to “support the communities in their commitment shown for the tasks of addiction prevention and make good examples of community prevention visible to a large (expert) public for the inter-community exchange of experience as well as to give the personnel working in community addiction prevention a clear sign of appreciation and support for their work” (Difu 2007). The assessment criteria are available on the Internet (<http://www.kommunale-suchtpraevention.de>). They take into account, among others, the long-term nature or the sustainability respectively as well as the measurement of the success and the documentation of the projects together with the linkage of the players. A total of 282 communities took part in the three competitions. All entries for the competition can be looked up on the Internet, but there are also documentations available in book-format.

In the year 2007, the three competitions were analyzed to investigate the effect of the instrument “National competition” (ibid). A central result of the analysis was that the communities wished “to have a follow-up of the series of competitions for community prevention of addiction“ (ibid.). From the other results of the study recommendations were derived for the tendering, implementation and evaluation of the next competition which is planned for 2008/2009.

### **3.2.4 Driving school**

The consumption of alcohol, medical or illicit drugs considerably impairs the ability to drive and often leads to an increase of risky behaviour. Thus, addictive substances pose a special, incalculable risk both to the drug user and other road users. A series of prevention projects is dedicated to the problem of drugged driving. They follow various approaches. An example of these projects is the initiative “don't drug + drive“ launched by the Accident Research of the Insurers in the Umbrella Organization of the German Insurance Industry ([www.dont-drug-](http://www.dont-drug-)

and-drive.de ). Within the frame of this initiative, high-publicity events (like for example the foto competition "Zeig uns Deinen klaren Blick" ("Show us your clear eyes) in 2007) are staged and media and information material developed, among them a brochure for driving teachers.

Some of the measures devoted to the topic "drugged driving" are embedded in the setting "driving school" where a peer-approach is often used. In 2007, an expert meeting was held on the experiences made with the "peer-project at driving schools" ([www.peer-projekt.de](http://www.peer-projekt.de)). The participants of the meeting developed common recommendations for the further implementation of peer-projects for driving schools.

Placed under the motto "PEER-Drive Clean!", a peer-project has been carried out since 2006 as a European demonstration project on behalf of the European Commission in driving schools in Germany and another nine countries: Belgium, Estonia, Italy, the Netherlands, Austria, Portugal, Romania, Slovenia and Spain. At a conference held to evaluate the set-up phase of the project in August 2007, the implementation of the project so far was rated successful and the partners involved in the projet decided to apply for a follow-up project for the period from 2009 to 2011.

The project "Prästo" (Prävention in Fahrschulen – starkes Fahren ohne Stoff) carried out by the Lower-Saxon Land Centre for Addiction Issues offers a two-day-training programme to peers who then organize events for learners on the topic "drugged driving". The goal of the project is to enhance the participants' awareness as how to deal with addictive drugs especially when riding a car.

### **3.3 Selective / indicative prevention**

Selective prevention is to address groups of people who appear to be specifically at risk of abusing addictive substances without actually displaying any abusing behaviour yet (Bühler and Kröger 2006). Prevention measures targeted to specific at-risk groups very often take place in the recreational setting. The special role played by the setting "recreation" is also shown within the framework of the documentation of the prevention measures in "Dot.sys"<sup>17</sup>: out of all entries, 7% of the measures involve the recreational setting. If the activities are geared to specific at-risk groups, this portion is by far higher. Thus, 26% of the measures targeting "adolescents/young adults having experience with drug consumption" involve the recreational setting. Related to activities undertaken for "socially disadvantaged persons", the portion amounts to even 48%. Therefore, the following chapters will first present (organized and non-organized) leisure-time activities before looking into individual at-risk-groups.

#### **3.3.1 Organized leisure time**

As for organized leisure time activities addressing young people, there are drug prevention measures undertaken both at local government, regional, Land and Federal Government

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<sup>17</sup> For the description of the documentation system Dot.sys see p. 46.

level (Schmidt 2004). In the following, the working fields “youth welfare” and “sports clubs” are presented.

### **Youth Welfare**

The Children and Youth Welfare Act regulates and describes the right of young people to be promoted and educated to become independent individuals capable of living in a community. Substance abuse prevention is part of this description of tasks (Hallmann et al. 2006).

Classic facilities of youth welfare and youth protection are day care centres, youth centres and facilities offering child-rearing support. Youth centres are often a meeting point for adolescents who engage in high or risky substance use, who are involved in criminal activities, who are economically or socially disadvantaged or display psychological disturbances.

In order to teach these adolescents skills like risk competence and risk management, staff of youth centres need to, as part of substance abuse prevention, take a holistic approach to the lives of the adolescents without focusing exclusively on substance abuse and harm reduction. Instead, they need to give support in coping with existing risks or difficult life circumstances. They need to address substance use and risks connected to it, set up rules in the facilities to control the consumption of psychoactive substances and develop strategies to implement these rules and make sure that they are observed (ibid.).

### **Sports clubs**

Alongside schools and families, sports clubs form an important part of the lives of children and adolescents and are therefore particularly suited for carrying out prevention measures. More than 70% of all adolescents are members of a sports club for a shorter or longer period of time. The countrywide existence of sports clubs across different social strata creates a higher accessibility also of socially disadvantaged children and their parents, especially through football.

Within the framework of the campaign “Make children strong“, the BZgA succeeded in 2007 to integrate the topic of addiction prevention into the regular curriculum of the teaching activities undertaken by the German Football Association (Deutscher Fussballverband, DFB). About 600 professional and honorary trainers working in the 21 Land associations of the DFB, as well as youth trainers and counsellors were qualified in a short training programme in “addiction prevention in sports clubs“. The DFB was the first mass sports association to develop such a programme together with the BZgA in Germany. The goal of the programme is to go beyond the practical football training and motivate young players in the age group from 5 to 14 years to lead their lives without drugs.

The campaign served to create a basis for an independent continuation of a qualified training and further education in early prevention of addiction by the DFB. The aim for 2008 is to introduce a similar procedure for the junior players (14-18 years) with a focus on tobacco and alcohol prevention. It is furthermore planned to have talks with the cooperation partners, the

German Olympics Sports Association (Deutscher Olympischer Sportbund, DOSB) and its affiliated youth organisations as well as with the German Athletics Association with the purpose to integrate the evaluated teaching methods and material into their educational work.

Within the framework of the so-called “club service“, the Federal Centre for Health Education furthermore lends support to sports clubs by providing them with material on addiction prevention and counselling on the planning and execution of their own activities. In 2007, more than 1,400 sports clubs or approx. 4,300 multipliers respectively were reached by this initiative.

Furthermore, the topic “prevention of addiction in sports clubs“ was playfully and imaginatively picked up within the framework of 18 major events spread over 22 days at federal, Land- and local government level. The events also offered the occasion to have numerous talks with parents and representatives from children and youth work.

### **3.3.2 Non-organized leisure time**

As for non-organized leisure time, drug prevention measures - and especially those relating to nightlife – continue to be scanty. In some (mostly larger) cities though, party projects – offered and carried out by scene initiatives - have established themselves. They are often linked with youth centres or drug counselling facilities or other party projects at local government level. On their websites and through media like flyers, they inform about the risks of consumption (especially) of scene-related substances. These initiatives often work at ground level at festivals, parties or events of clubs or in discotheques to provide information on drug prevention. Almost all initiatives offer online-counselling for users on their websites. The party projects [www.party-pack.de](http://www.party-pack.de) (Cologne), [www.drugscouts.de](http://www.drugscouts.de) (Leipzig), [www.party-project.de](http://www.party-project.de) (Bremen), [www.chill-out.de](http://www.chill-out.de) (Aachen), [www.alice-project.de](http://www.alice-project.de) (Frankfurt), [www.drobs-hannover.de](http://www.drobs-hannover.de) (Hannover) are mentioned here as examples.

The brochure “Living at night – measures of health promotion in nightlife“ was developed by the working group “Healthy Nightlife“ and is addressed to central institutions and players who want to promote risk-minimizing strategies for the nightlife. The medium is designed as a work tool and is to promote the implementation of best practice prevention measures in the nightlife. The working group “Healthy Nightlife“ was initiated by the BZgA and is composed of representatives from drug counselling facilities, scene-related initiatives, the office of the Federal Government Commissioner on Narcotic Drugs, the BZgA, local government authorities and party organizers.

### **3.3.3 At-risk groups**

#### **Adolescents and young adults with (problem) cannabis use**

Young people consuming cannabis and other illicit substances are difficult to reach over prevention activities. In addition, this target group is assumed to be rather heterogeneous. Apart from the parameters age and gender, the specific life circumstances, social situation

and psycho-social health of the adolescents or young adults respectively need to be considered. Set against the background of these special challenges, a series of differentiated offers and preventive measures have been developed for different sub-populations in Germany.

- International conference on new developments in the prevention and treatment of cannabis-related disorders

In March 2007, the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction organized together with the EMCDDA and the Federal Ministry for Health an international expert conference on the topic of “Cannabis – new developments in prevention and treatment“. The results have been reported in the last REITOX report (Pfeiffer-Gerschel & Simon 2008; Reitox Academy 2007).

- Cannabis cessation programme “Quit the Shit“

The briefly presented expert conference on the prevention and treatment of cannabis-related disorders showed among others that “(Internet-assisted) short interventions [...] carried out within the framework of targeted prevention measures for cannabis users who normally would not get into contact with treatment facilities, proved very useful“ (Reitox Academy 2007).

[www.drugcom.de](http://www.drugcom.de) is the website of the Internet-based cannabis cessation programme “Quit the Shit“ offered by the BZgA since 2004 especially for adolescents and young adults with risky and regular consumption of cannabis products.

The programme aims at significantly reducing the individual consumption of cannabis within 50 days. After a chat-based admission interview with a counsellor, the participants keep an online log book for 50 days. In this log book, they document their cannabis consumption and all other aspects pertaining to it (quantity, social context, reasons/motives). They receive qualified feedback to their diary entries by the counselling team on a weekly basis. In 2007, the programme was successfully integrated into the municipal structures of outpatient addiction aid within the framework of a demonstration project. To this purpose, cooperation agreements with counselling facilities from seven Länder were made. The professionals working at these facilities were trained for participation in the programme. A core element of quality assurance was a systematic case-by-case monitoring by the drugcom-team.

The transfer of “Quit the Shit“ was scientifically evaluated. It was investigated in how far a decentralized use of “Quit the Shit“ was possible and which quality assurance measures were necessary. The evaluation showed a high acceptance of the programme and a significant reduction of the consumption among clients.

In 2007/2008, a randomized control group study is to find out whether and to what extent “Quit the Shit“ can contribute to reducing individual cannabis consumption in particular beyond the participation period.

- INCANT – “International Cannabis Need of Treatment Study“, the CANDIS-study – “modular therapy of cannabis-related disorders“ as well as the German-Swiss project “Realize it“ have been presented in chapter 1.3.3. Final results are pending yet.

## Young delinquents

There are various projects carried out for young delinquents in the Länder with the purpose to prevent addiction. About 2% of the measures for final addressees documented within the framework of Dot.sys cover this specific target group. The project “FreD – early intervention in drug users who have come to the police attention for the first time“ has meanwhile found wide usage and will be roughly outlined in the following.

- Early intervention projects “FreD“ and “FreD goes net“

The programme “FreD“ was developed by the addiction coordination centre of the Area Association Westfalen-Lippe. The main purpose of the programme is to offer young drug users who have come to the attention of the police for the first time a counselling talk followed by a short intervention. In a first phase, the concept was implemented within the framework of a demonstration project in eight Länder. Encouraged by the positive experience made with regard to the acceptance and effect of the project, the approach was expanded in a next step by publishing a manual, organizing transfer events and engaging in PR-work (transfer phase).

In the year 2007, a follow-up survey was carried out by the Federal Ministry for Health involving all facilities which offer “FreD“ or a “comparable initiative“. The survey was to investigate the expansion of the working approach, the conceptional further development, the organisational framework conditions, the financial back-up of the offers, the clients and the accessibility as well as the user-related and structural effects of early and short interventions (FreD) within the framework of the regular care offer made by the outpatient addiction and drug aid system (FOGS 2007).

When the survey was carried out, “FreD“ or similar programmes were offered by 140 facilities in Germany. 42 funding organizations announced their intention to implement such a concept in the future. It showed that about a quarter of the adolescents got access to the offer through their judicial conspicuousness (e.g. juvenile court assistance, public prosecution, courts of justice, police and assistance of juveniles placed on probation). Other ways of access, e.g. over parents/family members or school are relatively rare in this context. The large majority of the users complete the programme as scheduled, about one participant in ten is referred to other institutions providing further support.

Approx. 90% of the participants of the programme were afterwards rather satisfied with the early intervention measure, 76% rated it as personally important. Almost 70% have not come to the attention of the police since the participation in the programme. Half of the adolescents (50%) stated not to have taken any illicit drugs anymore, 33% reported to have reduced their consumption of illicit drugs. 44% of the participants have reduced their alcohol consumption. But the implementation of the measure had also an impact on the facilities themselves offering “FreD“ or a comparable programme. For example, the rating of early intervention has improved since<sup>18</sup> according to the questioned staff of the facilities. In the year 2007, the European project “FreD goes net“ which is derived from the abovementioned early

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<sup>18</sup> [http://www.lwl.org/ks-download/downloads/fred/FRED-Nachbefragung\\_lang.pdf](http://www.lwl.org/ks-download/downloads/fred/FRED-Nachbefragung_lang.pdf).

intervention project was kicked off at an event in Warsaw. "FreD goes net" is funded by the European Union within the framework of the Public Health Programme and the Federal Ministry for Health and runs for 3 years. The scientific evaluation of "FreD goes net" is carried out by FOGS. Institutions from 17 European countries in which the concept is to be implemented take part in the project as partners. The concept of "FreD goes net" also comprises, among others, the training of facility staff and the development of a manual.

Insofar as prevention measures relate to the context of preventing criminal acts, they lie in the domain of police authorities of the Länder. A number of Land Offices of Criminal Investigation, police authorities and municipal police offices carry out specific drug prevention projects within the frame of their prevention activities. These measures comprise for example information campaigns on illicit drugs and criminal offences or specific anti-drug activities carried out mostly in the context of dance or other leisure time events. These projects aim primarily at young people, in particular at students (Schmidt 2004).

### **Ethnic groups**

The Federal Government promotes non-age-related integration measures through the Federal Ministry of the Interior (Bundesministerium des Innern, BMI) and integration projects for young people below 27 years through the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (Bundesministerium für Familie, Senioren, Frauen und Jugend, BMFSFJ). Community-related integration measures are promoted by the Federal Agency for Migration and Refugees (Bundesamt für Migration und Flüchtlinge, BAMF) in close cooperation with the BMFSFJ. By promoting the stabilization of the personality of immigrants (Die Drogenbeauftragte der Bundesregierung 2008a) the projects are also preventive in nature.

The project "Integration through sports" - carried out in cooperation with the German Olympics Sports Association - is named here as an example. By strengthening the sense of self-worth through achievement in sports and by setting fixed rules and norms for the membership in the sports clubs, the project gives support and orientation to the immigrants making them less prone to addiction ([www.integration-durch-sport.de](http://www.integration-durch-sport.de)).

Out of the more than 240 non-age-related projects funded in 2007, nine focus, in addition to social integration, also on the special aspects of drug and addiction prevention. The BAMF follows the approach in addiction prevention of drawing the immigrants' attention to the existing (regular) help structures in Germany, of "picking them up" and leading them to regular addiction treatment as well as convincing them to make use of the regular help facilities. Out of the 190 community-oriented projects funded by the BMFSFJ in 2007, 36 were youth projects aiming at addiction prevention which received Federal Government funds to the amount of more than € 1.034 million.

Addiction prevention measures geared to ethnic groups comprise a multitude of activities reaching from PR-work to direct work with the final addressees and considering different sub-populations and language knowledge. As an example of these specific measures, a project carried out in Münster will be presented in the following.

The demonstration project “SeM – secondary addiction prevention among young German repatriates in Münster”, which ran until March 2007, was implemented in three steps: the first phase (three months) was dedicated to problem assessment using the RAR (Rapid Assessment and Response) method and selecting focus groups. In a second step (nine months) the existing secondary prevention concepts were adapted to the work with the young repatriates and their families. Then the individual multiplier groups (peers, key persons of youth work and parents) were trained. In the third phase (15 months), the trained multiplier approaches and methods were put into practice and evaluated (FOGS 2007). The authors of the scientific study on the project conclude that “SeM” succeeded in “improving the awareness of the risks linked to the consumption of psychoactive substances and in influencing the opinion and attitude towards alcohol and drug use” (ibid).

In a research project, the Medical College Hanover investigates the accessibility of Turkish or Russian speaking migrants via addiction prevention counsellors who are native speakers. The study analyses various access ways in terms of efficiency and cost effectiveness: two active access ways (“go-to-structure”) – the access over communities with a migration background as well as over language schools – and three passive access ways (“come-structure”) – telephone counselling, an Internet-based offer as well as the access over publicly announced events. The study is to give insight into the health and prevention behaviour of migrants and to detect possible barriers and ways to overcome them (<http://www.mh-hannover.de/spr-migranten.html>).

The Federal Ministry for Health funds a “Competence network “addiction self-help” for migrants from Eastern Europe and Asia (Kosmos)” within the framework of a three-year-demonstration project. The project is to carry out a scientific analysis of two different self-help approaches. One is about the family-based self-help concept used by the Dorkas-groups<sup>19</sup> which is specifically geared to the family situation and life circumstances of migrants, in particular of German repatriates from Russia. The other one is about the concept used by the Exjuse-groups<sup>20</sup> which establish contact with drug consuming young youth over the Internet and provide counselling.

#### **3.3.4 At-risk families**

Approx. 2.6 million children aged below 18 years currently live with alcohol-addicted parents. Additionally, there are between 40,000 and 60,000 children growing up with parents who are dependent on drugs. Every 5<sup>th</sup> to 6<sup>th</sup> child (17.6 %) on average is affected by addiction in the family. The number of children who suffer from non-substance-related addictions prevailing in their families (compulsive gambling, sexual obsession, workaholism, co-dependence) is not quantifiable ([www.nacoa.de](http://www.nacoa.de)). Children from families with addiction problems are the largest known group at risk of developing addictions themselves in their later lifes.

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<sup>19</sup> DORKAS-groups (reg.ass). is a self-help organization consisting of about 20 groups and about a further 20 individual contact persons spread over the whole of Germany.

<sup>20</sup> The Exjuse – Groups are affiliated with the associaton "Dorkas-Groups".

In 2007, the Ministry for Health published a metastudy on the topic “Work with children and their addicted parents“ (Arenz-Greiving & Kober 2007). All projects dealing with the subject which were carried out in the period between end of 1999 and end of 2006 at national level were included in the study. It assesses the documentation and evaluation quality in the working field and derives recommendations for optimization from it. Furthermore, the authors of the study conclude that the existing projects and offers do not sufficiently reach the potential target groups and recommend in this context among others to make the measures better known in all areas of the help system and increase their acceptance.

The measures and institutions presented hereinafter serve as examples to demonstrate the large spectrum of current support offers made to at-risk families; additionally, a representative research-project will be presented:

- Self-help-offers

Many German cities have self-help-offers for families with addiction problems. Targeted offers for children and adolescents are provided by the Alateen-groups<sup>21</sup> as well as by the children groups of the self-help-associations (Guttempler, Kreuzbund, Blaues Kreuz, Freundeskreise für Suchtkrankenhilfe). In case there are no specific offers available for children in families with addiction problems, there are at least often help offers for substance users and their relatives ([www.nacoa.de](http://www.nacoa.de)).

- Inpatient and outpatient help offers

Furthermore, there are professional help offers, i.e. outpatient services provided by drug counselling centres as well as inpatient offers of drug care facilities which cater for the children while their parents undergo inpatient treatment and sometimes also provide targeted therapeutic support for the children. Even if these offers are not always directly addressed to children from families with addiction problems, they can make a contribution to improving the family situation and easing the burden on the children.

- Internet-assisted counselling offers

The Internet offers numerous portals to support children of addicted parents, the (addicted) parents themselves and multipliers. Here are a few examples:

- [www.encare.de](http://www.encare.de): ENCARE (European Network for Children Affected by Risky Environments within the family) – European network for experts who work with children in families with addiction problems. Website of the German ENCARE-Network.
- [www.kidkit.de](http://www.kidkit.de): Funded by donations, this Internet website informs children on questions around addiction and provides counselling. The initiative is carried out by a team of 15 members.

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<sup>21</sup> Alateen is a self-help-organization for children and adolescents of families with alcohol abuse and form part of the Al-Anon-Family Groups. Alateen has around 40 self-help-groups in Germany.

- [www.proli-sucht.de](http://www.proli-sucht.de): Countrywide list of help offers for children of addicted parents. The homepage gives a countrywide overview of the projects and help offers available for children from families with addiction problems. Both professionals and children/families affected find quick information on local help offers (sorted by postcode) on this website.
  - [www.huckleberry-und-pippilotta.de](http://www.huckleberry-und-pippilotta.de): A registered association which supports children, adolescents and parents in addiction-stricken families.
  - [www.seitenstark.de](http://www.seitenstark.de): Working group for networked Internet websites for children.
  - [www.nacoa.de](http://www.nacoa.de): Registered association representing the interests of children in addiction-stricken families.
- Telephone Counselling

In the year 2003, the nationwide “Addiction & Drug Hotline” was set up. It is made up of several regional providers of emergency call services in Germany who have joined up under the organisational umbrella of the Federal Centre for Health Education.

The “Addiction & Drug Hotline” can be reached countrywide under the uniform telephone number 01805/313031. The hotline offers telephone counselling, support and information provided by experienced professionals from the area of addiction and drug aid. The Addiction & Drug Hotline is available both for people with addiction problems and relatives, friends or colleagues. The hotline is staffed 24 hours a day and costs 14 cents per minute on the German landline network<sup>22</sup>. In the year 2007, about 4,000 people seeking help and advice called the addiction and drug hotline. The Bundes-Arbeits-Gemeinschaft (BAG) Kinder- und Jugendtelefon e.V. provides two anonymous telephone counselling services in Germany. The services are available countrywide and free of charge.

The services offered for children/adolescents and for parents are separated from each other. Especially children and adolescents should not have the impression that counsellors possibly also talk to their parents. Both service lines offer anonymity to all callers – children, adolescents and parents alike. If the callers request further – also personal – help, the counsellors can refer to the corresponding organizations ([www.kinderundjugendtelefon.de](http://www.kinderundjugendtelefon.de)).

### 3.4 Indicative prevention

#### Children and adolescents with behavioural disorders

Behavioural disorders are taken as constituting an important risk factor for the development of addiction and violence during youth and adulthood. There are indications that about a fifth of the children and adolescents in Germany (21.8%) are psychologically disturbed. This results from an evaluation of the BELLA-study ([www.bella-studie.de](http://www.bella-studie.de)), which is integrated as

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<sup>22</sup> Different mobile phone tariff

an additional survey module in the countrywide Health Interview and Examination Service for Children and Adolescents (KiGGS, [www.kiggs.de](http://www.kiggs.de)) carried out by the Robert-Koch-Institute ([www.rki.de](http://www.rki.de)). The survey was conducted in the period between 2003 and 2006. The results indicate that 12.2% display psychological disorders and a further 9.6% are “very likely to be psychologically disturbed”. Some of these children and adolescents display specific disorders ranging from anxiety over depression to disturbed social behaviour.

In the framework of the study it was found that indications of psychological disorders significantly increase with a lower socio-economic status. It could furthermore be shown that a good family solidarity or a good family atmosphere has a protective effect in respect of psychological disorders, i.e. it considerably decreases the probability of developing psychological disorders. It can be concluded from this that the risk and protective factors identified by the study, should be taken into account both in the prevention and the treatment of behaviourally disturbed children and adolescents (ibid).

### **Children with ADHS**

The aforementioned BELLA-study ([www.bella-studie.de](http://www.bella-studie.de)) conducted by the Robert-Koch-Institute concludes that about 2% of the children and adolescents suffer from the attention-deficit-/hyperactivity-syndrome (ADHS). Various studies could show that children with ADHS have a higher risk of developing an addictive disorder. Ohlmeier (2005) found for example that patients with an alcohol- and substance-related addiction overproportionally fulfill the DSM-IV criteria for ADHS (Ohlmeier et al 2005). Individual results were already presented in last year's Report.

Various factors are discussed as possible reasons for the correlation between ADHS and the development of an addiction. It is to be assumed that children and adolescents with ADHS often do not fulfil the expectations of their environment. As a consequence, feelings of disappointment and of a low sense of self-worth can develop in the long-term. By consuming addictive substances, these children and adolescents can find access to peer groups with drug-affinity (Wilens 2004). Ohlmeier adds that clinical experience shows that patients concerned report about a – at least apparent – improvement of their ADHS-related symptoms as a result of cannabis and cocaine consumption in the sense of a kind of “self-medication” (Ohlmeier et al. 2005).

In the care and treatment of children suffering from ADHS, cooperation with kindergartens and schools forms an integral part. The BZgA for example picks up the topic ADHS within the frame of the teaching tool “Chronic illnesses as a problem and topic in school”.

With more than 250 regional self-help groups and more than 5,000 members, ADHS Germany ([www.adhs-deutschland.de](http://www.adhs-deutschland.de)) is the largest association representing the interests of people suffering from ADHS and their families. Although the potential correlation between ADHS and addiction is taken account of by ADHS research, it is seldomly integrated into therapy concepts in addiction treatment (BZgA 2005).



## 4 Problem Drug Use

### 4.1 Overview

#### 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. prevalence estimation of the EMCDDA). Generally, consumption is regarded as problematic if at least one of the following criteria is fulfilled:

- Risk carrying use (risky consumption)
- Harmful use (F1x.1) or addiction (F1x.2x) in terms of a clinical diagnosis (ICD / DSM)
- Harm inflicted on other persons
- Negative social consequences or delinquency

In addition to the collection of clinical diagnoses "dependency" 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." 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 of 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 above mentioned 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 limit 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 hard drugs tend to report only the consumption of 'soft' drugs like for example hashish correctly while denying using for example heroin or attenuating 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 estimations 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 opiates, cocaine or amphetamines" (Kraus et al. 2003). However, as it would not have been possible to exclude multiple mentions in police figures 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.

### **Injecting and non-injecting drug use**

In view of the particular risks carried by intravenous drug use, this use pattern is of particular interest when trying to minimize secondary harm. In Germany, injecting drug use 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 estimates**

### **4.2.1 Estimate methods of the EMCDDA**

For the year 2007, 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 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.

The estimate based on treatment admissions which was reported on in the previous years was not recalculated. As a result of the introduction of the revised Core Data Set on treatment centres for substance use disorders at the beginning of the year 2007, a few parameters and items of the treatment statistics changed so that it was not longer possible to continue the estimate on this basis. After a comprehensive analysis of the treatment data supplied by the German Centre for Addiction Issues in 2008 (for the reporting year 2007), the estimates are expected to be continued from the following year onwards. First approximations however suggest that the treatment data lead to robust results which are comparable to the other estimation methods and results of the previous years.

- 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. The other methods have not been used since the necessary parameters were not available in a timely, empirically evidenced form.

The individual estimates can be found in standard table 7.

### **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 82,000 and 162,000 persons (if one takes the estimates of the previous year as a basis for the treatment data). Due to slightly raised number of drug-related deaths in 2007, the lower limit of the estimated interval is somewhat higher. The figure is somewhat lower than in previous years and corresponds to a rate of 1.5 to 2.9 persons per 1,000 inhabitants in the age between 15 to 64 years (table 4.1). These estimates are similar to the prevalences recently calculated by a new European meta-study conducted on the dependence on illicit substances for the age

group 18 to 65 years: (3.0/1,000; threshold values 0.2-0.6; Wittchen & Jacobi 2005). Further details are contained in 4.2.2.

**Table 4.1** Prevalence estimates of problem opiate consumption from 2004 to 2007  
(number in 1,000; age group 15-64 years)

Data source	Reference year				Prevalence per 1,000
	2004	2005	2006	2007	
Treatment	102-150	155-184	136-162	<sup>1)</sup>	2.5-2.9
Police contacts	136-172	128-166	117-159	108-149	2.0-2.7
Drug-related deaths	87-115	78-111	76-108	82-116	1.5-2.1

1) Cf. chapter 4.2.1 on the missing calculation of the estimate based on treatment data for 2007.

(DBDD special calculation 2008)

When choosing a broader definition of the target group including users of opiates, 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 prevalence..

Up-dated calculations based on treatment data from the year 2006 which include clients with cocaine and amphetamine problems, produce a prevalence of 169,000 to 201,000. This corresponds to a prevalence of 3.1 – 3.6 (in 1,000 inhabitants). Estimates based on police data and drug-related deaths are not performed for the extended target group because of the problems explained in chapter 4.1.

#### 4.2.2 Other approaches to collect data on problem drug use

In order to broaden the narrow concept of “problem drug” use according to the definition of the EMCDDA, further data sources and approaches will be used in the following to estimate the figures for the target group in Germany.

In a young age group of users (14-18 years) in Hamburg, risky consumption of cannabis (at least 25 times in the lifetime and at least once in the last week and also in the school context or alone at home) was found in 4.0% of the interviewees (2005: 5.1%). The portion of this group continually decreased in the follow-up surveys carried out since 2004 (5.6%). The portion of risky users among the male interviewees (5.3%; 2005: 7.3%) was still double as high than the one among the female group (2.5%; 2005: 2.9%) (Baumgärtner 2008).

According to a study recently carried out by the BZgA (2007b), the portion of adolescents and young adults who regularly consume (defined as >10 times in the last year) cannabis has remained stable since 2004. 4.3% of the 18- and 19-year-olds reported in 2007 to have regularly consumed cannabis in the last year (2004: 4.4%). There were hardly any changes neither among the 14-17-year-olds (2007: 2.3%; 2004: 2.0%) nor in the overall group of the

12-19-year-olds (2007 and 2004: 2.3%) in comparison with 2004. The portion of the regular users among the young men is with about 7% significantly higher than among the young women (about 2%) (BZgA 2007b).

The correlation between the risk of the development of cannabis addiction and the intensity of consumption (Nocon et al. 2005) was already reported on last year. A meta-analysis based on the data collected in 16 European countries found a prevalence of 0.3% for dependence on illicit substances (Wittchen & Jacobi 2005).

The studies and approaches presented above are to be understood as a rough approximation. Limitations in the representativeness of data (regional data sets, small samples), insufficient standardization of age groups and other points don't allow for exact comparisons to be drawn between the groups. Problem use in respect of the EMCDDA definition amounts to less than 0.5% of the overall population. When lowering the criterion for problem drug use (substance, consequences) and choosing a younger age group, prevalence increases to about 3% and intensive consumption patterns to more than 10%.

National prevalence estimates are contained in standard table 7, local prevalence estimates in standard table 8.

### **4.3 Profiles of clients in treatment**

Information on characteristics and use patterns of clients in therapy are available from various sources. Based on the German Core Data Set (Sonntag 2007), the German statistical report on treatment centres for substance use disorders (Deutsche Suchthilfestatistik, DSHSb Sonntag et al. 2008b) provides extensive data for clients in outpatient therapy from the vast majority of the facilities which receive regional and municipal funding. The Treatment Demand Indicator (TDI) of the EMCDDA is integrated in the Core Data Set.

For inpatient therapy, extensive data are also available from the German statistical report on treatment centres for substance use disorders. However, only about 147 facilities took part in the federal survey in 2007 (Sonntag, Bauer & Hellwich 2008a). Many large, especially psychiatric clinics providing addiction therapy are not represented in the statistical report. In order to fill these gaps as far as possible, two other sources were tapped for data. The statistical report on hospital diagnoses documents the diagnoses on the discharge of all patients of inpatient facilities. Though complete, it is not addiction-specific and offers little detailed information for this specific area. It does however allow a differentiation of the number of cases according to the ICD-classification (F10-F19). The statistics of the pension insurance funds show 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 hereby. Therefore, it is more difficult to describe the profile of inpatient patients than of the outpatient ones. While it is necessary to tap various sources simultaneously, one needs to bear in mind that each source has a different type of selectivity.

### **Revised Core Data Set on treatment centres for substance use disorders**

Since January 2007, most of the addiction support facilities in Germany have been using the new German Core Data Set to document treatment for substance use disorders (Sonntag 2007). This Core Data Set originated in 1998 from a common minimum data set which was the product of a consensus procedure between many institutions and persons involved. It took a several-year process to revise the Core Data Set to improve user friendliness and data collection precision. It assures uniform documentation standards in psychosocial counselling facilities and inpatient facilities for persons with substance-related disorders, eating disorders and pathological gambling in Germany. The compatibility with the Treatment Demand Indicator (TDI) required in connection with the reporting to the EMCDDA, but also the need for comparability and harmonization between the Länder, different regions and funding organs have made a revision of the standards necessary. Derived from the introduction of the revised Core Data Set, two important factors will influence reporting to the EMCDDA as of the reporting year 2007:

- The classification of the types of facilities increased from originally 9 to 16. With this, it is now better possible to describe the characteristics of individual types of care facilities in a discriminating manner. However, the categories “outpatient” and “inpatient” formed out of the combination of several facility types in the past are not identical any more with the categories of previous reporting years. In this year, it is however possible for the first time to report selected data from counselling and treatment provided in prisons and in low-threshold facilities. The data on the response rate are to be optimized through a special register in the future which is currently set up and tested by the DBDD. With regard to the classification of different facility types, this register follows the logic of the Core Data Set.
- With the introduction of the revised Core Data Set, some documentation variables in respect of the surveyed category (e.g. stronger differentiation, other, more or supplementary answer categories) also changed. These modifications also limit the direct comparability of some items with the results of previous years.

The Core Data Set has not yet been introduced across the board in all Länder in 2007, since a transitional period has been agreed on until 2008 after which usage is compulsory. In most of the cases however, it was possible to merge data (categories) of the former Core Data Set and the revised Core Data Set for the evaluations at federal level.

Summarizing, it can be said that great caution is required when comparing the results of the evaluations of the German statistical report for 2007 on inpatient and outpatient treatment centres for substance use disorders with the data from previous years. Therefore, the comparative data of the previous years have been cancelled or marked with corresponding comments. First analyses suggest however that in most of the cases there are no major differences to be found in comparison with the previous years. Statements on trends require utmost caution, since, apart from the abovementioned changes, also a series of technical and content-related alterations (e.g. minor changes of definitions) were performed. All in all, it is to be welcomed that the revised Core Data Set is generally fully compatible with the TDI of

the EMCDDA. However, divergences continue to exist as a result of the orientation of the German treatment system to the ICD-10 which makes analyses at substance level sometimes more difficult or impossible. But then there are new interesting data (e.g. analyses from low-threshold facilities) available now, which usefully complement previous reports.

Data on the characteristics of treated drug users can be found in standard table 3.

### 4.3.1 Outpatient treatment

The data presented in the following are based on the published detailed data of the tables of the German statistical report for 2007 on treatment centres for substance use disorders (Sonntag et al. 2008b). In the year 2006, a total of 220,669 (excluding one-time-contacts) cases treated in outpatient facilities were recorded by the DSHS. However, this report only takes account of the clients who were treated for illicit substance use.

#### Socio-demographic information

In the year 2007, 80.5% of all 40,053 outpatient clients with drug problems recorded by the German Annual Statistical Report on Addiction Therapy were male. About 57.6% of them were between 15 and 30 years old. 82.9% of them were of German nationality, 3.6% were from countries of the European Union, 8.7% from non-EU countries such as Turkey or the former Soviet Union.

As living conditions of the clients vary considerably depending on the main diagnosis or the used drug respectively, table 4.3 discriminates accordingly.

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

**Table 4.2** Socio-demographic data broken down by main drug (outpatient)

Characteristics	Main diagnosis			
	Opiates	Cannabis	Cocaine	Amphet.
Age starting treatment (mean)	32.6	23.8	30.9	25.6
Age of first use (mean)	20.5	15.2	21.2	18.1
Gender (ratio males)	77.3%	87.7%	86.1%	76.4%
Single	50.5%	59.1%	44.5%	52.6%
Working situation <sup>1)</sup>				
Unemployed	60.3%	33.4%	37.1%	39.4%
In school / education	3.4%	29.6%	6.5%	14.6%
Homeless <sup>1)</sup>	3.0%	0.6%	1.2%	0.8%

<sup>1)</sup> On the day before the start of the therapy.

(Sonntag et al. 2008b)

### Consumption patterns

Table 4.3 shows the most common use patterns for various substances. Heroin is mainly injected by almost two thirds of the clients; however, intravenous use of heroin has declined, yielding to smoking since 2003. This use pattern was also found in almost a third of the cocaine users. All other substances are mainly orally consumed. The most diversified use pattern was found for amphetamines.

**Table 4.3** Drug administration routes in outpatients 2004-2007

Substance	Application modes					Total
	Injection	Smoking	Oral	Sniff	Others	
Heroin	64.7%	25.8%	1.6%	7.5%	0.4%	11,615
Methadone	2.8%	1.1%	95.1%	0.3%	0.7%	5,800
Buprenorph.	3.3%	1.2%	87.4%	5.8%	2.4%	1,042
Others Opiates	4.0%	3.8%	85.8%	3.9%	2.6%	1,952
Cocaine	23.7%	23.8%	1.0%	49.8%	1.8%	6,680
Crack	7.1%	88.8%	1.0%	2.9%	0.2%	863
Amphet.	1.7%	11.7%	37.5%	43.8%	5.3%	4,565

Multiple entries possible.

(Sonntag et al. 2008b)

### Diagnostic data

For the year 2007, the German Annual Statistical Report on Addiction Therapy contains data on the main diagnoses of a total of 40,077 treatments which were started or completed in an outpatient psychosocial addiction support facility 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 addiction).

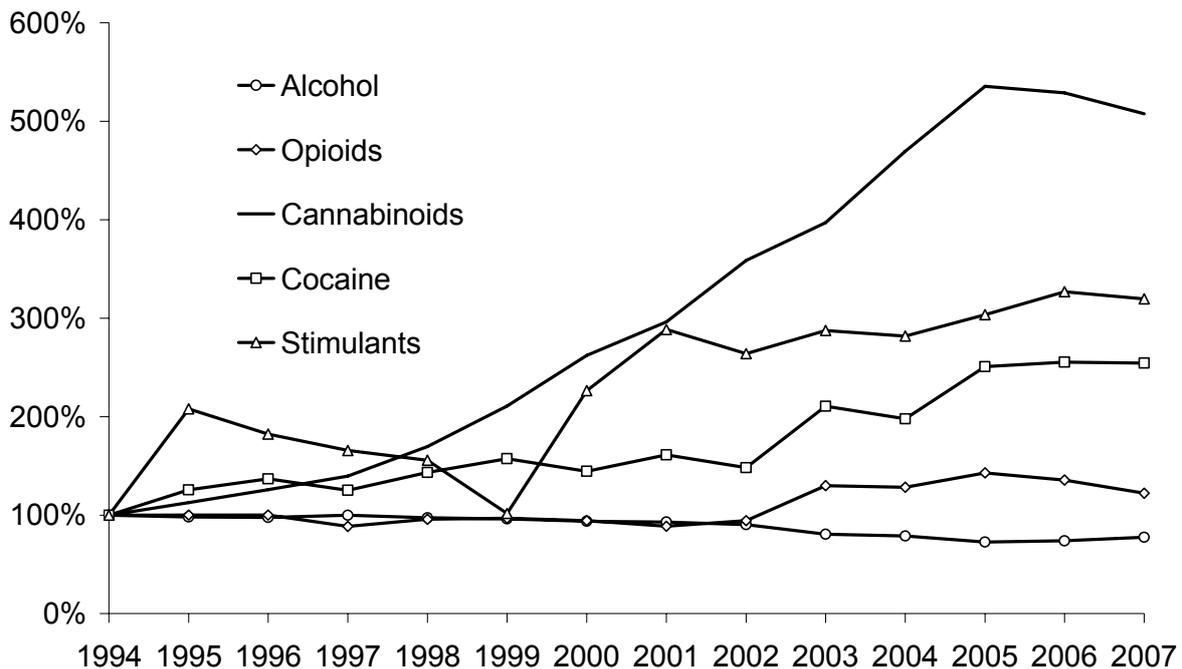
Looking only at the statistical data on illicit substances, it shows that less than half of the clients (49.6%) sought treatment or counselling primarily for dependence on or harmful use of opiates. In almost a third of the cases (32.5%), clients were treated for primary cannabis-related-problems. Being the main reason for first-time-treatment in 51.2% of the clients, cannabis clearly leads the league of substances (table 4.4).

**Table 4.4** Main diagnoses in outpatient treatment

Main diagnosis (ICD10: F1x.1/F1x.2x)	All intakes (%)			First treated clients (%)		
	Men	Women	Total	Men	Women	Total
Opioids	47.7	57.2	49.6	25.9	35.7	27.7
Cannabinoids	35.4	20.6	32.5	54.9	35.3	51.2
Sedatives/Hypnotics	1.0	6.7	2.1	0.8	7.4	2.0
Cocaine	8.2	5.4	7.6	8.2	5.2	7.7
Stimulants	6.4	8.2	6.7	9.4	14.9	10.4
Hallucinogenic drugs	0.1	0.2	0.1	0.2	0.2	0.2
Volatile substances	0.1	0.1	0.1	0.1	0.3	0.1
Multiple/other substances	1.2	1.5	1.3	0.6	1.1	0.7
Total	32,281	7,589	40,077	14,964	3,318	18,321

(Sonntag et al. 2008b)

When calculating the changes in the patients' admissions by the shares held by various main diagnoses since 1994, it shows that the increases found were most marked for cannabis until 2005. After the increases of previous years, figures started to somewhat stagnate already between 2005 and 2006. Even though it is only possible to make trend analyses with restrictions due to the abovementioned reasons in connection with the introduction of the revised Core Data Set, the enormous increase rates found in the period before 2005, do not seem to find a continuation. The portions of other substances have stabilized too (fig. 4.1).



(Sonntag et al. 2008b)

**Figure 4.1** Long-term changes in the admissions to outpatient addiction treatment broken down by main diagnoses (1994=100%)

Secondary addiction diagnoses in addition to the main diagnosis are relatively common. Out of the clients with primary opiate-problems, 27.5% also have alcohol-related disorders (addiction or harmful use) and 27.1% cocaine-related disorders. With 35.7%, dependence on or harmful use of cannabis is the most common non-opiate-related secondary diagnosis to be found among these clients. 41.7% of the clients with opiate-related problems have a single diagnosis for methadone. In the case of primary cocaine-related problems, cannabis (48.1%) also play an important role, followed by amphetamines (19.1%) and ecstasy (10.7%). Still, 12.0% of the clients with a primary cocaine problem, also fulfil the diagnostic criteria of a heroin-induced disorder. 16.0% of the clients with a primary cannabis-problem make harmful use of or are dependent on amphetamines, 11.7% on cocaine. Seen across all substances, about a third of the clients also have an alcohol-related disorder in addition to the primary reason for treatment admission, in clients with a primary cocaine-related disorder, the portion amounts to more than 40% (Sonntag et al. 2008b).

In a study recently published on the alcohol consumption of drug addicts, Körkel and Waldvogel (2008) investigated the consumption of psychoactive substances among the population of clients of low-threshold-facilities for drug users. They found that 43% of the interviewed drug users fulfilled the DSM-4-criteria of alcohol addiction, 18% were already undergoing withdrawal treatment. The quantity of alcohol consumed increased with the number of drugs used. Given these results, the authors recommended to make alcohol

consumption an integral part of diagnostics, motivational and treatment measures both in low-threshold facilities and other help areas. This request is supported by the fact that 64% of the drug users addicted to alcohol also want to change something about their alcohol consumption.

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.

At the end of 2007, the meanwhile 8th annual report (for the reporting year: 2006) of the series "Modern documentation in outpatient addiction help" of the Land Schleswig-Holstein was presented (Ministry for Social Affairs, Health, Family, Youth, Senior Citizens of the Land Schleswig-Holstein 2007). According to this report, 28% of the clients in Schleswig-Holstein have approached an outpatient drug counselling facility because of their dependence on opiates, 12% because of the consumption of cannabis and 3% because of consumption of cocaine. Especially heroin addicts (28%) and cannabis clients (23%) live in precarious housing conditions. Since, on the other hand, 4 out of 10 cannabis clients (41%) still live with their parents, the group of clients with cannabis-related disorders appears to be very heterogeneous. It is subdivided into a subgroup with relatively good (social, psychological and physical) resources and a population with considerably complex problems and multiple difficulties at various levels. The portion of heroin addicts in outpatient treatment dropped by almost 10 percentage points in Schleswig-Holstein between 2001 and 2006, whereas the portion of patients with the main substance cannabis soared from 9% in 2001 to 14% in the reporting year. The authors of the annual report assume however that this percental increase in cannabis clients is partly to be seen in connection with the changes made to the documentation of the core data set within the framework of the introduction of the new data set in Schleswig-Holstein.

### **Medical drug abuse**

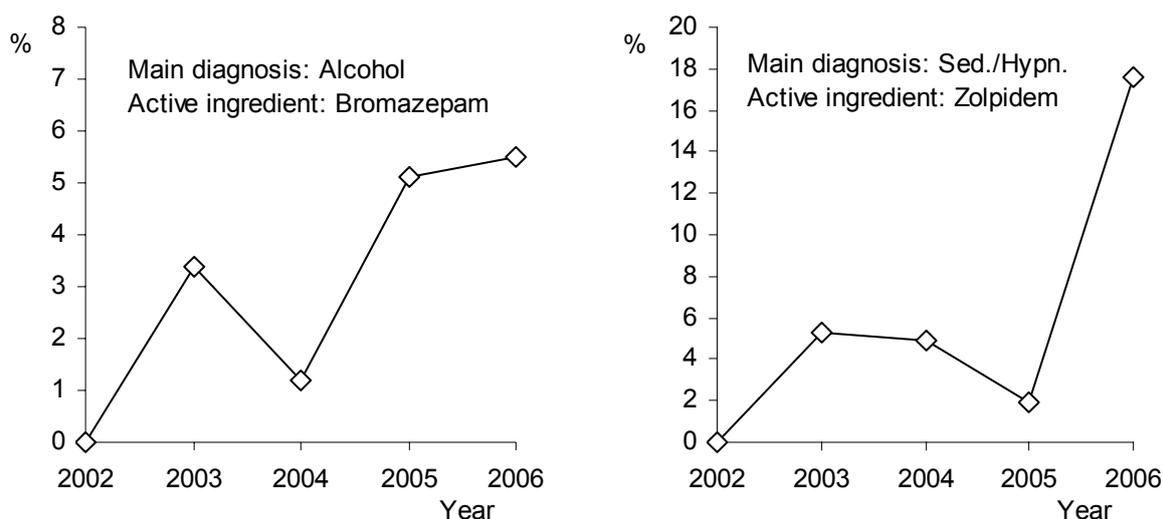
Estimates of the prevalence of dependence on medical drugs range between 700,000 (Schwabe 2007) and 1.9 million people addicted to medicines in Germany (Kraus & Augustin 2001; Soyka et al. 2005). According to the results found by the Epidemiological Survey on Substance Abuse 2006, almost 5% of all people interviewed in the age group from 18 to 64 years display a problematic use of medical drugs according to the criteria of the short questionnaire on the use of medicines (Watzl et al. 1991). Despite the high prevalences of the dependence on medical drugs, the addiction of medical drugs - often named "quiet addiction", is hardly perceived by the public in contrast to drug and alcohol addiction (Rabbata 2005). The situation is similar in the care of people addicted to medical drugs who are significantly underrepresented in out- and inpatient addiction treatment. Among the clients of outpatient facilities documented within the framework of the German statistical report on treatment centres for substance use disorders, only 0.8% have a main diagnosis "sedatives/hypnotics". Among the women, the portion is with 2.0% five times higher than among men (0.4%) (Sonntag et al. 2008b). A comparable portion of this client group and a

similar gender distribution were also reported for 2005 within the framework of the base documentation of the outpatient addiction support system in Hesse (COMBASS) (Hessische Landesstelle für Suchtfragen 2008).

In order to gain information on the abusive or addictive potential of medical drugs, a monitoring system – Phar-Mon (former ebis-med) – has been in use since 1988 to collect data on the abusive or addictive consumption of medical drugs among clients of outpatient addiction aid facilities. Specific characteristics of the sample such as the easier access to the grey or black market, the use of pharmaceuticals as a substitute or as modulators for drugs and alcohol and the special needs of the clients with substance-related disorders should considerably contribute to the sensitivity of the Phar-Mon monitoring (Küfner & Rösner 2008).

In the year 2006, a total of 448 entries on 276 clients mainly addicted to alcohol and drugs were included in the evaluation (Rösner & Küfner 2007). Almost two thirds (66.3%) of the Phar-Mon clients have a main diagnosis from the area of illicit drugs while clients with alcohol-related diagnoses account for less than a quarter of the cases (23.7%) and clients with a dependence on sedatives/hypnotics for only 2.2% of the cases.

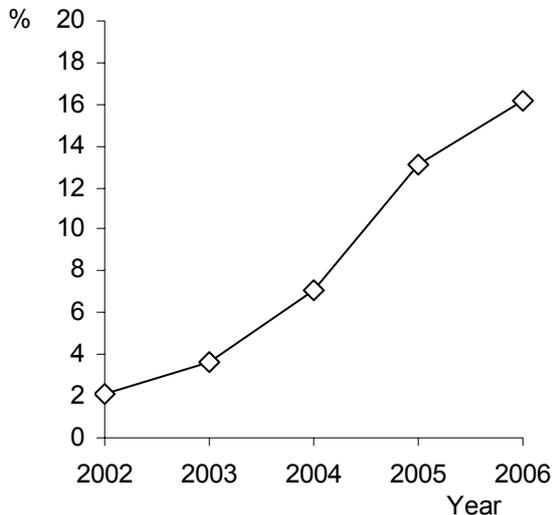
As in the previous years, tranquilizers of the benzodiazepine type were the most frequently documented drugs in Phar-Mon in 2006 for all client groups with portions ranging between 29.1% (main diagnosis: alcohol) and 35.5% (main diagnosis sedatives/hypnotics). Among the main diagnosis group “alcohol”, problematic consumption of bromazepam, a benzodiazepine-tranquilizer with intermediate half-life increased from 0.0% to 5.5% of the total of numbers (Fig. 4.2). The increase in the 5-year-period was interrupted in the reporting year 2004 by a decline in the documentation frequency before the misuse continued to increase in the following year.



**Figure 4.2** Trends (main diagnoses alcohol and sedatives/hypnotics)

Within the main diagnosis group “sedatives/hypnotics”, problem consumption of chemically defined hypnotics increased significantly in the five-year-comparison. This is reflected by the

increased consumption of the active ingredient zolpidem: The portion of the problematic use of this active ingredient increased from 0.0% in 2002 to 17.6% of all documentations in 2006 (Fig. 4.2). Hoffmann et al. (2007) also found in a cross-sectional study based on data from the health insurance schemes that the duration of use or dosage in the general population was frequently exceeded, warning against an uncritical usage of these substances.



**Figure 4.3** Trend in the main diagnosis group opiates; active ingredient: methadone

The trend of an increasing abuse of opiates observed over the last years in the clients of the main diagnosis group “opiates” continued in the reporting year. The trend analysis involving the level of active ingredients reveals that the increase is attributable to the non-regular use of opioid substitution substances (especially methadone). With an increase from 2.1% in the year 2002 to 16.2% of all the entries in the year 2006, the number of methadone cases documented in Phar-Mon has significantly increased (figure 4.3).

New possibilities of procuring drugs, like for example online-pharmacies, have so far played a relatively small role in the cases documented in Phar-Mon. The Phar-Mon-sample did include the supply of benzodiazepines by on-line-pharmacies, but the prescription rules were observed in all cases. Mutschler et al. (2007) casuistically report on the case of an opioid-addicted patient who managed to cover his needs for opioids exclusively over online-pharmacies. The authors warn about the consequences which result from the possibilities offered by online-pharmacies to evade prescription requirements in respect of problematic patterns of use of medical drugs.

#### 4.3.2 Inpatient treatment

##### Data from the German statistical report on treatment centres for substance use disorders

Out of the total of 34,186 inpatients with substance related-disorders recorded by the German statistical report for 2006 on treatment centres for substance use disorders, 6,855 persons were treated for illicit substances (including sedatives/ hypnotics and volatile

solvents) (Sonntag et al. 2008a). Out of these in turn, 5,710 were males, this corresponds to a male portion of 83.4%. Alcohol-related disorders continue to be the main reason for inpatient treatment (by comparison: in 2007, 17,310 treatments for alcohol-related disorders were registered). Here too, the main diagnosis is based on the diagnostic categories of the international classification system of the WHO.

Clients with the main diagnosis "dependence/harmful use of opiates" continue to represent the largest individual group among drug users in inpatient treatment (48.6%). The second largest group is formed by clients with cannabis-related disorders (19.6%) followed by clients with polydrug use (9.9%). Problems in connection with cocaine or stimulants were in 9.8% or 9.2% respectively of the cases the primary reason for treatment. Whether the fact that cannabis has overtaken polydrug use as the second most important diagnosis group, is attributable to the changes connected to the introduction of the new documentation standard (Sonntag 2007) or whether cannabis continues to play a more important role also in the inpatient setting, will be shown by the data collected in future years. Cannabis continues to play a markedly less important role among women than among men: only 12.7% of the women vs. 21.1% of the men have a cannabis diagnosis. Gender differences of this scale have otherwise only been found for sedatives and hypnotics— however in a reversed ratio by a factor 1:10 (table 4.5).

#### **Data from other sources**

An overview of all clients in inpatient therapy in Germany can be gleaned from the statistics on hospital treatments (statistical report on hospital diagnoses) of the Federal Statistics Office, whose most recent data are available for the reporting year 2006. By documenting main diagnosis, age and gender, the statistical hospital report mainly provides framework data which are complemented by specific data from the National Statistical Report on Addiction Treatment. Data provided by social security administration (Deutscher Rentenversicherung Bund, DRV) are related to rehabilitation therapies of drug addicts. The two statistical reports largely tally in their discrimination by main diagnoses, although the DRV data contain a considerably higher portion of undifferentiated diagnoses in respect of F19 (multiple substance use and by-consumption of other psychotropic substances) which needs to be taken into account.

When excluding alcohol, opioids are, in terms of figures, clearly in the foreground in acute treatments (carried out in hospital) followed by sedatives/hypnotics and third by cannabis. The largest sub-category however, is related to multiple substance use. In most cases however, primary use of illicit substances may be hidden beneath it, since alcohol appears much more often as the only addictive substance. However, with no substance-related data being available, verification of this assumption is not possible.

**Table 4.5** Inpatients with addiction diagnoses

Main diagnosis	Hospital treatment		DRV		DSHS (2007)		
	2005	2006	2005	2006	Total	Men	Women
Opioids	32.2%	33.5%	19.9%	20.3%	48.6%	48.3%	50.1%
Cannabinoids	6.5%	6.7%	7.1%	8.1%	19.6%	21.1%	12.7%
Sedatives/Hypnotics	9.8%	9.9%	2.3%	2.1%	2.7%	1.2%	10.0%
Cocaine	1.4%	1.5%	3.5%	3.6%	9.8%	10.6%	5.5%
Stimulants	1.4%	1.6%	1.9%	2.2%	9.2%	9.1%	9.4%
Hallucinogenics	0.6%	0.5%	0.1%	0.1%	0.2%	0.2%	0.1%
Volatile substances	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%
Multiple/other subst.	48.0%	46.1%	65.2%	63.6%	9.9%	9.4%	12.2%
Total	88,487	87,907	10,573	11,737	6,855	5,710	1,144

(Deutsche Rentenversicherung Bund (DRV) 2007; Sonntag et al. 2008a; Statistisches Bundesamt 2008a)

When comparing the data from the addiction-specific diagnoses (German statistical report on treatment centres for substance use disorders) to these statistics, one gets the following picture: opiates rank first among the illicit substances in inpatient treatment. If one adds the cases of multiple-substance use which, in most cases, probably involves a combination of opiate addiction and cocaine- and other drug-related addiction problems, the portion amounts to 70%-80% among inpatient clients. Intoxications caused by sedatives and hypnotics are relatively common in acute treatment with every tenth addiction diagnosis being related to these substances in hospital therapies. In withdrawal therapies (funded by the German social insurance administration) however, they play a rather minor role. Patients suffering from a cannabis-disorder rank second in rehabilitation therapy, followed - at a large distance though - by opioids. Cocaine comes third in the category of individual substances (table 4.5).

Among the group of illicit drugs, heroin-induced disorders continue to lead the league both in in- and outpatient settings. Cannabis however ranks top among those admitted to outpatient treatment for the first time and also plays an important role there contrary to opiates. Inpatient treatment of cannabis cases however, gains in importance.

Within the framework of a study on primary cannabis-related disorders (CARED) Simon and Kraus (2007) investigated the validity of cannabis-related diagnoses in outpatient addiction counselling facilities. To this purpose, clients who were undergoing treatment in the period of enquiry in a (randomly selected) facility, were diagnosed by means of computer-assisted clinical interviews (CIDI; Lachner et al. 1998) and the results of this validation diagnosis were compared to the diagnoses assigned within the framework of the routine procedure of the German statistical report on treatment centres for substance use disorders. In about three quarters of all cases, a clinically relevant cannabis-related disorder was found in the validation diagnosis. About two thirds of the cannabis patients received a mono-diagnosis,

about a quarter received another diagnosis (mostly an alcohol-related disorder) in addition to the cannabis disorder. This result underlines as well the fact already known from literature that the therapy of clients suffering from cannabis-related disorders often requires the treatment of multiple problem fields calling for a cooperation between addiction aid, psychiatry and other help structures (e.g. youth welfare).

### **4.3.3 Diagnostic data from other areas**

Persons who serve a custodial sentence for drug-related crimes – mostly drug-trafficking offences – or for other reasons, often continue to consume psychotropic substances in prison. Epidemiological data on the consumption of psychotropic substances in penal institutions are very difficult to collect and have little validity. A general picture of the situation can be obtained from Simon & Tischer (2006) on the basis of the data provided by the Ministries of Justice of the individual Länder. Insofar as data were collected and estimates of the prevalence or dependence on licit and illicit substances performed, figures range between 40% and 50%. The portion of prison inmates who are assumed to be addicted to illicit drugs amounts to about 33%. Prevalences for female inmates tend to be somewhat higher than those for male ones.

## 5 Drug-Related Treatment

### 5.1 Overview

People willing to overcome their substance dependency with professional support are offered a wide range of quitting 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:

- 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 addiction treated. All measures undertaken should be embedded in a treatment and help plan for the therapy which 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 which 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 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.

## Treatment organization

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). Rehabilitation therapies are mainly carried out in specialized clinics or in therapeutic communities

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 Länder as well as by quite considerable 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 involves some administrative work and it needs to be clarified who will take over the costs for inpatient therapy (generally the 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 gender distribution.

Pharmacologically assisted substitution therapy offers reach quite a large number of drug addicts. Since 2001, substitution therapy has been regulated in detail by the Narcotics Act and is meanwhile fully accepted as a medical therapy method. Already in the year 2002, the Federal Medical Council passed guidelines on the state of the art. In 2003, the national health insurance system acknowledged substitution therapy as a SHI-accredited care service without any restrictions taking over the costs of therapy for the insured. The majority of patients in substitution therapy are treated by office-based doctors or in specialized outpatient facilities. Doctors carrying out substitution therapy need to be qualified in addiction-medicine. If not, they can treat up to three patients maximum in consultancy with a qualified colleague. Meanwhile, also some inpatient facilities have started to accept patients for substitution therapy. However, the status of integration between general health care and special drug care is still rather dissatisfying. At regional level however, cooperation and coordination of the offers are clearly better. Medical substitution therapy should generally be accompanied by psychosocial care.

As a result of the successfully completed study on the use of heroin in the treatment of opiate addicts in 2006, the admission of diamorphine for regular treatment is currently under consideration. This kind of treatment is meant for a small portion of patients who could not sufficiently profit from other therapy offers. The legal changes necessary for this and the definition of modalities allowing for a continuation of the treatment with diamorphine also after the completion of the study, are currently still subject of a political decision process. The

positive results of the demonstration project show that this group of heavily addicted persons is in need of specific offers in addition to the already existing ones. Despite the positive results of the “heroin study”, it is still uncertain whether treatment with diamorphine will be continued in Germany. In 2006, an application for the admission of diamorphine as a prescription drug was filed with the Federal Institute for Pharmaceutics and Medical Devices (Bundesinstitut für Arzneimittel und Medizinprodukte, BfArM). Although the BfArM has meanwhile given its technical endorsement, the drug can not be admitted yet because the Narcotics Act, which in its present wording prohibits the prescription of diamorphine, needs to be changed accordingly. However, a corresponding bill of the Bundesrat and Federal Government has not yet been put on the agenda of the German Bundestag. The patients who have already undergone treatment within the framework of the demonstration project continue to be treated for the time being with diamorphine with an exceptional permission based on the public interest according to §3.2 of the Narcotics Act effective as of 1 January, 2007. All ambulatories involved in the project have requested a renewal of their license which originally was to expire on 30 June, 2007. The Federal Institute for Pharmaceutics and Medical Devices (Bundesinstitut für Arzneimittel und Medizinprodukte, BfArM) did not only grant the requested continuation of the project for patients already undergoing therapy in Hamburg, Munich, Bonn and Hanover but also approved of the admission of new patients in Karlsruhe, Cologne and Frankfurt. The licenses granted by the BfArM end on 31.12.2008 for Munich, on 31.12.2009 in Hamburg and on 30 April, 2010 or respectively 30, June 2010 for all other cities (as of July 2008). Federal Government funding for the cities participating in the project stopped at the end of February 2008. However, documentation and monitoring of diamorphine-assisted treatment in Germany continues to receive Federal Government funding in order to ensure quality assurance in the further course of the project including organization standards and treatment effects.

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.

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 Länder 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 above mentioned 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 Länder, cooperation between the different fields of work and organizations is promoted by Länder-financed institutions.

### **Funding and supporting organs**

According to the most recent overview dating from the year 2005, there are about 934 specialized drug counselling facilities which treat patients mainly for problems with drugs or other psychotropic substances<sup>23</sup>. Countrywide, there are more than 2,078 treatment slots available for inpatient detoxification and about 5,260 places in rehabilitation. The majority of the facilities are independent non-profit organizations. Besides, there are also public and private providers which carry out inpatient therapy (Simon 2005). Supported by the Federal Government, the Länder and the associations, the German Reitox Focal Point currently sets up a central register of all addiction aid facilities in Germany which, for the first time, will provide an almost complete overview of all existing professional offers in the area of addiction. The register is oriented to the classification of the German Core Data Set (Sonntag 2007).

Low threshold services and counselling 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 Länder and municipalities. However, the institutions have no legal claim to these funds. Withdrawal treatment lies in the hands of the statutory health insurance funds. The statutory pension insurers in their turn are responsible for the rehabilitation therapy which they fund as a medical rehabilitation to restore the earning capacity of the client. They also decide on the type, scope and duration of the therapy. Except for a few specific cases, there is no legal funding basis provided by the Social Security Code (SGB XII) for the integration and after-care phase. Here, the legally and economically responsible bodies of the facilities have to resort to financing models which tap federal government budgets or budgets of the social security funds and job agencies.

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. In the meantime, it has already become possible to undertake a post-graduate course and earn a Master's degree in substance abuse and addiction counselling.

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<sup>23</sup> This figure is based on an estimate of the total number of psychosocial counselling facilities among which facilities which exclusively or primarily treat users of illicit drugs are in the minority.

## Data Sources

By integrating other documentation systems into the reporting system, the portion of addiction support services recorded by the National Report on Addiction Therapy has been considerably increasing over the last years (for the description of the data sources see also chapter 4.3). In the first year after the introduction of the revised Core Data Set for the documentation of treatment for substance use disorders (Sonntag 2007), 720 facilities funded by the Federal Government and the Länder, were registered in the system.

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 2007, this data source provides information on the number and gender of treated clients and on the substitution drugs used, complete with a list of names of the doctors in charge of therapy.

In Germany, hospitals carry out acute treatments of drug-related problems and detoxification as well as rehabilitation aiming at long-term abstinence to restore working capacity. The main diagnoses made for all persons treated in German hospitals are reported to the Federal Statistics Office which publishes the data on a regular basis (statistical report on the hospital diagnoses). Statistical data on rehabilitation are available from the pension insurance funds which document the services provided by rehabilitation facilities.

## 5.2 Treatment system

### Institutions and organizations

A differentiation between drug-free and pharmacologically assisted treatment is not very useful to describe the therapy system in Germany. Whereas a large part of the activities undertaken by GPs can be assigned to medication assisted therapy, services offered by psychosocial counselling facilities which represent a central element of care, can only be clearly assigned in those cases in which they themselves supply the substitution drugs. In many cases however, medical substitution takes place outside the counselling facilities. In this way, psychosocial care or therapy provided by the counselling facilities is, per se, neither obligated to a drug-free nor a medication-assisted approach. In order to avoid repetitions, outpatient counselling facilities will be presented under the section "drug-free therapies".

Parallel to and partly in cooperation with professional help offers, there are host of self help organizations being active in the field of addiction. So far however, their activities have been mainly geared to alcohol addicts and older target groups.

Herrmann and Lorenz (2007) investigated attitudes and behaviours adopted by general practitioners and addiction counsellors. They found considerable differences in the theoretical and conceptional approach and identified different styles of communication typical for the respective professions which are at the bottom of the problematic cooperational relationship between the two occupational groups. Herremann and Lorenz observed that general practitioners often focus on somatic findings and sequelae without looking into or

treating underlying addiction. The authors regard the intensified introduction of quality circles or health conferences which are to improve interdisciplinary cooperation as a good precondition for developing a satisfying cooperation and complementarity in the treatment of addicted patients on a long-term basis. Based on a survey carried out among office-based physicians in Mecklenburg-Western Pomerania, Coder and colleagues (2007) also report that only about a quarter of the physicians cooperated with practices specialized in the treatment of addiction. This lack of cooperation had its reason in the fact that the concept of the specialized addiction clinics was unknown to many general practitioners or that the practices of the GPs were not located closely enough to the specialized addiction practices. Here it shows that especially in rural areas the concept of specialized addiction practices has met its limits. Therefore, the authors recommend to, first and foremost, improve the qualifications of GPs in the diagnostics and therapy of addicted patients. A contribution to an improved cooperation could also be made by participating in respective cooperation and quality circles within the framework of medical remuneration systems.

### **Treatment demand and evaluation**

Planning of the treatment demand in the different segments of the medical and/or social help system at national level is not compatible with the federal structure of the Federal Republic of Germany. Instead, planning is done at Land and municipal level. Examples of demand planning on the basis of situation assessments and health reports are to be found in Berlin (Senatsverwaltung für Gesundheit, Soziales und Verbraucherschutz 2005), Frankfurt (Müller et al. 2007) and Hamburg (Baumgärtner 2006; Behörde für Soziales Familie Gesundheit und Verbraucherschutz Hamburg 2006). In Hesse, integrated youth and addiction support centres were set up (Hessisches Sozialministerium (Ed.) 2006).

Faced by the increasing numbers of older drug users seeking treatment in the medical care system (which is illustrated by the growing average age of the users of help offers), the European Commission has lent its support to setting up an international project to facilitate and speed up the concrete planning of (demonstration) projects for older drug users. The four project goals are to create a basis for assessing the extent of the problem, to define the framework conditions for the care to be provided by different facilities, to develop country-related guidelines for the care of older drug users and to develop PR-work using different information channels. In the project, older drug users are defined as persons older than 35 years of age. Germany, Austria, Poland and Scotland share and exchange their findings and experience within the framework of the project. Qualitative interviews carried out both with experts and patients, literature research and examples of good practice complement the pool of information. A website (<http://www.sddcare.eu/>) serves to facilitate communication within the project and with the public. Various seminars and a European conference which will be held in 2010 in Frankfurt round off the planned activities within the framework of the project (Vogt 2008). The Federal Ministry of Health funds an extended survey to gain deeper insight into the situation in Germany (still under reserve).

Küfner and assistants (2007) have developed and tested a motivational programme for drug addicts who are difficult to reach. They succeeded in about 50% of the cases of the

intervention group in improving the integration of the addicts into the professional addiction support system (in comparison with 9% in the control group). The programme was also able to improve the psycho-social condition of the patients in the intervention group. Therefore, the authors conclude that active outreach work and contingency management are helpful approaches which are yet to be complemented by a psycho-educational component.

An extensive project recently carried out on behalf of the European Commission, investigated the quality of drug treatment in Europe and the exchange of “good practice” (ZIS Hamburg 2008). The report, which contains the systematic analysis of the effectiveness of the interventions carried out to treat drug addiction in Europe, presents the support offers and the usage made of drug treatment in the EU-member states, sketches the situation and models on the transfer of knowledge and “good practice” and deals in a second part in detail with prevention, treatment and harm reduction offers made for inmates of penal institutions (Stöver et al. 2008).

Data on treatment availability are contained in standard table 24.

### **5.3 Drug-free treatment**

Generally, not much has changed in this area. The only partially existing legal basis for the funding of outpatient services has often led to financing problems. The municipalities which provide the funds for most of these services are currently 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. The profiles of clients in in- or respectively outpatient treatment have already been described in chapter 4.3.1 (as of page 71) or 4.3.2 (as of page 78) respectively.

#### **Client figures in inpatient treatment**

In general, inpatient treatment in Germany is carried out under drug-free conditions. Documentation standards discriminate by type of funding and not by type of treatment (drug-free vs. pharmacologically assisted). Therefore, 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 and rehabilitation therapy. Hospital treatment aims at detoxification, physical and psychiatric treatment and remedy of the effects of acute intoxication. Apart from accounting information on services provided, there is no systematic compilation of comprehensive statistical data on the treatments provided for these clients. However, for general psychiatric clinics or facilities providing psychiatric treatment for children and adolescents there exist documentation standards which also contain information on the treatment of patients with addiction problems. A systematic analysis on the transfer of these data to the standard of the German Core Data Set has not been carried out as of yet.

Rehabilitation therapy aims at long-term abstinence and drug-freeness as a precondition for restoring the working capacity of the client. It is generally carried out in an inpatient, but, to an increasing extent, also in an outpatient setting (so far, it is however almost exclusively restricted to the treatment of alcohol addiction).

As for acute treatment, alcohol continues to rank first among the main diagnoses distancing all other substances. Opiates and cannabinoids play the most important role among illicit substances. In third place, after alcohol, come (among the individual substances) acute treatments carried out because of acute intoxications with sedatives/hypnotics. About half of the drug cases treated in hospitals is carried out because of polydrug use. The total figure for addiction- or drug-related treatments slightly decreased from 2005 to 2006, whereas the treatment figures for stimulants increased again by about 16%, for cocaine by about 10% (table 5.1). It needs however to be added that the case figures of these substances are markedly lower in comparison with alcohol, opiate or cannabis so that it quickly comes to major changes in the percentages. Looking at the distribution of diagnoses with their relative shares, there are hardly any differences to be found compared to the previous year (cf. 4.3.1 and 4.3.2).

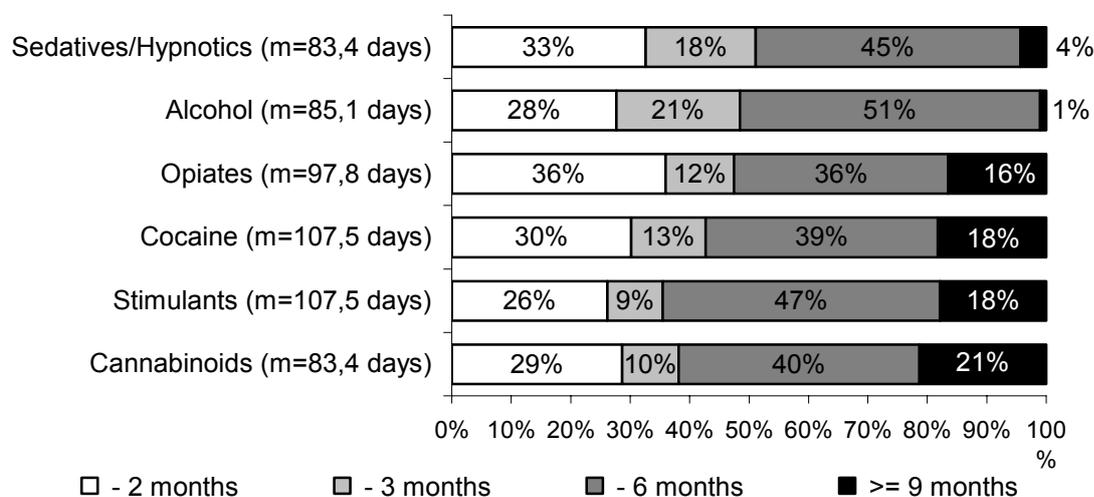
**Table 5.1** Inpatient treatment of addiction-related problems in hospitals 2003-2006

Main diagnosis	Year				Changes 2006 vs. 2005
	2003	2004	2005	2006	
Alcohol	288,115	290,864	299,428	298,955	-0.2%
Opioids	25,145	25,889	28,476	29,472	+3.5%
Cannabinoids	4,151	5,107	5,789	5,932	+2.5%
Sedatives/Hypnotics	8,035	8,504	8,667	8,661	-0.1%
Cocaine	1,112	1,096	1,210	1,336	+10.4%
Stimulants	1,074	1,139	1,226	1,424	+16.2%
Hallucinogenic drugs	573	562	518	471	-9.1%
Tobacco	944	420	278	234	-15.8%
Volatile substances	197	151	122	119	-2.5%
Multiple/other substances	43,252	41,699	42,479	40,492	-4.7%
Total addictions	372,598	375,431	388,193	387,096	-0.3%
Total drugs	75,307	84,147	88,487	87,907	-0.7%

(Statistisches Bundesamt 2008a)

The data provided by the German Annual Statistical Report on Addiction Therapy for inpatient facilities (Sonntag, Hellwich & Eichmann 2008) show considerable differences in average therapy duration for the various main diagnoses (figure 5.1). According to the Statistical Report for 2007, the average duration therapy (in weeks) was 16.0 for cannabis, 15.4 for stimulants and cocaine, 14.0 for opiates, 12.2 for alcohol and 11.9 for sedatives/hypnotics. It needs however to be considered that the treatment durations are subject to considerable variations. It is striking that the therapy duration of 14-16 weeks for disorders in connection with illicit substances is longer than the one for alcohol and sedatives/hypnotics. This is primarily attributable to the clearly smaller part of patients with treatment durations  $\geq 9$  months for alcohol and sedatives/hypnotics. The therapy duration

for most of the drug addicts in inpatient therapy has been on a marked decline for several years (figure 5.1).



(Sonntag et al. 2008)

**Figure 5.1** Duration of inpatient therapy broken down by substances 2007

The analysis of the case figures on rehabilitation therapy (based on the figures of withdrawal therapies) gives a varied picture of the drug patients. After having slightly increased between 2004 and 2005, inpatient treatments rose again by 4.6% to 8,458. Outpatient treatments increased significantly between 2003 and 2005, but stagnated in 2006 amounting to 1,124 cases. The shift from in- to outpatient treatment observed over several years did not continue in the reporting year 2006. So far, the available statistics do not present the partially inpatient treatments separately. Here, the attempt of a discriminating approach could lead to a deeper analytical insight into changes in the years to come.

**Table 5.2** Rehabilitation therapies for addiction problems (Withdrawal treatments)

Main diagnosis	Inpatient				Outpatient			
	2004	2005	2006	Δ '05/'06	2004	2005	2006	Δ '05/'06
Alcohol	28,88 4	27,21 3	26,41 6	-2.9%	10,73 9	10,38 7	9,145	-12.0%
Drugs	7,613	8,086	8,458	+4.6%	1,020	1,141	1,124	-1.5%
Pharmaceutics	372	314	297	-5.4%	83	77	67	-13.0%
Multiple use	3,359	3,097	3,541	+14.3%	466	520	478	-8.1%
Total addictions	40,22 8	38,71 0	38,71 2	0.0%	12,30 8	12,12 5	10,81 4	-10.8%

(Verband Deutscher Rentenversicherungsträger 2005; Deutsche Rentenversicherung Bund (DRV) 2007, 2008)

A similar trend is to be observed in the figures for patients with multiple use of psychotropic substances (which generally may also include use of illicit drugs). However, the changes in

percentage of patients in rehabilitation therapy for medication abuse require cautious interpretation due to the small case figures. There are still seven to eight times more drug patients in inpatient than in outpatient rehabilitation therapy, while the ratio for alcohol is only about 1:3 (Verband Deutscher Rentenversicherungsträger 2005; Deutsche Rentenversicherung Bund (DRV) 2007, 2008) (table 5.2).

### **Client figures in outpatient treatment**

In 2007, figures on new admissions to outpatient therapy are based on the data entered by 646 facilities within the framework of the German statistical report on treatment centres for substance use disorders (Deutsche Suchthilfestatistik, DSHS) (table 5.3). The distribution of the individual main diagnoses among the illicit drugs has already been described in chapter 4.3.1 (table 4.4 on page 74). First analyses indicate that, despite the changes made in connection with the introduction of the revised Core Data Set for the documentation of treatment for substance use disorders (Sonntag 2007), there were hardly any noteworthy developments in the distribution of the addiction diagnoses between 2006 and 2007.

The DSHS also contains some basic data on the therapy intensity (Sonntag et al. 2008b). The average number of contacts during therapy was the highest for opiate clients amounting to 32.6 and the lowest for cannabis clients with 11.2. Women who receive counselling or treatment because of problems with opiates, cannabis, hallucinogenes or sedatives/hypnotics, have more contacts than men with comparable main diagnoses. The gender distribution is reversed with regard to cocaine and other psychotropic substances. As for stimulants, no difference in the number of contacts was found between the genders (table 5.3).

**Table 5.3** New admissions to outpatient treatment 2007

Main diagnosis	%	N	Number of contacts (M)	Duration of treatment (weeks)
Alcohol	59.5	61,348	19.9	34.9
Opioids	19.3	19,891	32.6	44.9
Cannabinoids	12.6	13,005	11.2	25.7
Sedatives/Hypnotics	0.8	839	18.5	36.8
Cocaine	3.0	3,051	16.1	30.5
Stimulants	2.6	2,692	15.3	31.3
Hallucinogenics	<0.1	49	13.0	37.6
Tobacco	1.6	1,677	9.5	13.9
Volatile substances	<0.1	34	12.7	19.7
Multiple/other substances	0.5	516	19.2	37.7
Total		103,102		
Total drugs		40,077		

(Sonntag et al. 2008b)

The average therapy duration corresponds in its distribution to the contact figures. Opiate clients are, on average, the longest time in therapy, cannabis clients the shortest (clients with disorders caused by the consumption of volatile disorders have not been taken into account because of low case figures) (table 5.3).

### Regional data

Fischer and colleagues (2007a, b) conducted a prospective study to enquire about the outcome quality of the therapy of drug addicts in two abstinence-based facilities in the Rhineland-Palatinate. To this purpose, the authors surveyed a total of N=429 patients upon admission and discharge over 18 months as well as six and twelve months after the end of the therapy. The overall response rate of the study was at 42%. The overall population surveyed is described as being subject to multifold medical, psychological, social and vocational disadvantages. The authors come to the conclusion that patients were more successful when they completed their therapy according to schedule, were in therapy longer than four months, started therapy on their own free will and rather had short addiction careers. Young women appeared to respond particularly well to the therapy (Hessische Landesstelle für Suchtfragen (HLS) 2008). However, only 12% of the patients were also integrated into the job market after the end of the therapy. Furthermore, more than a third of the patients were homeless at the start of the therapy and it remains unclear how the housing situation developed during therapy. Measured by the abstinence criterion, the follow-up surveys carried out half a year and a year later produced a catamnestic success rate of 26% and 22% respectively (abstinent and abstinent after relapse). Relapses occurred mainly in the first three months after the end of the therapy. Fischer and colleagues arrive at the

overall conclusion that an abstinence-based therapy is useful and successful and that many patients can be said to have had an “effective course of therapy“ (Hessische Landesstelle für Suchtfragen (HLS) 2008).

### **Innovative therapy offers and demonstration projects**

The cessation programme “quit the shit“ developed by the Bzga for people with cannabis disorders as part of the Internet-based initiative [www.drugcom.de](http://www.drugcom.de) was already presented in the last REITOX-reports and has also been referred to again in chapter 1.3.3 as of page 10. The bi-national project “realize it“, a counselling programme for cannabis consumers, has also already been referred to under 1.3.3. Both programmes are currently being implemented on a broader scale or are already offered by quite a few facilities.

Funded by the Federal Ministry of the Interior, the demonstration project CANDIS - a modular therapy programme addressing cannabis users, – is currently also in a process of transfer into the care system which is subject of an analysis of a systematic study (cf. 1.3.3, page 10).

## **5.4 Pharmacologically assisted therapy**

### **Withdrawal**

In the withdrawal treatment of opiate 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 hospital reports (cf. table 5.1 and chapter 4.3.2).

Abuse of benzodiazepine is relatively common in persons undergoing methadone-maintenance treatment. Inpatient withdrawal of benzodiazepine – in many cases in combination with other substances like cocaine – is necessary for the success of substitution and in most cases also possible. However, the majority of the treated patients have a relapse within three months (Specka & Scherbaum 2005).

### **Substitution**

Substitution has been the standard therapy of opiate addicts in Germany for many years. Its beneficial effects for the psychological and physical health of the treated patients have been proven by numerous studies (Michels et al. 2007). Gerlach & Stöver (2005) have given an excellent overview of the status of substitution therapy in Germany. The results of a study recently published by Wittchen and colleagues (2008b) underline once more the general effectiveness of different types of substitution treatments with methadone and buprenorphine. The results tally with the results of earlier clinical studies but are based on a representative sample drawn among opiate patients in routine care who were surveyed in a cross-sectional design over a period of 12 months. The naturalistic design of the study and the missing randomization of the participating patients only allow cautious conclusions to be drawn from the results of this study. Despite these restrictions, it was still striking that the retention quota of the patients undergoing substitution treatment was relatively high and

comparable to the results of controlled clinical studies. Furthermore, it was shown once more that co-consumption (especially of cannabis and benzodiazepines as well as of opiates and cocaine) was 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 stress caused by somatic and psychological disorders. To summarize, the study gives numerous indications of long-term substitution therapy carried out within the framework of primary care being a promising therapy option for patients with opiate addiction.

### Substances eligible for substitution therapy

Substances eligible for substitution therapy in Germany are levomethadone, methadone and buprenorphine. Codeine and DHC can only be prescribed in exceptional cases. Usage of buprenorphine has about doubled since 2003, but methadone is still the predominant drug despite declining portions (Die Drogenbeauftragte der Bundesregierung 2008b) (Table 5.4).

In a comparative study on substitution therapy with slow-release-morphine and methadone, Winklbaur and colleagues (2008) arrive at the conclusion that the two substances do not differ from each other in terms of quality of life of the treated patients. The authors derive from this that slow-release-morphine represents another promising option in the long-term treatment of opiate patients which usefully complements the spectrum of therapies for this group of clients.

Hakansson and colleagues (2007) found in a study conducted among users of a syringe exchange programme in Malmö (Sweden) as a result that not only a considerable portion of the heroin users but also a quarter of the amphetamine users reported – at least occasional - abuse of buprenorphine within the last 12 months. Almost a third of the users reported nasal administration of buprenorphine and slightly more than 40% applied it intravenously. Although intravenous use of buprenorphine has been documented relatively often in the past, the portion of users with nasal administration of buprenorphine seems relatively high in this sample. However, generally speaking, the data situation in this area remains dissatisfying.

**Table 5.4** Type and percentage of substitution substances reported to the substitution register

Substitution substance	2002	2003	2004	2005	2006	2007
Methadone	72.1%	70.9%	68.3%	66.2%	64.1%	61.4%
Levomethadone	16.2%	14.8%	15.0%	15.8%	17.2%	19.0%
Buprenorphine	9.7%	12.9%	15.6%	17.2%	18.0%	18.6%
Dihydrocodeine	1.7%	1.2%	0.9%	0.7%	0.6%	0.5%
Codeine	0.3%	0.2%	0.2%	0.1%	0.1%	0.1%
Diamorphine						0.4%

(Die Drogenbeauftragte der Bundesregierung 2008b).

According to the register kept by the BfArM, 6,626 (2006: 6,329) physicians were licensed to carry out substitution treatments in 2007. However, the actual number of medical practitioners with a respective additional qualification is presumably higher because some Länder have granted the qualification automatically to psychiatrists and psychotherapists without them being fully registered. From a care point of view however, the fact that only 2,786 (2006: 2,706) physicians reported substitution treatments to the substitution register in 2007 is of much greater relevance (Die Drogenbeauftragte der Bundesregierung 2008b). However, the number of doctors reporting to the substitution register has been on a (slow) increase since 2003. In the year 2007, about 210 (2006: 300) double treatments could be discovered through the substitution register. The doctors in charge were informed by the register and the double treatments stopped. Looking at the relation between reported substitution patients and population figures in the individual Länder, the three city states Hamburg, Bremen and (at a considerable distance) Berlin are at the top of the list as expected. The lowest numbers of substituted patients per inhabitant are reported by the three eastern Länder Thuringia, Mecklenburg-Western Pomerania and (at a considerable distance) Brandenburg. With regard to the Land Brandenburg, it is to be presumed that numerous users turn to the metropolis Berlin for substitution treatment. The number of registered patients per substitution doctor is also subject to considerable variations between the Länder. Whereas a substitution doctor in Hamburg treats on average 42.3 patients (followed by Saxony with an average of 37.6 and the Saarland with 33.5), the average in Brandenburg is only 4.9 (Mecklenburg –Western Pomerania: 10.2 and Thuringia: 16.4).

Generally, access to substitution treatment is particularly difficult in rural regions in the east of Germany. Only 2.8% (N=1,988) of the registered substitution patients and 3.8% of the substituting doctors (N=106) are from the eastern Länder (without Berlin) (Die Drogenbeauftragte der Bundesregierung 2008b). An alternative explanation would be that the number of opiate users in rural areas is lower than in conurbations.

### **Number of substitution treatments**

With no identifying codes being used in the substitution register, persons admitted to several practices for substitution treatment may possibly be counted several times. The most recent census carried out by the substitution register permits to evaluate the number of persons reached on a set day but not over the course of the year. The number of people recorded in the substitution register on the set date 01.07 of the calendar year increased considerably from 46,000 at the introduction of the register in 2002 to 68,800 in 2007 (Die Drogenbeauftragte der Bundesregierung 2008b).

In the current discussion on substitution treatment which is meanwhile established in the care system, the question as to what goals are pursued by substitution treatment is still controversially debated. The success criteria for substitution treatments diverge 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 opiate dependence or the successful treatment of other (somatic and psychological) disorders (Wittchen 2008). The attempt to give an overview of the care situation in Germany is

problematic not least because of the different sets of goals and the regional differences resulting therefrom.

The as of yet insufficiently known long-term effects of substitution treatment are to be investigated by a three-year-research study which is funded by the Federal Ministry for Health (cf. also chapter 1.3.3) (see 5.6 for a detailed description of the study).

### **Substitution in prison**

Kastelic and colleagues (2008) have, in cooperation with numerous experts, published a practical guide on substitution therapy for opiate addicts in prisons or comparable environments. Based on the experience of international experts, international literature on the subject and relevant data banks, this guide was developed to actively support people in the field in their daily practical work. Complementing the international recommendations on substitution treatment in prison (Kastelic et al. 2008), there is also a recent publication on substitution carried out in prison available in the German language (Stöver 2007). It looks at the various aspects of substitution therapy in prison from different angles and discusses the reasons which restrict or even prevent therapy which would be adjusted to the specific needs of prisoners in Germany. The authors sketch the preconditions which are to be fulfilled to carry out a successful therapy in this setting. A recently published overview underlines the effectiveness of substitution treatments carried out also in prisons pointing out that especially substitution with methadone can contribute to reducing risky behaviour (i.e. risky drug consumption) and substance abuse in general (Stallwitz & Stöver 2008). The authors emphasize however, that, in order to achieve good retention quotas and to reduce co-consumption and criminal behaviour, both dosage of the substitution substance and duration of the therapy – which ideally should stretch over the whole period of detention – appear to be decisive.

### **Psychosocial care**

Although psychosocial care of substitution patients is explicitly requested, offers are funded only to a limited extent by statutory pension and health insurers. Therefore, the funds provided by the municipalities and especially by the Länder play an import role in this care sector.

In this connection, it needs to be taken into account that there are nationwide differences in the organisation, funding and the type of psychosocial care offers made and consequently in the interpretation by the Länder and municipalities.

The psychosocial care of patients is provided as a part of the substitution treatment according to the specifications of the BtMVV and the regulations of the Common Federal Committee (G-BA) respectively the German Medical Association (BÄK), as far as it is “necessary”. The doctor has to decide whether a psychosocial care is necessary in the individual case. As offers in psychosocial care are financed only to a limited extent by funds of statutory pensions and health insurers, the funds provided by the municipalities and by the Länder are decisive for this part of care. The different interpretations of psychosocial care by

the Länder and municipalities lead to very unequal organization, financing and offers of psychosocial care.

It was confirmed by a judgement of the Hamburg Administrative Court in April 2008 that necessary psychosocial Counselling/care of substitution patients constitutes a service to which exists a legal claim (provided the necessary preconditions according to SGB XII are fulfilled) and which is to be provided by the local social administration authority (Deutsche Hauptstelle für Suchtfragen (DHS) 2008).

## **5.5 Quality assurance**

### **Therapy guidelines**

Various professional societies and experts have worked together over the last years to develop guidelines for the treatment of drug dependence and addiction problems. 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. 2003), for the post-acute treatment of opiate addicts (Havemann-Reinecke et al. 2004), for patients with cannabis-related disorders (Bonnet et al. 2004) as well as behavioural disorders caused by cocaine, amphetamines, ecstasy and hallucinogens (Thomasius & Gouzourlis-Mayfrank 2004). In the year 2006, the Working Group of the Scientific Medical Professional Societies (Arbeitsgemeinschaft der medizinisch-wissenschaftlichen Fachgesellschaften, AWMF) published the elaborated 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. 2006).

At a consensus conference held in 2006, the guidelines of the German Society for Addiction Medicine (Deutschen Gesellschaft für Suchtmedizin, DGS e.V.) for the therapy of chronic hepatitis C in injecting substance users were passed (c.f. Backmund et al. 2007a). Contrary to recent practice, these guidelines recommend the treatment of opioid-addicts affected by hepatitis C, in particular when they are in substitution treatment (Backmund et al. 2006).

### **Revised Core Data Set on treatment centres for substance use disorders**

The revised Core Data Set for the documentation of treatment for substance use disorders was introduced by the German Centre for Addiction Issues (Deutsche Hauptstelle für Suchtfragen, DHS) together with the German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (DBDD) (German REITOX focal point), the special departments of the central associations of the private charity organizations, the Professional Association "Addiction" (Fachverband Sucht), the statutory health, the pension insurance organizations at federal and Land level in 2007. Further information is contained in chapter 4.3.

In addition to the above mentioned core data set, a catamnestic module was passed to provide also outpatient facilities with the possibility to evaluate results at the end of therapy – especially of outpatient rehabilitation therapy. Information ranging from the organisation of a survey over sample taking to the calculation of outcome quotas was published in a comprehensive manual ([www.dhs.de](http://www.dhs.de), [www.dbdd.de](http://www.dbdd.de)).

## **5.6 Research**

### **Scientific publications on the heroin study**

In addition to the earlier presentations of technical reports, further scientific works were published in professional journals in 2007 presenting the results of the national demonstration project on the dispensing of diamorphine for heavily dependent addicts. In two editions of the journal "Sucht", a running commentary was published on the results yielded by the demonstration project in which representatives from politics, science and professional associations and the Federal Medical Council engaged in a critical discussion on the presented results (cf. also the running commentary in Sucht 53(6) and Sucht 54(1)).

After the completion of the national demonstration project on heroin-assisted therapy of addicts, Haasen and colleagues (2007) arrive at the conclusion that the study confirms the effectiveness of diamorphine-assisted therapy in non-responders to methadone substitution. They suggest using the superiority of the therapy to integrate heavily dependent persons who are not in therapy into the addiction support system. For the transfer of diamorphine-assisted therapy into regular care they furthermore advise to continue with the conditions tested in the study as long as no new findings with regard to useful modifications are available.

Within the framework of the demonstration project, attention was also paid to the criminal activities undertaken by the participants of the study. The goal was to find an answer to the question whether the dispensing of synthetic heroin in comparison with methadone would lead to a stronger decrease in criminal activities. It showed that the decline in delinquency was much more pronounced under diamorphine-assisted treatment compared to substitution with methadone (Löbmann 2007). Löbmann assumes that in particular the crime reducing effect of heroin-assisted therapy could contribute to the social acceptance of this type of therapy. An analysis of those patients who participated in the heroin study over the whole project period of 24 months yielded as a central result that the physical and psychological

health conditions had improved and the consumption of illicit drugs had declined under heroin-therapy. In these areas, the greatest achievements were reached already during the first therapy months followed by slight improvements or stabilization later on. Contrary to this, improvements of the social conditions were continually observed over the whole period of two years which can be regarded as evidence that the stabilization of the life and work situation as well as the development of new social (drug-free) contacts require considerably more time. The decline in delinquency rates was significant (see below) and comparable to the improvements in the health condition (Verthein et al. 2008). Lintzeris (2008) stresses that the abovementioned social improvements often are the decisive factors for achieving long-term abstinence and that the results yielded by the heroin study underline the relevance of long-term-therapies and provide further prove of the safety and effectiveness of clinical heroin therapy also beyond a period of 12 months.

In a sub-study of the heroin study, it was analyzed in how far type and setting, usage and intensity of psychosocial care had an impact on the effectiveness of the therapy provided within the framework of the demonstration project (Kuhn et al. 2007). The authors conclude that the psychosocial interventions offered within the framework of the study do not differ from each other in terms of the effects on the improvement of the health condition and the reduction of illicit drug use: both the case management and the psycho-educational group programme were successfully used in the substitution programme with heroin or methadone and did not differ from each other in their impact on the primary effects of the therapies carried out under the study. Kuhn and colleagues conclude that the positive impact of the two psychosocial methods on the therapy outcome depends less on the type of the method but more on its professional and structural implementation.

### **PREMOS-Study**

Controlled clinical and naturalistic epidemiological studies have provided evidence that a qualified substitution-based therapy of opiate addicts with methadone and buprenorphine can significantly improve the health and social condition of persons affected and lower the death risk considerably. Although the short- and medium-term (up to one year) effectiveness and safety of substitution maintenance therapy has been proven, the several-year long-term therapy course in substituted opiate addicts is unclear and insufficiently researched. Based on the results of the COBRA-study, the PREMOS-study (Predictors, Moderators and Outcomes of Substitution Treatment) set itself the goal in 2007 to investigate the long-term (several-year-) effects of substitution treatment. It is planned to analyze the 4-5 year-course of substitution therapies, describe long-term effects as well as to identify predictors and moderators of the therapy outcome. To this purpose, the study will resort mainly to the original cohort of the substitution patients already analyzed within the framework of the COBRA-study. The PREMOS-study is a combination of a nationwide representative, clinical-epidemiological study on central parameters of the care structure for heroin addicts in substitution and a longitudinal cohort study of representatively selected patients. The statistical evaluation of the long-term effectiveness as well as of the predictors and moderators is based on established instruments suitable for the practical work (scales, questionnaires, urine tests) and is stratified according to the duration of the foregoing

substitution therapy in terms of categorical (e.g. successful completion of the therapy) and dimensional outcomes (e.g. quality of life). Additional in-depth-studies will look at critical aspects like substitution substances and dosage, outcome and predictors of substitution therapy in women (pregnancy, children). Through a multi-level conception and multi-point-data-collection, the application concept makes it possible to provide a clinically differentiated and comprehensive answer to the main questions and give valuable insight into the conception of the indication criteria meeting the needs of patients and care structures with regard to substitution therapies. The study started in November 2007, first results will be available at the beginning of 2009 (for further information turn to: <http://www.premos-studie.de>).

### **Staff training**

In Germany as in many other European countries, courses of studies are currently restructured. In the restructuring process, post-graduate training for social workers, psychologists and physicians play a particularly important role for addiction aid. The relevance of the current introduction of bachelor and master study programs at German universities is still under discussion. A new "European Postgraduate School in Addiction Research" is to promote the young generation of researchers specifically in the area of addiction research. Under the supervision of the Institute for Clinical Psychology and Psychotherapy of the University of Applied Sciences Dresden, a curriculum for doctoral candidates will be tested and evaluated to promote addiction research. The training programme stretches over a period of two years, during which the doctoral candidates participate in seminars, work in leading European research groups and do a practical training in a therapeutic facility. The Volkswagen Foundation funds the training programme with little less than 200,000 Euro (further information under: <http://www.psychologie.tu-dresden.de/i2/klinische/index.html>).

### **Other studies and results**

Other studies – in particular projects funded by the Federal Government – were already referred to in chapter 1.3.3 and in the corresponding passages in the text.



## 6 Health Correlates and Consequences

### 6.1 Overview

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 Office of Criminal Investigation (Bundeskriminalamt, BKA) and the General Mortality Registry of the Federal Statistics Office (Statistisches Bundesamt, StBA). 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.

#### Drugs Data File

Drug-related fatalities are always recorded by the Land offices of criminal investigation in the individual Länder. 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-related fatalities differ between the individual Länder. The portion of autopsied drug-related fatalities as a measurement for the quality of the assignment of drug-related fatalities varies (in some cases considerably) between the Länder. 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 not sufficiently taken into account in the classification of drug-related fatalities.

In order to facilitate the recording of drug-related fatalities and reduce mistakes, the following categories for drug-related fatalities were defined by the BKA (Bundeskriminalamt 1999):

- drug-related fatalities 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
- 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 Registry<sup>24</sup>**

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 with specific causes of death are reported from the General Mortality Registry to the EMCDDA. The selection is based on the specifications of EMCDDA (section B), which – in comparison with the specifications of the Federal Office of Criminal Investigation – have a narrower definition of drug-induced fatalities. As a basis for the assignment to the group of drug-related fatalities, the assumed underlying disorder (ICD10-Codes F11-F19) or the assumed cause of death (ICD10-Codes X, T, and Y) were used respectively.

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 which 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.

### **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 intervals ([www.rki.de](http://www.rki.de)). According to the German Regulation on Laboratory Reports of 1987 and the Infectious Diseases Control Law (Infektionsschutzgesetz, IfSG) 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 ways of transmission. These data are complemented by supplementary anonymous reports of the doctors in charge, by limited clinical data and HIV-related laboratory parameters.

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<sup>24</sup> The usage of the term "General Mortality Registry" is oriented to the terminology of the EMCDDA. The herein reported data are from the "Statistical report on the causes of death" ("Todesursachenstatistik") of the Federal Statistics Office.

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 better possible 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.

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

The up-dated data are published yearly by the Robert Koch Institute in Berlin in the "Yearbook – Infection epidemiology of notifiable infectious diseases" (Infektionsepidemiologisches Jahrbuch meldepflichtiger Krankheiten) (Robert Koch-Institut 2008b). HIV-related reported data have so far been presented in half-yearly reports as a special edition of the Epidemiological Bulletin of the RKI (Robert Koch-Institut 2008a)

## **6.2 Drug-related deaths and mortality of drug-users**

### **6.2.1 Drug-related deaths**

#### **Data from the police register of drug-related deaths**

The reliability of information on drug-related deaths strongly depends on the question as to whether autopsies and toxicological examinations have been used to validate the initial classification as drug-related death or not (cf. 6.1). On average, the autopsy rate in the reporting year was 62% (2006: 67%), a few individual Länder however, diverged considerably from this value (Bundeskriminalamt 2008b). During the last years, autopsy rates tended to decrease which experts attribute to rising costs or respectively shrinking budgets.

After having dropped in 2006 (1,296 cases) to the lowest level recorded since 1989, the overall figure of drug-related fatalities (1,394 cases) increased by 7.6%% from 2006 to 2007. With 907 cases, overdose of heroin (including use of heroin in combination with other drugs) remains the most common cause of death (65%; 2006: 66%). This portion of cases has remained stable over the last three years. The portion of drug-related deaths in which substitution substances alone or in combination with other drugs were detected, declined again (2007: 14%; 2006: 16%; 2005: 25%); in 2002, the portion was still 40%. In 2006, the BKA statistics showed the detected substitution substances broken down for the first time by methadone/polamidone and buprenorphine. According to the BKA data, the majority of death cases which were exclusively attributable to a substitution substance (81%), happened in connection with methadone/polamidone (N=46). Among the 131 death cases, in which

substitution drugs in combination with other drugs were found, there were also six cases in which buprenorphine was detected.

Since the data collected by the Land Offices of Criminal Investigation 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 an overdose of cocaine. 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 which have no 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 (cf. table 6.1.).

The number of death-cases in which substitution substances played a role, is still low which can be attributed to the good qualification of consultants 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 can be underestimated due to frequently missing exact toxicological data on a death-case. Regional evaluations of toxicologically analyzed cases show that for example there were only 6.6% solely heroin-induced intoxications among 151 cases of intoxication recorded in Hamburg between 2002 and 2005, 42.5% heroin-intoxications in combination with other substances as well as 43.7% involving methadone. Among 750 intoxication cases toxicologically analyzed in Berlin between 2002 and 2006, 10.4% were solely heroin-induced, 50.4% were heroin-intoxications in combination with other substances and in 32.7% of the cases methadone was involved (personal communication<sup>25</sup>).

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<sup>25</sup> Source: Länder analysis for the field trial to improve the toxicological reporting of the EMCDDA. The data for Berlin/Hamburg were provided by the LKAs, i.e. the cases recorded by police (LKA-data for BKA-reporting) in combination with the evaluation of all the relevant toxicological reports.

**Table 6.1** Drug-related deaths 2002-2007 broken down by substances

Death causes	Percentage						Figure
	2002	2003	2004	2005	2006	2007	2007
1. Overdose of: <sup>1)</sup>							
Heroin	36	31	34	40	38	39	550
Heroin + other drugs	19	18	22	23	27	26	357
Cocaine	3	2	2	2	2	1	15
Cocaine + other drugs	6	6	10	9	9	10	136
Amphetamines	1	0	0	1	<1	<1	10
Amphetamines + other drugs	2	1	2	2	3	2	34
Ecstasy	1	0	0	0	<1	<1	3
Ecstasy + other drugs Drogen	1	1	1	0	1	1	10
Pharmaceuticals/Substitution subst.	10	4	3	6	5	4	57
- Methadon/Polamidon						3	46
- Subutex (Buprenorphin)						--	--
Substitution subst. + other drugs <sup>3)</sup>					12	9	131
- Methadon/Polamidon						8	115
- Subutex (Buprenorphin)						<1	6
Narcotic drugs + Alcohol + Substitution substances <sup>4)</sup>	30	24	22	19			
Other narcotic drugs/unknown	4	9	10	10	8	10	135
2. Suicide <sup>1)</sup>	9	8	7	8	6	6	81
3. Longterm damage	11	14	12	12	11	12	166
4. Accident/other	2	3	2	2	13	12	163
5. Total (N)	1,513	1,477	1,385	1,326	1,296		1,394

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-related deaths.

2) Since 2006: substitution substance.

3) Since 2006

4) Does not exist anymore since 2006.

(Bundeskriminalamt 2008b)

### Regional data from police sources – Bavaria as an example

After a 16-year decline in drug-related deaths, the number of drug-induced deaths increased for the first time again to 242 (2006:191) in 2007. It is noteworthy that among the drug-related deaths there were numerous users whose general health condition had noticeably deteriorated as a result of the year-long abuse of illicit drugs.

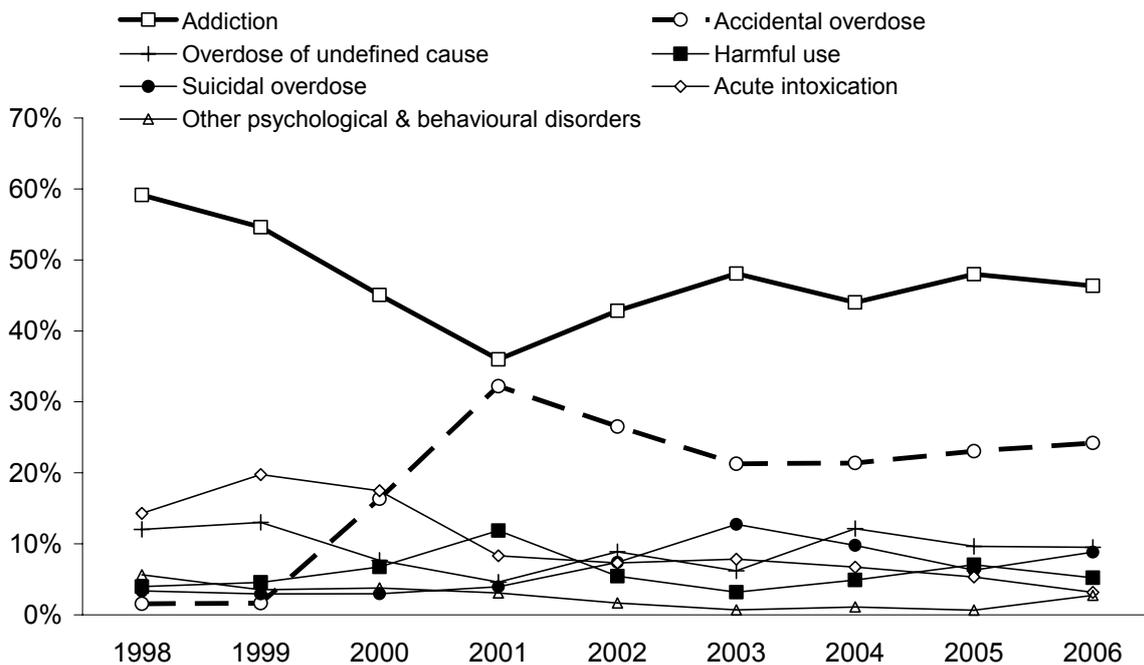
The data situation (see also chapter 10) does not allow high concentrations of active ingredients to be held responsible for this development. Although narcotics with a higher content of active ingredients were seized in a few individual cases, it is not possible to derive any connections with the increase in drug-related deaths from this. The concentrations found by the toxicological reports lie within the usual trade range recorded among the users. The underlying reasons are connected to a multitude of factors like for example the consumption

behaviour in terms of type and dosage, age, duration of dependence, already existing, latent untreated illnesses, readiness to undergo therapy, etc. With 33 years (2006: 32.6), the higher average age of the injecting drug users in the Bavarian cities Munich, Augsburg and Nuremberg is also attributable to better emergency medication.

Stretched over several years, the comparison of the figures of drug-related deaths shows an undulating course with increases and declines. The years 1998 and 2000 saw significant increases with 313 deaths and 340 deaths respectively whereas figures declined from 2004 to 2006. The cause of death no. 1 among all recorded cases still is heroin abuse – increasingly in combination with the consumption of cannabis, medical drugs or alcohol (Bayerisches Landeskriminalamt, personal communication).

### **Data from the General Mortality Registry**

The most recent figures on drug-related deaths available from the General Mortality Registry are from the year 2006. For that year, a total of 1,169 persons - 248 women (2005: 231) and 921 men (2005: 992) – who died in connection with illicit drugs, were recorded. With this, the number of drug-induced deaths recorded by the General Mortality Registry in the year 2006 is about 3% higher than the overdose-cases registered by the BKS and only about 6% (2005: around 8%) lower than the total of cases recorded by the BKA. In more than half of the cases (54%; 2005: 56%), the underlying illness (addiction, harmful substance use or others) were coded as cause of death in the year 2006. Furthermore, 43% (2005: 39%) were registered in connection with overdose and allow conclusions to be drawn with regard to the underlying (combination of) substance which caused the death (this indirectly applies also to 3% of the cases which – against the rules for the coding of death cases - were still registered in 6 Länder with the clinical ICD-code F1x.0 for “acute intoxication). It shows that codings which do not allow any inferences to be made to the direct cause of death continue to be preferred. In addition, it appears that the coding behaviour is very heterogeneous in the various Länder. Bavaria, Hamburg and Bremen still only code the underlying illness in more than 90% of the cases but not the direct cause of death. The up-coming introduction of a multi-causal coding system together with the change of the coding guidelines effective as of 1 January 2007 should bring about improvements across the Länder (figure 6.1).

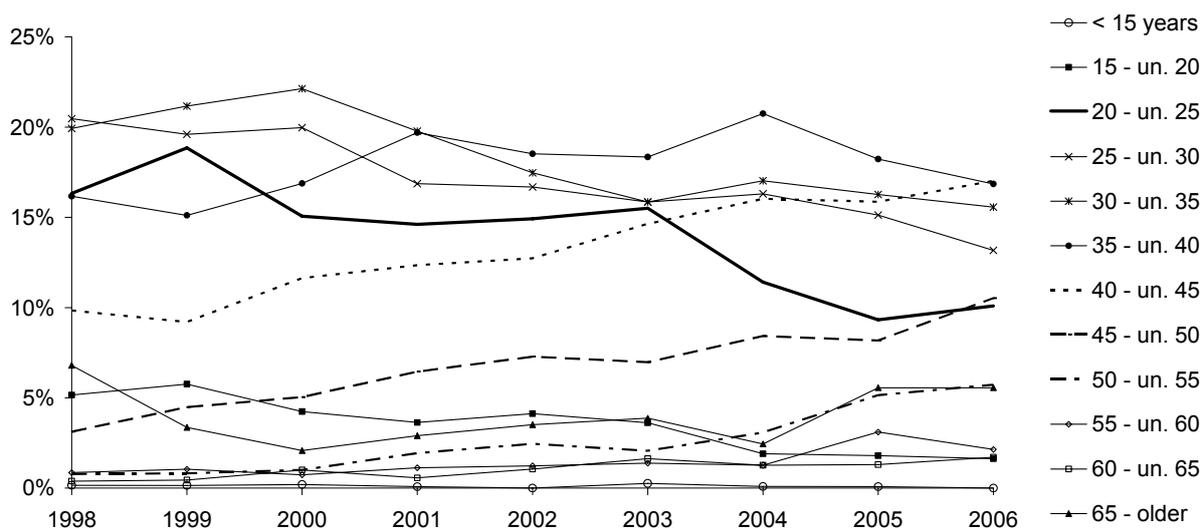


(Statistisches Bundesamt), special calculations

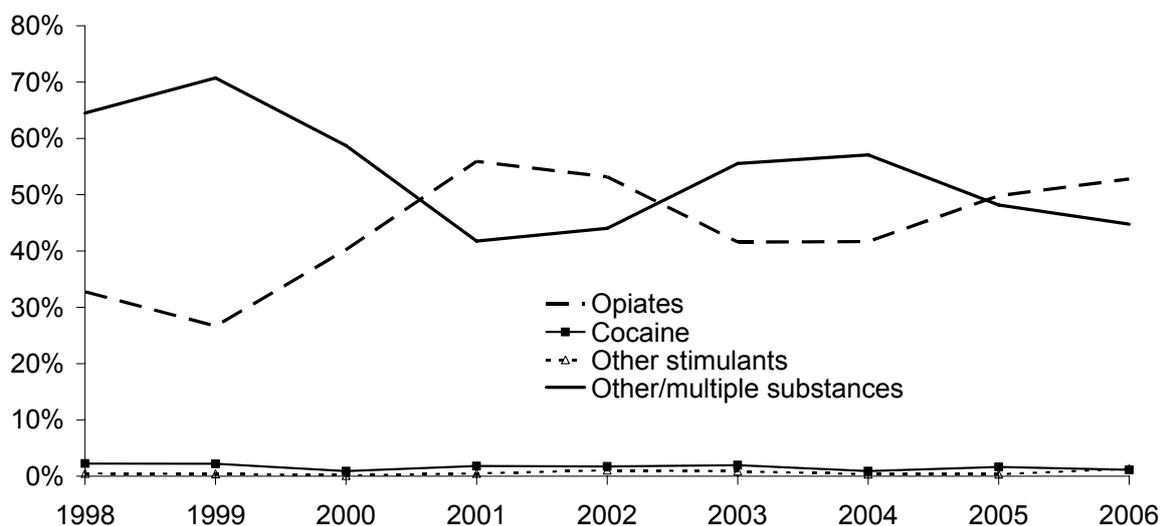
**Figure 6.1** Coded causes of drug-related deaths in the General Mortality Registry (1998-2006)

Looking at the age distribution of the drug-related deaths over the last eight years, one notices that the portion of older drug users, especially of the 40- to 50-year-olds has been increasing for some years. This increase is paralleled by a decline of younger age groups, recently in particular the one of the 25-40-year olds. These changes together with the also increasing average age of opiate users in outpatient treatment over the last years can be taken as an indication of fewer young heroin users to follow, although it needs to be added that no further declines were found in the 15- to 25-year-olds (figure 6.2).

In an analysis of the drug-related emergencies which occurred in Hamburg in the period between 1997 and 2004, Walloch and colleagues (2007) report an increase in the average age of emergency drug patients of both genders. At the same time they found that the number of drug-related deaths which happened in the public decreased by half in the period of enquiry. The overall number of recorded drug-related emergencies dropped by about half compared to 1996 and by a further 23% in the period of enquiry.



**Figure 6.2** Drug-related deaths broken down by age groups 1998-2006



**Figure 6.3** Distribution of the substance categories in the coded direct causes of death, overdose 1998-2006

Figure 6.3 shows the substances which were the direct cause of death in the respective death case based on relevant ICD-10-categories. For 2006, these data were only available for 46% of the death cases (see above). When the death cases were coded, they were registered either under “acute intoxication” as F1x.0 or with X/Y-codes as external causes of death. Apart from opiates, there was almost exclusively mixed consumption found which probably contained opiates again. Summarizing it can be said that there has been a slight trend towards opiates over the last 3 years until 2006 combined with a relative reduction of the portion of mixed intoxication spectrums. Other substances accounted for maximum 2% of the death cases. It is not exactly known how many of these classifications are actually based on chemical-toxicological data on the spectrum of substances which caused the death.

Still in planning is a study which is to examine tallies between the general mortality registry and police records. The general mortality registry however, also often assigns codes to intoxications without them being based on sufficient toxicological information. In addition, there is the problem that the present coding rules and the mono-causal orientation of the register do not allow to give a differentiated presentation of the information content of possibly available toxicological data.

Detailed data on the drug-related deaths are contained in standard table 5, the development of the case figures in standard table 6.

### 6.2.2 Overall mortality and causes of death in drug users

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 which exist on drug addicts in therapy.

According to the German statistical report for 2007 on treatment centres for substance use disorders (Deutsche Suchthilfestatistik, DSHS), therapy in outpatient counselling facilities ended in 1.4% (2006: 1.3%) of the clients with death of the opiate patients (opiate users accounted for 87.7% of the deceased patients recorded by the DSHS). 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 in 2007 was at the levels of previous years (since 2000).

However, when looking at these data, it needs to be taken into account that the counselling 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).

**Table 6.2** Mortality of outpatient opiate addicts - trend

	2000	2001	2002	2003	2004	2005	2006	2007
Proportion of deaths amongst treatment outtake	1.1%	1.1%	1.2%	1.2%	1.2%	1.4%	1.3%	1.4%
Duration of treatment (days)	244.3	263.2	280.7	282.1	297.5	305.2	301.7	314.3
Mortality p.a.	1.6%	1.5%	1.6%	1.5%	1.5%	1.7%	1.6%	1.6%

(Sonntag et al. 2008b) and own calculations.

In parallel with the increase of substitution therapy offers, the number of drug-related deaths dropped at the national and regional level in Germany. Mortality of patients in substitution therapy was measured at 1.1% by the COBRA-study in the course of one year (Wittchen & Apelt 2006) ranging in the same dimensions as the ones recorded by the DSHS. Contrary to

methadone, which was involved as a single drug in 46 deaths reported by the BKA in 2007, and in combination with other substances in another 115 deaths, buprenorphine was only recorded in connection with six deaths in combination with other substances

### **Overall situation**

Compared to the situation 10 years ago, the number of drug-related deaths is currently relatively low despite an increase in the reporting year 2007. Overdose of opiates was by far the most common cause of death, though with the involvement of additional licit and illicit substances in many cases. There were still no indications found of an increase of drug-related deaths during therapy. Striking is the increase in the portion of older users in the drug-related deaths which has been observed for several years. The portion of the 20-25 year-olds by contrast, has considerably decreased over the last years.

In comparison with the police register, the general death register records even less data on other substances, apart from opioids, which played a role in drug-related deaths. The reason for this could be that the results of differentiated toxicological examinations arrive too late to be coded and entered into the general death register, while the police register allows for these pieces of information to be added at a later point of time. Generally speaking, the general mortality registry does not appear to be suited for a substance-related evaluation. Changing from mono- to multi-causal coding of the causes of death could definitely improve the data situation. After a successful field trial in Saxony the new coding system will be introduced in the whole of Germany in the following years.

Data on the mortality of drug users are contained in standard table 18.

## **6.3 Drug-related infectious diseases**

### **6.3.1 HIV**

Drug users are still one of the most important groups at risk of contracting HIV-infections. According to the Robert Koch-Institute, 5.5% (2006: 6.1%) of the persons with an initial HIV-diagnosis were out of the group of the injecting substance users in 2007 (Robert Koch-Institut 2008a). By 2000, this value was still at 10.1%.

Data on the way of transmission were available for 87% of the newly diagnosed HIV-infections in the year 2007 (2006: 85%). 65% (2006: 61%) of them are men who have sex with men (MSM). This group has been the largest for years, growing in absolute and relative figures since 2001. Individuals who acquired their HIV-infection through heterosexual contacts and do not come from high-prevalence countries represent with 17% the second largest group affected by HIV for the second year in a row. The portion of persons who come from countries with a high HIV-prevalence among the general population and who were newly diagnosed with HIV in 2007, continued to shrink to 9.2% which is the lowest level since 1998. It is to be assumed that the major part of the latter group of persons acquired the infection already in the country of origin. If one only takes account of the cases in which information was available on the existence of an infection risk, the portion of the injecting

drug users increases to 6.3%. The absolute figure of newly infected persons with injecting drug use declined by 6.6% in comparison with the previous year (152 cases; 2006: 162 cases), but still clearly ranged above the comparative values of the years 2001 (N=115) and 2002 (N=108). With 41<sup>26</sup> cases, the number of female injecting drug users stayed more or less the same in respect of the previous year (N=42), while the number of new diagnoses among the male injecting drug users declined by about 6.5% (108 cases in 2007 vs. 114 cases in 2006).

One of the still lesser known reasons for the increase in HIV-infections is the high number of syphilis-infections in Germany. The syphilis bacterium and other sexually transmissible pathogenic agents induce inflammatory processes which make the person affected more likely to contract HIV. If, for example, someone affected by syphilis is also infected with HIV, he can pass on the HI-virus more easily, i.e. that person is more contagious (Robert Koch-Institut 2008a, b).

In 2007, the HIV-incidence in the overall population was at 3.3 per 100,000 (2006: 3.2). However, there are considerable regional differences. The highest incidence of new HIV-diagnoses was found in the city states of Berlin (12.0) and Hamburg (11.4) with values lying above 10/100.000 cases. Even higher figures were found for Cologne (18.1). The figures reported from Munich (11.7) and Frankfurt on the Main (12.0) tally with the ones reported from the city states.

According to the BKS, a positive HIV-status was found in 3.4% of the drug-related deaths (48 out of 1,394) (2006: 2.9%). However, a few Länder do not have any information on HIV-infections. In Berlin for example, the results of HIV-examinations are not reported to the police by the forensic institutes. The value available for the city of Berlin results from records (e.g. interviews of relatives or family doctors) which are not usable for statistical purposes. Data from outpatient counselling services show a prevalence of 5.6% (N=198) among the opiate users and 4.6% (N=223) among the users of all illicit drugs in 2007 (Sonntag et al. 2008b).

The generally relatively good substitution offer in Germany certainly contributes to the relatively low HIV-infection rate among IDUs (Backmund & Reimer 2007b).

Data on HIV-prevalences are also available from outpatient counselling facilities and drug consumption shelters in Hamburg, Berlin and Frankfurt. Since the target groups and the way of data collection differ between the facilities, the data provided are not directly comparable with each other. The data recorded by consumption rooms in Frankfurt (Simmedinger & Vogt 2008) are based on self-reports of the clients. According to these data, 69% of all consumption room users and 80% of the new users had their last HIV-test taken in the years 2006 or 2007. HIV-prevalence in 2007 (5.9%) was slightly below the figure of 2005 (6.5%);

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<sup>26</sup> The sum of female and male cases is lower than the total sum since there were sometimes no data available on the gender.

broken down by genders, the prevalence among females (9.9%) was almost double as high as among males (5.0%).

The basic documentation system of outpatient addiction support in Hamburg (BADO) (Buth et al. 2007) reports, like in previous years, a higher HIV-infection rate of the females (approx. 8%) in comparison with the males (approx. 6%) among the opiate clients who made use of outpatient addiction aid services in Hamburg in 2006 (Buth et al. 2007).

Within the framework of an evaluation of three consumption rooms (out of them one mobile consumption facility) in Berlin for the years 2004-2007 (Schu & Tossmann 2007), data were also collected on the HIV-prevalences among the clients. It was found that the prevalences calculated from the case files (2006: 3.0%; out of 566 case files) diverge considerably from the self-reports given by the users of the consumption shelters (2007: 1.4%, out of 71 reports by the users).

### **6.3.2 Viral hepatitis**

#### **Data from the population statistics**

There are basic data available for viral hepatitis in the general population. According to the Robert Koch-Institute (2007a), 5-8% of the German population in the age between 18 and 79 years have a history of hepatitis B infection, 0.4-0.8% are virus carriers. The federal health survey conducted in 1998, found a seroprevalence of HBc-antibodies as an indicator for an infection history in 7.7% in the old and in 4.3% in the new Länder (Thierfelder et al. 2001).

Reported cases of hepatitis B infections have been on a downward trend since 2001. Accordingly, comparative figures declined between 2006 (1,179 reported cases of acute hepatitis B) and 2007 (1,008). The incidence in the general population was at 1.2 in 100,000 inhabitants (2006: 1.4). Regarding possible routes of transmission, sexual exposition was most commonly stated (340 cases, multiple entries possible). Injecting drug use was only reported in 34 cases (2006: 38) (3.9%). Out of these, 28 were male IDUs. With that, the portion of injecting drug users registered by the RKI has fallen by 75% since 2004 (from 138 cases) (Robert Koch-Institut, 2008b).

In the same year, 6,858 (2006: 7,561) initial hepatitis C diagnoses were reported to the RKI. The incidence was at 8.3/100,000 inhabitants (2006: 9.2), however, there are considerable differences between the various Länder (ranging from 3.0 in Brandenburg to 22.1 in Berlin). Currently, it is not possible to differentiate between acute and chronic hepatitis C infections among the cases reported. Since 2003, cases with an earlier laboratory HCV-test result, are removed from the register. In all other cases, i.e. when there is no documentation of the existence of an earlier infection, the case is entered as a newly reported infection in the statistics (first laboratory diagnosis). Injecting drug use was reported as a route of transmission in 35% of the cases with exposition data (1,769 out of 5,012 cases). In the group of the 20- to 29-year-old men affected by an HCV-infection and with data available on their exposition risk, the portion of injecting drug users is markedly higher amounting to 73% (614 cases) (Robert Koch-Institut, 2008a). The fact that men are clearly overrepresented in

the injecting drug users explains the considerably higher incidence of first hepatitis C diagnoses in men in comparison with women.

### **Data from addiction support facilities and vaccination programmes**

In 2007, data on HBV and HCV were collected for the first time in the German statistical report on treatment centres for substance use disorders (Sonntag et al. 2008b) (cf. 6.1). For HBV, the prevalence among the tested opiate clients in outpatient facilities was 13.8% (N=410), among patients with illicit drug problems it amounted to 10.6% (N=446). The HCV-quota of the tested opiate clients was at 59.1% (N=2,325), the one of all patients with illicit drug problems amounted to 49.8% (N=2,778).

54% of the users of consumption rooms in Frankfurt reported to have (had) a hepatic disease. Approx. 45% of the clients are infected with hepatitis C, 2.4% with hepatitis B and another 6.6% with hepatitis B and C (Simmedinger & Vogt 2008).

The hepatitis quota among opiate clients of addiction support facilities in Hamburg even amounted to 53% (Buth et al. 2007) in 2006, while, based on the self-reports of the users of the consumption rooms in Berlin (2006: N= 79; 2007: N=71), it declined from 46.8% in the year 2006 to 31.0%.

Out of 2,694 patients from medical substitution practices who were surveyed within the framework of the COBRA-study, 69% tested HCV-positive. The overall infection quota of those study patients with follow-up results fell from 67% to 50%. Differences between the substitution substances (methadone, buprenorphine) were not found (Wittchen, 2006).

Summarizing, antibody prevalence (infection rate) of hepatitis B among IDUs in Germany can be estimated to range between 40-60% and for hepatitis C between 60-80%. Despite the unsatisfying data situation, it is to be noted nevertheless that antibody prevalence in IDUs is very high for hepatitis B and hepatitis C. Since drug users are strongly affected by new infections, they play a central role in the spread of these infections.

### **6.3.3 Sexually transmissible diseases, Tbc and others**

Since the end of the year 2002, infections of HIV, syphilis, gonorrhoea, chlamydiae and trichomonas have been recorded by the Robert Koch-Institute in a countrywide sentinel-network. A total of about 235 selected medical practices, specialized outpatient units and health offices have reported data on sexually transmissible diseases diagnosed by them. In addition, the persons concerned have been asked to fill out anonymized questionnaires on their sexual practices, drug use and social status. Current data on the prevalence of these diseases among drug users are not available.

Data on the prevalence of hepatitis B and C and of HIV among intravenous drugs users are contained in standard table 9.

#### **6.4 Psychiatric comorbidity**

Drug addicts have a higher suicidality than comparable groups. Police statistics (cf. table 6.1) reveal that living conditions are the reason for suicide in at least 6% of the drug-related deaths. 28% of the opiate clients recorded in BADO 2006 have at least one suicide attempt (Buth et al. 2007) behind them. Zimmermann and colleagues (2007) have recently investigated suicidal behaviour in young adults admitted to inpatient withdrawal therapy. The study is based on the known fact that suicidal behaviour is relatively common in addiction-stricken subjects and contributes to a third of the committed suicides. The study found that cannabis inpatients have a considerably increased propensity for suicidal behaviour and thoughts which are mostly connected with problems with family and friends. The authors advise to pick up suicidality as a topic already within the framework of withdrawal therapies in order to facilitate a referral to further treatment services in case of need. Despite the limitations of the present study, it remains to summarize from the viewpoint of the authors that the results of the study allow conclusions to be drawn for as how to deal with addicts in inpatient therapy.

A study conducted among the clients of the outpatient drug department of the university Hamburg for adolescents and young adults found - apart from substance dependence - also psychological disorders in more than 20% of the patients (Sack et al. 2005).

Based on the results of a prospective longitudinal analysis carried out among 1,395 adolescents in the age group 14-17 years over a period of 10 years, Wittchen et al. (2007) point to the role played by other psychological disorders (especially depressive and bipolar disorders: less consistently: anxiety disorders) and the extent of individual comorbidity for the incidence of cannabis use and its development into abusive or harmful use.

The result of a metaanalysis recently published by Conner and colleagues (2007) underlines again the connection between addiction and depressive illnesses. Depressive illnesses apparently act as a moderator variable for help-seeking and needle-sharing behaviour. The authors report that, all in all, the effects observed were small, they however clearly identified moderate gender-specific effects. No conclusions could be drawn with regard to possible future associations between depression and future drug use.

#### **6.5 Other drug-related health correlates and health consequences**

In connection with the (long-term) consequences of cannabis consumption, it still has not been conclusively shown whether the so-called "amotivational syndrome" is really attributable to the effect of cannabis or is rather linked to psychic comorbidity like affective disorders or psychoses (Beckmann-Többen & Küstner 2008). Nevertheless, Soellner and Gabriel (2008) point out that, despite the differentiated perception of consumption patterns, the cannabis-specific stereotype of the rather apathetic, low-performing and unmotivated "pothead", which existed between the 70ies and the 90ies of the last century, still prevails.

Summarizing the current state of knowledge, it can be assumed that problematic cannabis use increases the risk of developmental disorders and is a threat to health. Set against this

background, promotion of prevention and early prevention research assumes a particular role (Thomasius & Petersen 2006).

In view of the multifold interlinked problem areas and multimorbidity of drug users, close cooperation between different care areas is of particular relevance. Karow and colleagues (2008) have investigated in a study in how far personality disorders, family conflicts and framework conditions of the therapy are associated with the quality of life of opiate addicts. They conclude from the results of the study that personality disorders and conflicts with family and partners as well as the continual need for somatic and psychiatric treatment have the largest impact on the decline of the subjectively perceived quality of life. As opposed to this, changes in the consumption behaviour (drugs and alcohol), the economic situation, judicial problems and social problems with other people (non-family) are of no relevance with regard to the quality of life. The authors point out that the improvement of the quality of life is an important and relevant goal in the treatment of populations afflicted by chronic illnesses (like for example drug addiction). Furthermore, the result of the study provides evidence for the superiority of long-term interventions in long-term opiate users over solely short-term interventions which do generally not suffice to teach the users the necessary skills to master their intra- and interpersonal conflicts.



## **7 Responses to Health Correlates and Consequences**

### **7.1 Overview**

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 which could be specifically referred to the group of drug addicts. Except for individual cases, there are no data available on the number of emergency missions 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 which is generally provided by office-based doctors in their function as medical consultants. Dental treatments which have been put off for a long time and other medical treatments are common to be carried out during inpatient addiction therapy. Basic data hereto are available from the German Annual Statistical Report on Addiction Therapy. In a few *Länder*, specific projects on dental hygiene and infection prophylaxis are offered as part of low-threshold drug aid.

### **7.2 Prevention of drug-related deaths**

In the last few years various approaches have been aimed at preventing drug-related deaths: drug emergency prophylaxis, 'therapy now', use of naloxon, drug consumption rooms and the expansion of substitution treatment.

#### **Drug consumption rooms**

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 *Länder* may pass regulations specifying the authorization criteria to be fulfilled for setting up and running drug consumption rooms. In 6 out of 16 *Länder*, corresponding regulations have been passed. There are currently 25 consumption rooms operating in 16 German cities with 215 consumption places. The largest part of the places is reserved for injecting drug use (128 places), 52 places are reserved for inhalation. In addition, there are 35 places which can be

used either for injecting, inhaling or sniffing (AIDS-Hilfe Frankfurt e.V., personal communication) (see also [www.konsumraum.de](http://www.konsumraum.de)).

The four consumption rooms in Frankfurt were used by 4,603 persons in 2007 (Simmedinger & Vogt 2008). This corresponds to a slight increase of 1.3% compared to the previous year (N=4,544). In 2007, 171,235 (2006: 164,164) drug use activities were recorded (+4%). With 15%, regular clients who used the rooms more than 50 times only represent a small portion of the group of users, which however increased slightly compared to 2006 (14%). According to self-reports 55% (2006: 51%) of the users were medically treated in the last 30 days because of their drug use in 2007. The majority of clients consumed heroin (81%; 2006: 78%), 37% (2006: 43%) crack and 14% (2006: 9%) benzodiazepine. The users were on average 34.1 years of age, the ones who were recorded for the first time 32.4 years.

In 2006, the three drug consumption rooms in Berlin (out of these one mobile consumption facility) recorded more than 12,000 consumption activities by 835 users aged 31.3 years on average. In 2007, the number of consumption activities increased to 19,653 (no data are available on the total number of users). The higher figure is presumably attributable to the longer opening times. The most preferred drug among the 566 interviewed users was heroin with 91.6%. Contrary to 2004 (8.4%, N=489) and 2005 (3.2%, N=631), none of the users interviewed in 2006 reported a preference for heroin-cocaine-cocktails (Schu & Tossmann 2007).

The contact and communication facility "Fixpunkt" in Hannover reports 29,332 consumption activities which took place on its premises in the year 2006 (2005: 35,109). The significant decline compared to the previous year was observed in both women (2006: 4,986; 2005: 6,320) and men (2006: 24,346; 2005: 28,789) and is possibly attributable to (staff) restructuring measures. Consumption facilities in Hannover solely document injecting use of heroin (92%), cocaine (5%) and the mixed consumption of heroin and cocaine (3%). It is worth of note that the anyway high portion of heroin consumption activities increased again in respect of the previous year (Step (Ed.) 2007).

### **7.3 Prevention and treatment of drug-related infectious diseases**

#### **Syringe provision programmes in low-threshold facilities**

Distribution and exchange of syringes in low-threshold work is explicitly permitted under the Narcotics Act and is also practiced in many locations. Assuming that there are approximately 1,000 outpatient counselling facilities and contact centres out of which 25% offer syringe exchange programmes, one arrives at a figure of at least 250 needle exchange programmes which has remained relatively stable since 2000 (Bundesministerium für Gesundheit, personal communication). National statistics on the exact number of distribution locations or the number of distributed needles are not available. However, indications of developments and trends may be possibly gleaned from reports of individual facilities or supporting organs.

Five facilities from Schleswig-Holstein have supplied data going back to year 2002 on the number of distributed syringes (Ministerium für Soziales, Gesundheit, Familie, Jugend und

Senioren des Landes Schleswig-Holstein 2007). Since the end of the first documented year (2002), the number of distributed single-use syringes has continually and significantly decreased – from almost 55,000 syringes in the first quarter to 32,000 in the second quarter of 2004. For three years in a row (2004-2006), the number of provided syringes ranged between 32,000 and 40,000 per quarter.

### **Programmes in prisons**

The distribution of syringes to injecting users in prisons was tested in Germany since the mid-eighties and implemented in 7 penal institutions over a longer period of time. The results demonstrated the feasibility of such programs and also yielded some positive effects, but did not lead to a country-wide implementation. Apart from a relatively small penal institution for females in Berlin, all programs have meanwhile been stopped. The reason may lie, *inter alia*, in the lacking acceptance of this approach among prison staff who experienced their work as contradictory with regard to enforcement and acceptance of regulations.

As part of a study conducted in the years 1998 and 1999, sterile injection needles were distributed to inmates of a penal institution. Out of 174 IDUs, 75% continued injecting drug use during the project. However, needle sharing plummeted from 71% down to 0%. Seroprevalence at the beginning of the study was at 18% for HIV, at 53% for HBV and at 82% for HCV. During the period under review no new cases of HBC or HIV occurred, but 4 cases of HCV were found (Stark et al. 2006).

Data on the availability of syringes are contained in standard table 10.

### **Information on infection risks, vaccination and therapy**

In view of the high infection risks for hepatitis A and B, vaccination programs for IDUs are an important instrument of infection prophylaxis. They are used in many places.

With funding by the Federal Ministry for Health, the Aktionsbündnis Hepatitis und Drogengebrauch (Action Alliance Hepatitis and Drug Use) published the manual “Hepatitis C and drug use” (“Hepatitis C und Drogengebrauch”) providing up-to-date information on prevention and therapy of hepatitis C among this group of people complete with material on counselling, care and legal situation (Aktionsbündnis Hepatitis und Drogengebrauch 2006).

The topics debated at the fourth “International Expert Conference Hepatitis C“, held in Hamburg in 2007 are summarized in an extensive report (Aktionsbündnis Hepatitis und Drogengebrauch & ZIS 2008). The spectrum of topics discussed at the conference ranged from prevention approaches over infectious diseases in addicted migrants, open questions in research and in the practical field, HCV-therapy and substitution, experience with integrative HCV-therapy in demonstration projects and long-term inpatient therapy to experiences made with HCV-therapies in Switzerland and a few other new EU-member states ([www.hepatitiscfachtag.org](http://www.hepatitiscfachtag.org)).

The Federal Ministry for Education and Research provides funding for a research and application network called “Hep-Net“ which is to improve early recognition of hepatitis B and

C by means of a more efficient diagnostic system and to enhance treatment quality through medical staff training ([www.kompetenznetz-hepatitis.de](http://www.kompetenznetz-hepatitis.de)).

### **Therapy of hepatitis C in drug users**

For the guidelines developed by the German Society for Addiction Medicine (Deutsche Gesellschaft für Suchtmedizin, DGS e.V.) for the therapy of chronic hepatitis C in IDUs, turn to chapter 5.5. The development of guidelines for the “Treatment of viral hepatitis C” were also the topic of the consensus conference held by the German Society for Digestive and Metabolic Diseases ([www.dgvs.de/1116.php](http://www.dgvs.de/1116.php)).

In view of the considerable costs resulting from chronic hepatitis C infection, treatment of this disease also in drug users is important and appropriate not only for medical but also for economic considerations. Given the right framework conditions, therapies can indeed yield positive results (Gölz 2006). Treatment of hepatitis C carried out within the framework of the COBRA-study was successful for 56% of the patients in substitution therapy. This figure corresponds to the outcome quotas of general population studies (Backmund et al. 2006).

Even better results are achieved by specialized treatment facilities as has been reported by Backmund and Meyer (2006) on the basis of the data collected at a Munich outpatient substitution treatment clinic. A study conducted by Schäfer (2006) arrives at the conclusion that antiviral therapy in drug addicts is feasible even in the case of concomitance of psychiatric disorders and drug addiction. The assessment that it is possible to carry out a successful hepatitis C therapy also in opiate addicted patients – provided that there is a close cooperation between treating specialists and sufficient support for the patients– has been also confirmed by a recently published Norwegian study (Krook et al. 2007).

Eirund and colleagues (2007) report on a psychosomatically-oriented supporting programme for HCV-patients treated with interferon in an abstinence-based inpatient facility. This programme was integrated as a module of the overall therapy plan into inpatient withdrawal therapy. According to the authors, first (preliminary) results encourage a continuation of the programme. They stress how important it is to build up contacts with experts from the respective region to optimize therapy and guarantee qualified further treatment after the completion of inpatient therapy. Here again, interdisciplinary cooperation is regarded as a key to successful therapy.

### **7.4 Interventions related to psychiatric comorbidity**

Drug users who, in addition to their drug problems, suffer from psychological disorders which require treatment, need help which takes both fields into account. These individuals depend in a special way on the general diagnostic competences of addiction therapists also in the field of psychological disorders, and, at the same time, require cooperation between clinical psychology/psychiatry and addiction treatment which is appropriate to tackle both types of problems. The issue being stated and described at many places does not mean that the practical consequences are always easy to implement in the field of every day practice given the differences in work areas, responsibilities and financing modalities.

In practice, there are two ways of dealing with these problems: either, the two problem areas are dealt with by two different therapists/institutions who/which have to closely coordinate their activities. Alternatively, the treatment is carried out at one place, which however requires competences in both problem areas. In general, mixing these clients with other drug clients has not proven positive, as clients with double diagnoses sometimes require a slower and more flexible therapeutic approach (e.g. regarding medication, keeping agreements, accepting set structures).

### **7.5 Interventions related to other health correlates and consequences**

**Low-threshold interventions:** Low-threshold initiatives, syringe exchange programs (cf. 7.3) and in particular consumption rooms (cf. 7.2) contribute to curbing negative health effects of drug use.

**Children born to drug users:** Based on data of the DSHS (Sonntag et al. 2008b) about every fourth opiate addict in outpatient therapy lives together with her child. Proceeding on the known case figures, several hundred newborn babies are affected each year. A special information brochure with the title "You are pregnant ... and you take drugs?" tries to address the target group of pregnant drug users in order to reduce health risks and damage both for mother and child (DHS 2006). A few therapy facilities offer therapy places for mother and child. In general however, specific offers for this target group are scanty. This is a problem area in which difficult decisions are to be taken weighing between the caretaking obligations of the state on the one hand and the wish and right of the mother to raise her child on the other. Drug-addicted mothers undergoing substitution treatment need, according to expert opinion, considerable support to be able to cope with the complex demands of the role of a mother (Bartsch & Fröhlingsdorf 2007).

**Driving accidents:** Information on the connection between drug use and driving accidents can be found in chapter 8.3.6.



## 8 Social Correlates and Consequences

### 8.1 Overview

Drug use is often linked with difficult family and life circumstances. While it may be a consequence of these circumstances, it can also aggravate the situation and worsen the drug users' outlook for the future. The social framework conditions under which drug use takes place illustrate the marginalization especially of individuals with intensive drug use.

As the possession of drugs is illegal, the most important negative consequences drug users face in this respect not only in the EU member states, are penal sanctions. The Federal Office of Criminal Investigation (Bundeskriminalamt, BKA) differentiates in its statistics on drug-related crimes between punishable acts in terms of violations of the Narcotics Act (Betäubungsmittelgesetz, BtMG) and cases of direct economic compulsive criminality. The first ones are subdivided into four different groups of offences:

- General offences in terms of §29 BtMG (especially possession, purchase and distribution, so-called consumption-related offences)
- Illegal trafficking 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.

### 8.2 Social exclusion

Some indication of the aggravated general living conditions of drug users can be gleaned from socio-demographic data of treatment documentation. Opiate-addicted members of the open drug scene are affected the most. Insight into the situation can be gained from data provided by the national statistics on addiction aid and the regional monitoring systems used for example in Frankfurt and Hamburg.

A considerable portion of the opiate clients of outpatient facilities have not graduated from school yet at the beginning of their therapy (Deutsche Hauptstelle für Suchtfragen (DHS) 2008). 60.3% of the clients with primary opiate problems and 37.1% of the ones with primary cocaine problems are jobless at the beginning of therapy. In general, these conditions remain practically unchanged until the end of therapy. One in six clients with primary cocaine problems still has no school leaving certificate (15.8%). While as for cannabis clients, this may be partly due to the relatively young age, the rest (in particular opiate addicts) are mostly early school leavers (Sonntag et al. 2008b) (table 8.1). In the year 2006, a total of 4,851 opiate addicts (+400 in comparison with 2005) who made use of outpatient help were registered in the status report of the Hamburg basic documentation system (Buth et al. 2007). Out of these, 82% lived in stable housing conditions, but 69% were jobless or respectively without income.

For the first time, there are also data available for the reporting year 2007 from the DSHS based on own evaluations for low-threshold facilities (N=22). According to these evaluations, the socio-economic conditions of the clients who sought help from low-threshold facilities in 2007 are even worse than those found in other help areas. As can be seen in table 8.1, the figures for missing school leaving certificates, unemployment and homelessness are for all substances higher than in clients in out outpatient therapy. However, the percentage figures can only be interpreted with limitations since out of the total of 22 low-threshold facilities taken account of in the DSHS a maximum of 12 provided data on these variables and the absolute figures of clients with illicit drug problems (there are 998 valid entries on the housing situation, 737 on the economic situation, 970 on school graduation) are relatively low (Sonntag et al. 2008e). Additionally, the total number of low-threshold facilities participating in the DSHS represents with N=22 only a small fraction of all treatment offers made in Germany.

The portion of the clients of the Frankfurt drug consumption rooms who live under precarious housing conditions (homeless, in shelters or other provisional accommodation) has slightly increased to 12.6% in comparison with the previous year (11.5%) (Simmedinger & Vogt 2008). Even worse is the social situation of the open drug scene in Frankfurt. In 2006, 44% of the drug users of the open scene lived in precarious housing conditions. While the housing conditions have slightly improved for the male members of the scene, they have remained unchanged or have become rather worse for the females. The portion of scene members without any completed vocational training has declined from 52% (1995) to 43%, but the unemployment rate is still very high (86%) with unemployment persisting for 4.6 years on average. Long-term unemployment, a relatively high age average (36 years), little occupational qualifications and year-long association with the drug scene (13 year on average) make reintegration into the working life increasingly difficult (Müller et al. 2007).

There were no significant differences found between men and women of the Frankfurt open drug scene in terms of consumption patterns with the exception of crack. As for the latter, gender-related differences showed not only in the 24-hour-prevalence of crack consumption which was significantly higher among the female scene members (82%) than among their male counterparts (57%), but especially in excessive crack consumption. 57% of the crack using females reported more than three daily consumption units (men: 37%) and 31% more than eight daily consumption units (men: 11%) (Müller et al. 2007).

**Table 8.1** Social situation of persons in outpatient therapy broken down by main drug

Substance	Outpatient treatment			Low threshold facilities		
	without graduation <sup>1)</sup>	without employment <sup>2)</sup>	without home <sup>2)</sup>	without graduation <sup>1)</sup>	without employment <sup>2)</sup>	without home <sup>2)</sup>
Alcohol	5.6%	41.8%	0.5%	28.6%	65.3%	7.8%
Opioids	17.7%	60.3%	3.0%	21.9%	72.0%	7.6%
Cannabinoids	23.8%	33.4%	0.6%	23.7%	46.7%	2.2%
Sedatives/Hypnotics	6.6%	34.1%	0.0%	50.0%	100.0%	0.0%
Cocaine	15.8%	37.1%	1.2%	21.1%	63.8%	1.7%
Stimulants	15.7%	39.4%	0.8%	15.4%	46.7%	3.3%
Hallucinogenics	30.0%	53.3%	0.0%			
Tobacco	7.7%	8.4%	0.2%	70.6%	33.3%	0.0%
Volatile substances	44.8%	25.9%	0.0%			
Multiple/other subst.	13.1%	54.8%	0.0%	50.0%		

1) Or still at school.

2) On the day before the start of care

(Sonntag et al. 2008b, e)

As already presented in last year's Report, a study conducted by Lampert et al. (2006) found that families with a lower economic status make less use of health offers even when these are free of charge. However, no difference was found in the tobacco and alcohol use of the teenagers from wealthy and less wealthy families (compared were the groups "low" vs. "high"). Differences could probably develop later depending on the type of school chosen. This assumption is supported by the results found by the Health Interview and Examination Survey for Children and Adolescents (KiGGS) (Lampert & Thamm 2007). According to the survey, boys and girls attending a *Hauptschule* (lower level secondary school), smoke 4.6 or respectively 3.4 times more than their counterparts at a *Gymnasium* (grammar school); boys and girls going to a *Real-* (middle-level secondary school) – or a *Gesamtschule* (comprehensive school) 1.7 to 3.1 times more. The social status however only shows in the smoking behaviour of girls: girls from the lowest or middle social strata smoke 1.8 to 1.5 times more often than those coming from the highest social status group. The results show furthermore that adolescents with a migration background smoke comparatively little and that tobacco consumption is more common in the new Federal Länder than in old ones. The social status showed no influence on alcohol consumption, neither in boys nor in girls.

However, bad health behaviour is not directly linked to disadvantaged living conditions. Rather a high social capital in terms of strong support from family, friends and acquaintances can have a strong protective effect. The protective effect of strong family cohesion was also confirmed by Erhart and colleagues (2007) who showed that children and adolescents who are provided with more family resources, have significantly less experience with the consumption of alcohol and illicit drugs.

Some data found by the Hamburger Schulbus (Baumgärtner 2008) indicate that regular cannabis consumption of 14-18 year-olds has a significant impact on behaviour and performance at school. The number of self-reported missed lessons at school in the last 30 days was strikingly higher in the current regular cannabis users than in occasional users or abstainers. The average values for self-assessed performance at school and relationship with teachers were significantly worse in the regular cannabis users than in the questioned adolescents who used cannabis only occasionally or not at all.

### **8.3 Drug-related crime**

#### **8.3.1 Direct economic compulsive crimes**

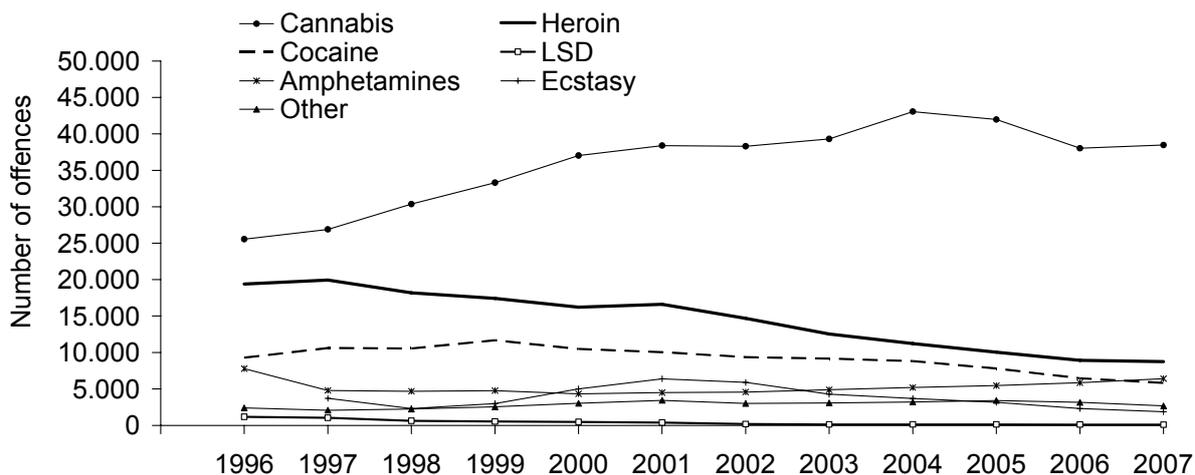
Direct economic compulsive crimes are taken as referring to all criminal offences which are committed in order to obtain narcotic drugs, substitute or alternative drugs. In 2007, 2,540 cases (2006: 2,234; 2005: 2,210) of direct economic compulsive crime were registered by the police crime statistics (Polizeilichen Kriminalstatistik, PKS). Thus, after having followed a stable course between the years 2006 and 2007, the number of these offences went up by 13.7%. Almost three quarters (71.3%) of these offences are related to forgery of prescriptions or theft of prescription forms to get access to narcotic substances. Forgery of prescriptions increased to 1,581 cases accounting for the largest part of the increase in direct economic crimes (2006: 1.313) (Bundesministerium des Innern 2008).

#### **8.3.2 Trafficking crimes<sup>27</sup>**

These crimes are related to offences committed in connection with commercial/professional trafficking of narcotics or smuggling of larger quantities. Just as consumption-related crimes, all trafficking crimes which were recorded by the police are taken account of in this report irrespectively of the outcome of later legal proceedings.

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<sup>27</sup> Trafficking crimes are taken as referring to offences related to illegal trafficking and smuggling of narcotics according to § 29 BtMG as well as offences related to the illegal import of narcotics according § 30 section 1 no. 4 BtMG.



(Bundesministerium des Innern 2008)

**Figure 8.1** Development of trafficking crimes

Both in terms of portion and absolute figures, cannabis plays the most important role in offences related to dealing/trafficking (38,460 offences, 60.0% of all offences; 2006: 38,029, 58.6%), followed – at a great distance – by heroin (8,752, 13.7%; 2006: 8,927, 13.8%) (figure 8.1). The number and portion of trafficking crimes in connection with heroin and cocaine (5,822, 9.1%; 2006: 6,462, 10.0%) have been declining over the years. After a continual increase until 2004, the absolute figure of cannabis-related offences decreased between 2004 and 2006 and remained stable in the last year. Since the year 2000, the number of offences involving amphetamines has been continually climbing. In 2007, amphetamines reached a portion of 10.0% (6,405 offences; 2006: 5,858, 9.0%) of all trafficking offences pushing cocaine out of third place on the list of substances (Bundesministerium des Innern 2008).

In North Rhine-Westphalia (NRW), the number of drug trafficking offences increased by 6.6% to 21,992 (2006: 20,625) which was mainly attributable to the increase in amphetamine- and cannabis-related offences. Cannabis-related cases accounted for about  $\frac{3}{4}$  (15,880 cases) of all trafficking/smuggling offences in NRW ranging still clearly above the national average (Landeskriminalamt Nordrhein-Westfalen 2008).

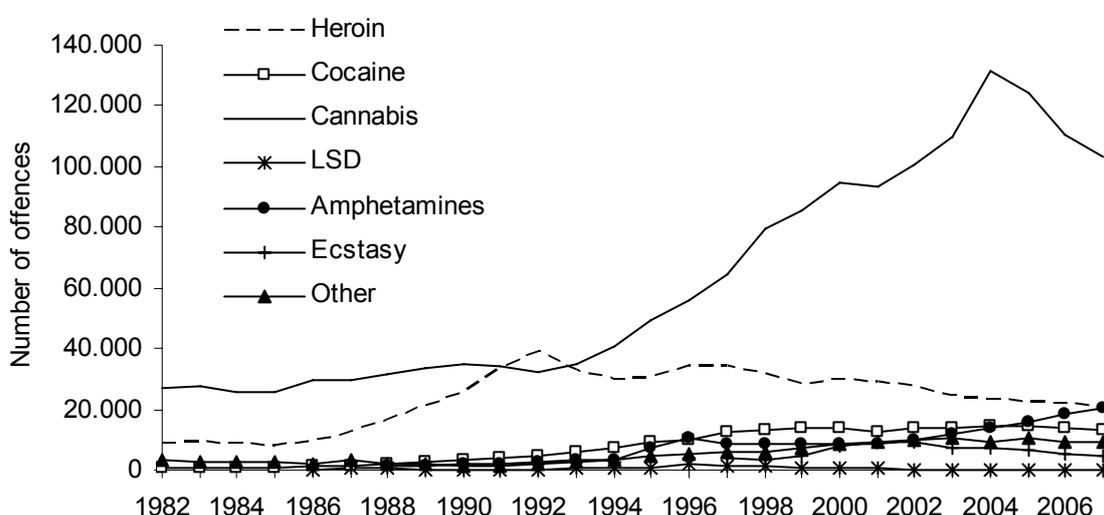
### 8.3.3 Consumption-related offences<sup>28</sup>

This section is about drug offences which 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.

<sup>28</sup> The term "consumption-related offences" is used to describe general offences committed against the Narcotics Act (Betäubungsmittelgesetz, BtMG). The offences committed in violation of § 29 BtMG comprise possession, purchase and distribution of narcotic drugs and similar offences.

In this category of offences cannabis plays a predominant role accounting for about 60.0% of all cases. Heroin (12.2%), amphetamine (11.9%) and cocaine (7.5%) make together 31.7% of all recorded cases, the rest are spread, at a similar scale, over ecstasy, LSD and other drugs. The decrease in the overall figure (2007: 171,496; 2006: 178,841; -4.1%) is mainly attributable to the still declining cannabis figures (2007: 102,931; 2006: 110,638; -7.0%).

But in 2007, there were also less offences registered in connection with heroin (2007: 20,986; 2006: 21,442; -2.0%), ecstasy (2007: 4,739; 2006: 4,996; -5.1%), cocaine (2007: 12,932; 2006: 13,755; -6.0%) and other drugs (2007: 9,201; 2006: 9,480; -2.9%). Following the trend of the previous year, amphetamine-related offences were the only ones to increase further (2007: 20,486; 2006: 18,329; +11.7%) (Bundesministerium des Innern 2008) (figure 8.2).



(Bundesministerium des Innern 2008)

**Figure 8.2** Development of consumption-related offences

### 8.3.4 Drug-users who have come to the notice of police for the first time

Alongside data on drug-related offences, the Federal Office of Criminal Investigation also publishes statistics on persons who have come to the notice of 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. 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.

The total number of users of hard drugs who have come to the notice of police for the first time has slightly decreased from year to year since 2004. In 2007, a total of 18,620 cases

(2006: 19,319 cases; -3.6%) were registered. The most marked declines were found for ecstasy (2007: 2,038; 2006: 2,319; -12.1%). The figures found for the users of heroin (2007: 4,153; 2006: 4,489; -7,5%) and cocaine (2007: 3,812; 2006: 4,225; -9,8%) who have come to the notice of police for the first time are also down on the previous year. Recordings of amphetamine-related cases by contrast, went up again (2007: 9,949, including 567 “crystal” users who have come to the attention of police for the first time; +1.2%). The users of amphetamines who have come to the attention of police for the first time meanwhile account for 53.4% of the total of substance abusing first-time-offenders (heroin: 22.3%; cocaine: 20.5%, ecstasy: 12.1%, crack: 2.7% and others including LSD: 2.4%)<sup>29</sup>. These statistics only contain data on so-called “hard” drugs leaving cannabis-related offences out of account.

In contrast to NRW, not only the number of users of amphetamines who have come to the attention of police for the first time (+20.9%) rose from 2006 to 2007 but also the number of first-time-offenders using cocaine (+17.5%) and heroin (+10.5%) increased significantly (Landeskriminalamt Nordrhein-Westfalen 2008).

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.

### **8.3.5 Convictions under the Narcotics Act and custody sentences**

According to the criminal prosecution statistics of the Federal Statistics Office (series 10, part 3), 52,165 persons (2005: 51,472) were convicted for offences committed against the Narcotics Act in 2006 (there are no data available yet for 2007). 43,063 convictions were rendered under the general criminal law relating to adult offenders (2005: 41,057) and 9,102 (2005: 10,415) relating to juvenile offenders. Regarding the convictions rendered in respect of the general criminal law, 17,546 (2005: 17,049) custody sentences – out of these 10,935 (2005: 10,587) were suspended on probation – and 25,517 (2005: 24,008) fines were imposed (Statistisches Bundesamt 2007b).

The overall figure of convictions went slightly up by 1.3 compared to the previous year (2004-2005: +3.5%), the rise being mainly related to the increase in adult offenders (slight decreases in adolescents<sup>30</sup> and young adults<sup>31</sup>) and especially unspecific consumption-

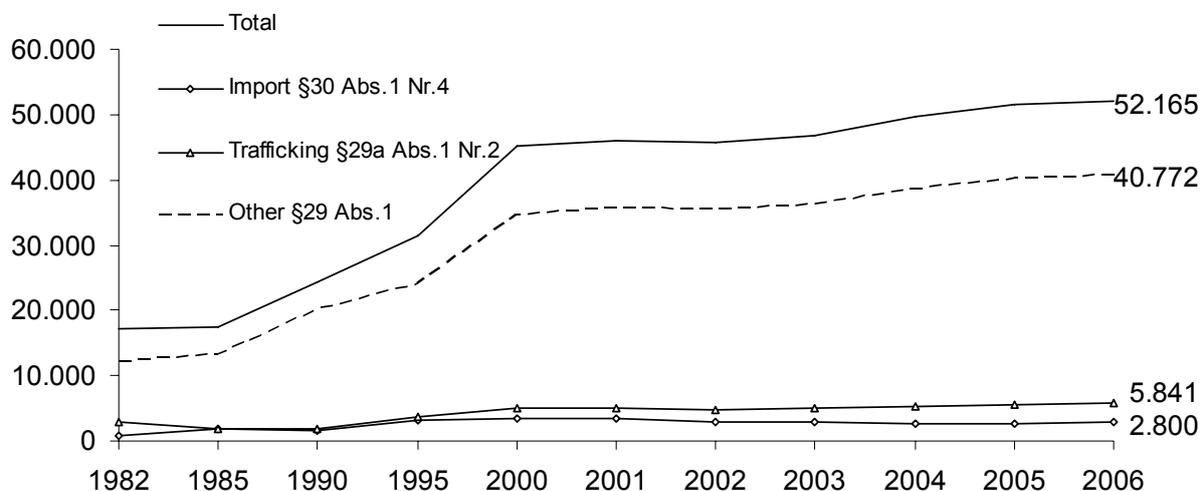
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<sup>29</sup> Each person is only counted once in the overall figure under the acronym “EKhD” (Erstauffälliger Konsument harter Drogen - first-time offender using hard drugs). However, to shed some light on the polytoxicomanic consumption behaviour, it is possible, to count one person several times for several drug types so that the percental breakdown by drug type exceeds 100%.

<sup>30</sup> 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 adolescent offenders.

<sup>31</sup> 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.

related offences (§29 paragraph 1 BtMG)). As in the previous year (2005: 5,561; +5, 0%), the number of trafficking crimes also increased slightly albeit still ranging at low level (figure 8.3).

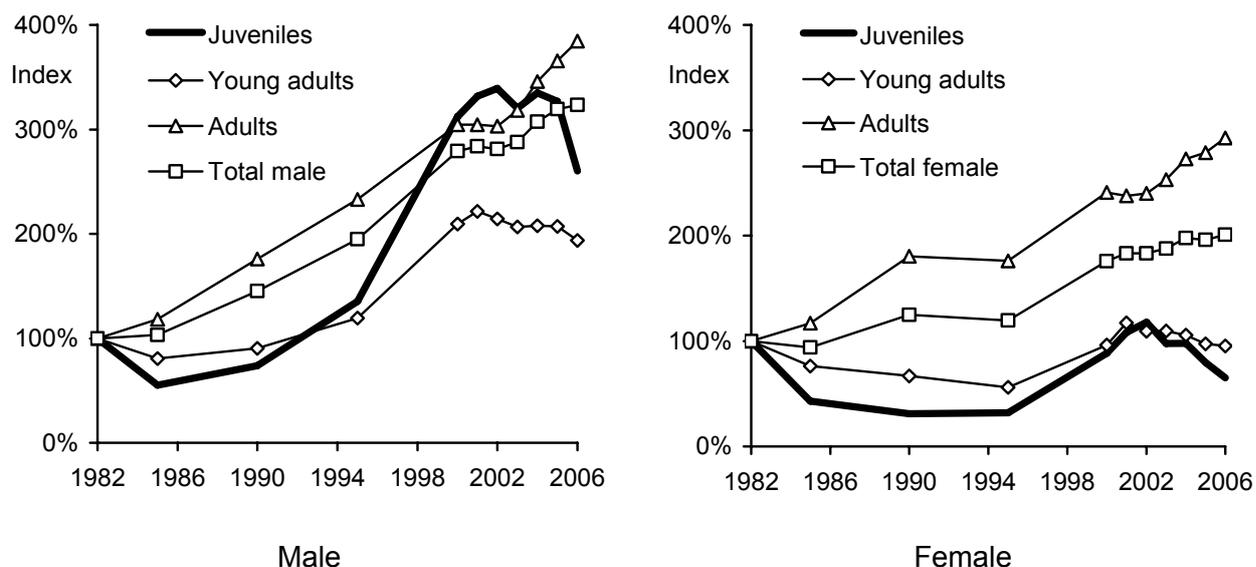


(Statistisches Bundesamt 2007b)

**Figure 8.3** Convictions under the Narcotics Act

Violations of the Narcotics Act accounted for 6.9% of all convictions rendered in 2006. The portion of men was about double as high as the one of women (7.5% vs. 3.8%). Referred to juveniles, the share of convictions imposed for violations of the Narcotics Act was 5.2% while young adults aged between 18 and 21 years had a considerable higher share with 11.2% (2005: 11,6%). As a result, drug-related offences committed by this age group have an above-average share in the overall crime rate. 61.0% of those convicted for offences committed against the Narcotics Act, have already been sentenced at least once before (men: 62.1%, women: 51.1%); in 60% of the cases, the crimes were committed by repeat offenders who had been sentenced at least three times before (Statistisches Bundesamt 2007b).

As in the previous years, about nine times more men than women were convicted for violations of the Narcotics Act (men: 47,018; women: 5,147). The development trends of the last 24 years also show marked differences. Using the figures of 1982 as an index (=100%), the number of convictions of men about tripled while the one of women doubled until 2006. Significant differences were found between juveniles and young adults. While for juvenile and young adult women the number of convictions in 2006 remained below the figures of 1982, the number of convictions of male juveniles tripled and the number of young adults doubled. This enormous increase mainly happened between the years 1995 and 2000. Between the years 2000 and 2005, there were no further increases found for either of the groups, from 2005 to 2006 there was even a declining trend observed (-20.3% among juveniles; -6.5% among young adults) (fig. 8.4).



(Statistisches Bundesamt 2007b)

**Figure 8.4** Trends in the convictions under the Narcotics Act

Data on violations of the Narcotics Act are contained in standard table 11.

A similar trend exists in the number of proceedings (5,763) which the public prosecution departments of the Land Saxony-Anhalt instituted in 2007 because of violations of the Narcotics Act. The number of proceedings declined by 10.4% compared to the previous year (6,433 proceedings) (Landeskriminalamt Sachsen-Anhalt 2008).

Further information on sentencing statistics are contained among others in chapter 11.

### 8.3.6 Drug use and road accidents

In its statistical report on road accidents, the Federal Statistics Office has also been providing information since 2003 on the question as to whether the operator of a motor vehicle involved in an accident was under the influence of other intoxicating substances 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 can not be taken as constituting an acute impairment of the fitness to drive (Bundesverfassungsgericht 2004).

In a recently published work, Grothenhermen & colleagues (2007) non-committally suggest a concrete threshold value for a THC-concentration in the blood serum (7-10 ng/ml) which they regard as comparable with the impairment caused by a blood alcohol concentration of 0.5 per mille. They have derived these limit values from meta-analytical calculations and experimental studies taking into account cannabis-specific factors.

In the year 2007, accidents on German roads totalled 336,002 with 409,641 operators of vehicles being involved (table 8.2). Out of these, 19,466 (5.8%) were under the influence of

alcohol and 1,354 (0.3%) under the influence of “other intoxicating substances” (Statistisches Bundesamt 2008c). Since alcohol is easier to detect than other intoxicating substances, it is to be assumed that drug-related cases are underrepresented in the road traffic statistics.

The number of accidents with injury to persons caused by “other intoxicating substances” more than doubled between 1996 (611) and 2006 (1,354), although the total number of road accidents with injury to persons declined by about 12% in the same period of time (Die Drogenbeauftragte der Bundesregierung 2008b).

When looking at these figures, it needs however to be taken into account that the public and political interest in this issue has developed in parallel with the empirical basis which could be expanded through the use of technical equipment to measure drug use and through training of police officers.

Further information on this matter is contained in chapter 11.

**Table 8.2** Drug use and road accidents

Year	Accidents total	Drivers involved	Drivers under the influence of	
			alcohol	other intoxicating substances
2003	354,534	443,293	22,674	1,341
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	336,002	409,641	19,466	1,354

(Statistisches Bundesamt 2008c)

#### 8.4 Drug use in prison

According to the data of the Federal Statistics Office the total number of those sentenced to a term of imprisonment for violations of the Narcotics Act was at 9,665 (2006: 9, 579) in 2007 (Statistisches Bundesamt 2008b). This corresponds to a portion of 14.9% of the overall prison population. Among the male adults, this portion is at 16.2% (2006: 15.7%) and has thus, as in previous years, slightly increased. The portion of women detained for violating the Narcotics Act by way of contrast, has reached the lowest level since 2003 declining to 15.0% (2006: 18.8%). Among the juveniles too, the portion of those detained for violations of the Narcotics Act has been on a slight (males) or respectively marked (females) decline reaching 6.2% and 8.9% respectively in 2007. While the number of those detained for having committed drug offences hardly changed between 2006 and 2007, their portion in the overall sentenced population has continually increased since 2003 – albeit at a minimal rate. As in the previous year, women only accounted for 6% of this group whereas the portion of drug-related cases among the female detainees has remained stable since 2003 ranging between 3-5 percentage points above the comparative value for men (table 8.3).

**Table 8.3** Number of detainees and drug-related crimes

		Detainees and preventive detention			Adults		Juveniles		Preventive detention
		Total	Men	Women	Men	Women	Men	Women	
2007	Detainees	64,700	61,323	3,377	54,212	3,072	6,685	304	427
	N								
	BtMG N	9,665	9,077	588	8,763	461	413	27	1
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
2004	BtMG %	14.5	14.3	18.1	15.3	18.6	7.6	13.8	0
2003	BtMG %	14.4	14.2	17.9	15.2	18.2	8	15	0.3

Note: "BtMG N": Number of persons detained for offences against the BtMG, "BtMG %": share of persons detained for offences against the BtMG

(Statistisches Bundesamt 2008b)

Drugs controls are carried out in prisons on a regular basis. The extensive control system comprises urine tests but also large-scale searches with police forces and tracker dogs. However, there has been no new data on drug seizures in prisons available from the Länder.

Within the framework of the DSHS, a table volume has been computed for the first time for 2007 giving insight into outpatient therapy carried out in prisons (Sonntag et al. 2008d). However, with no information on the selection mechanisms for the participation on hand and the representativity of the participating penal institutions being unclear, the figures require cautious interpretation all the more since this table is new, only comprises seven facilities and since it cannot be ruled out that individual results depend on data provided by only one or two facilities.

The average age of men with illicit drug problems who made use of outpatient care in prison in 2007 was 28.3 years (N=254), the one of women 26.9 years (N=25). Particularly striking is the finding that 80% of the detained women undergoing therapy were treated for primary opioid-related problems whereas the portion for men was only at 45%. In prison, the portion of men undergoing therapy with the main diagnosis cocaine and stimulants is markedly higher than the one of those undergoing outpatient therapy in freedom. As opposed to this, primary cannabis-related problems play a smaller role in the therapy of men in prison than in outpatient therapy outside prison walls. As for women, there was no case recorded (table 8.4).

Data on drug use in prisons are contained in standard table 12.

**Table 8.4** Outpatient therapy of drug-related problems in prison

Main diagnosis	Men N	Men %	Women N	Women %	Total N	Total %
Opioids	114	44.9%	20	80.0%	134	48.0%
Cocaine	42	16.5%	1	4.0%	43	15.4%
Stimulants	53	20.9%	4	16.0%	57	20.4%
Hypnotics/Sedatives	2	0.8%	0	0.0%	2	0.7%
Hallucinogenics	1	0.4%	0	0.0%	1	0.4%
Cannabinoids	41	16.1%	0	0.0%	41	14.7%
Multiple/other subst.	1	0.4%	0	0.0%	1	0.4%
Total	254	100.0%	25	100.0%	279	100.0%

(Sonntag et al. 2008d)

### 8.5 Social costs

The term “social costs“ relates to the overall costs which arise for the society from use of and trafficking with illicit substances. These comprise, apart from the direct public expenditure by government authorities and social insurance administration (see chapter 1.4), also private expenditures (e.g. of drug users for the procurement of substances) and indirect costs resulting from the loss of productivity and early morbidity and mortality in connection with drug use. There is no overall estimation of the financial implications of drug use for the society available as of yet.

## **9 Responses to Social Correlates and Consequences**

### **9.1 Overview**

Similar to the efforts undertaken to curb negative health effects, there are also general and specific measures used to address social consequences of drug use.

Specific aid is provided in particular by complementary addiction support facilities. They provide opportunities to work at sheltered work places, to catch up at school and obtain missing school leaving qualifications. They run hostels to facilitate the transition between the end of therapy and self-sufficiency. All these measures are intended to support reintegration into social life outside the drug scene. Further details can be found in the description of the addiction support system in Germany in chapter 4.3. Responsible for carrying out these measures are the Länder. However, there are no standard national statistics available on these services.

General social welfare services according to SGBII and SGBXII are also available to drug users who are for example in need of affordable accommodation, financial support to sustain their living or of support in other walks of life. However, as there are no statistics available on the activities deployed for this group of persons, it is not possible to give a quantitative presentation.

### **9.2 Social reintegration**

#### **9.2.1 General changes to the legal framework conditions and their impact on people with substance-related problems**

Last year's revision of the German Social 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 and 2007.

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. The countrywide expansion of outpatient rehabilitation for substance abusers led to an increase of the number of outpatient addiction support facilities authorized for rehabilitation treatment from 35 (2004) to 80 until the end of the year 2006. This expansion forms the basis for setting up regional treatment networks which can assure outpatient and inpatient care at regional level and at the interface between care levels. Within the framework of a 18-month demonstration project carried out by the former Landesversicherungsanstalt Sachsen (LVA) (Land Insurance Agency Saxony), the formerly required social report is dispensed with in the application

procedure for rehabilitation treatment. This is to considerably shorten the application procedure for persons suffering from addiction.

### **9.2.2 Housing**

There is a series of offers available for drug addicts to tide them over homelessness. Statistical material on this is contained in the Länder short reports for the reference year 2004 (Simon 2005). In 45 low threshold facilities 632 emergency beds are provided specifically for this target group. 277 facilities offer assisted living for 7,599 people. The transition from inpatient therapy to a fully self-sufficient life is to be facilitated by adaptation facilities. 81 of these are spread countrywide offering transitional support to 983 clients (Simon 2005). There are no new data available on this.

### **9.2.3 Education and training**

In the last few years, a series of measures to improve integration of jobless people with handicaps into the labour market has been tested. 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 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 certificates 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.

### **9.2.4 Employment**

The anyway tense situation on the labour market makes it difficult for substance dependent people to reintegrate into professional and social life. The unemployment quota among drug addicts is extremely high – depending on the severity of the problem up to 80%. Studies show however that social and professional integration is a crucial indicator 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 Abs. 2 S. 2 Nr. 4 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 Länder. 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.

On 5 November 2007, the Board on Drugs and Addiction unanimously passed a resolution which points out three measures to all players involved in the provision of basic social care for people seeking employment:

1. Case-by-case cooperation between working groups of the municipalities and the employment agencies (Arbeitsgemeinschaften, ARGEn) on the one hand and outpatient and inpatient rehabilitation facilities on the other already during rehabilitation.
2. Appropriate cooperation between the service providers if, as a result of a longer treatment duration, a change of providers from SGBII to SGB XII (social welfare), becomes necessary.
3. Target-oriented use of addiction counselling as a supporting measure. This resolution tasks the Federal Government Commissioner on Narcotic Drugs to collect data on best practice approaches at local level and communicate it. Three focal areas were identified by the resolution: the early identification of jobless people with addiction problems by the job centres, the referral to addiction counselling taking into consideration the implications for the employment situation as well as effective integration measures for people with addiction problems. A corresponding research project has been tendered (cf. chapter 1.3.3).

The anyway tense situation on the labour market makes it difficult for substance dependent people to reintegrate into professional and social life. The unemployment quota among drug addicts is extremely high – depending on the severity of the problem up to 80%. Studies show however that social and professional integration is a crucial indicator for sustained abstinence.

Countrywide, there were 51 work projects or qualification measures with 711 places specifically available for drug addicts in 2004. A total of 1,787 places in 124 facilities were offered to persons with substance-related problems (Simon 2005). There has been no new data available on this field.

Within the framework of the content-related and structural further development of existing rehabilitation offers, the targeted promotion of employment opportunities of jobless addicts in rehabilitation therapy by the Federal German Pension Insurance (Deutsche Rentenversicherung Bund)<sup>32</sup> at national level has become an integral part of the therapy for persons with addiction-related illnesses. It comprises for example indicative groups with

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<sup>32</sup> BfA (Bundesversicherungsanstalt) (National Pension Insurance for Salaried Employees) and LVAs (Landesversicherungsanstalten) (Land Pension Insurances for Wage Earners) were merged to form the "Deutsche Rentenversicherung Bund" (Federal German Pension Insurance) as of 1.10.2005.

regard to unemployment and trainings for job application. From the viewpoint of the social security administration, the central goal of addiction therapy is the restoration of the working capacity. Apart from somatic aspects also psychological factors – i.e. personal and social competences of the client – are taken into account to prepare clients for work 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.

Further activities were described in chapters 9.2.1 and 9.2.2.

### **9.2.5 Social assistance and welfare benefits**

People suffering from addiction receive the same social assistance services – among these also outreach services - and welfare benefits from the government, employment agency and social insurance funds as other needy groups. However, differentiating statistics are not available.

## **9.3 Prevention of drug-related crime**

### **9.3.1 Assistance to drug users in prison**

#### **Syringe exchange programmes**

In the past, syringe programmes for injecting inmates of penal institutions were developed and evaluated in several Länder. However, all but one small penal institution for women in Berlin have meanwhile been stopped (cf. chapter 7.3).

#### **Therapy in prison**

Substitution therapy carried out in prison is subject to very different regional regulations. In general, the continuation of a substitution therapy which started before the beginning of a prison sentence is guaranteed in all Länder. The same applies to the use of methadone in withdrawal treatment. Whether substitution therapy can be started in prison, depends on the Land regulations and the prison doctor's decision. The possibility of undergoing substitution therapy in prison is only offered region-wide in a few Länder. Programmes are generally limited to 3-6 months (Pollähne & Stöver 2005).

A survey commissioned by the working group "German Statistics on Addiction Treatment" (Arbeitsgruppe Suchthilfestatistik, AG DSHS) carried out by the DBDD at the Ministries of Justice of the Länder in the year 2005, gives a broad overview of the current situation. In six out of 10 Länder for which detailed information was available, the clients are attended to by external consultants. These generally come from outpatient private charity counselling facilities (NGOs). In many Länder, internal and external consultants are used.

Substitution therapy is primarily accompanied by internal medical prison staff (Simon & Tischer, 2006). The main areas of addiction work in prisons are prevention, motivation to undergo rehabilitation treatment, referral to inpatient withdrawal facilities or after care (Hessisches Sozialministerium (Ed.) 2006).

Stöver and colleagues (2007) recently published an extensive compilation of best practice examples. The authors based the compilation on visits to prisons in different EU-member states and a systematic literature review in order to - apart from identifying good practice examples - also identify obstacles hindering the implementation of these measures in prisons as well as the requirements to be fulfilled to maintain these projects. Stöver and colleagues (2008) furthermore published a final report on the project for the European Commission containing a detailed presentation of the prevention, treatment and harm reduction measures undertaken in prisons and of reintegration offers made after the release from prison as well as of methods of collecting data on drug use among inmates of penal institutions. In their report, the authors found that there is still a demand for systematic research with regard to the effectiveness of treatment offers for drug users in prison. Although there is a whole range of interventions available for drug users in prison, their implementation repeatedly turns out as difficult and, in many cases, as not sufficient. This applies both to substitution therapy and harm reduction measures. In general however, the data and research status with regard to drugs and health aspects in European prisons remains patchy.

A recently published overview underlines the effectiveness of substitution treatment carried out in prison pointing out that especially substitution with methadone can contribute to reducing risky behaviour (i.e. risky drug consumption) and substance abuse in general (Stallwitz & Stöver 2008). The authors emphasize however, that, in order to achieve good retention quotas and to reduce co-consumption and criminal behaviour, both dosage of the substitution substance and duration of the therapy – which ideally should stretch over the whole period of detention – appear to be decisive.

### **Therapy instead of punishment**

The Narcotics Act (Betäubungsmittelgesetz, BtMG) allows for 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 Schäfer & Paoli (2006) (cf. chapter 11). 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 Länder. Meanwhile, 11 Länder have introduced a limit value of 6g (as upper/lower limit). Further details can be found in chapter 1.2.2.

Furthermore, it is possible to defer prison sentences of up to 2 years to provide drug addicts with a chance to undergo therapy (‘therapy instead of punishment’, §35 BtMG)..

In a press statement given last year (31.07.2007), the Minister of Justice of the Land North Rhine-Westphalia declared that preliminary investigation proceedings against juveniles and

young adults on the same footing may - unlike in the past - only be discontinued in the future under certain conditions. Envisaged conditions are regular drug screenings, participation in drug counselling seminars, therapies or community service.

### **Alternative judicial measures to prevent drug-related offences**

Under certain circumstances, criminal proceedings may be ceased 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 (cf. chapter 11).

### **9.3.2 Other interventions to prevent drug-related crime**

There is a series of other possibilities available to curb drug criminality 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 scenes. The deployment of indicated prevention measures through peers at local level as practiced in the widely used program FreD also represents a possibility to intervene without starting criminal proceedings right away (cf. chapter 3.3.2).

## **10 Drug Markets**

### **10.1 Overview**

#### **Availability and Supply**

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) (not in 2006), the Drug Affinity Study carried out by the BZgA and by several school surveys. The perceived availability reflects the situation on local and regional drug markets but also personal opinions. Referred to the suppliers, the market situation is presented in terms of number of seizures, quantity 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, the country of departure, origin or transit is identified by police and customs authorities. Alongside the number of seizures and quantities seized, prices, content of active substance or respectively purity of substances are also indicators of the situation on the drug market. In order to understand the chemical structure and effects of new designer drugs, considerable efforts in form of chemical analyses need to be undertaken. Such analyses are for example carried out by the Forensic Science Institute of the Federal Office of Criminal Investigation (Kriminaltechnisches Institut des BKA).

#### **Prices**

Based on the drugs seized and delivered by the Land Offices of Criminal Investigation, the Federal Office of Criminal Investigation has been calculating the average prices for different drugs since 1975 differentiating between small quantities of several grams and quantities of 1 kilogram and over. The price for small quantities corresponds rather to the price paid by the user at street level, while the price for large quantities reflects the wholesale price relevant for drug dealers. These prices are mean values calculated on the basis of the market prices found in the individual Länder.

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.

## Purity

Apart from establishing prices, the Federal Office of Criminal Investigation 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, irrespectively 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 the Statistical Evaluation Program "Narcotic Drugs" (Statistisches Auswerteprogramm Rauschgift, SAR) (Zerrell & Thalheim 2008) and on the Annual Report (abridged version) - Narcotic Drugs 2007 - (Jahreskurzlage Rauschgift 2007) (Bundeskriminalamt 2008a). 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 (e.g. sugar).

## 10.2 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.

### 10.2.1 Availability

The perceived availability of drugs is contained in the data presented in the REITOX-report of the year 2005. There have been no new epidemiological studies published on availability.

### 10.2.2 Production, distribution sources and supply

For the German heroin market, South-West-Asia and there mainly Afghanistan are the main regions of origin. The transport routes to Germany lead mainly over Turkey and variations of the Balkan route as well as through Italy and Austria. The deliveries are not infrequently bound for the Netherlands where users and small dealers from Germany provided themselves in many cases with mostly small quantities.

Cocaine is, for a large part, smuggled in from the Netherlands and directly from South America (Brazil and Peru were the most frequently recorded countries of origin or transit). As in the previous year, West-African countries served as depot or transit countries for cocaine

smuggled from South America. However, the number of cases in which the transport route evidently went through Nigeria or Ghana, was on the decline.

Amphetamine comes mainly from the Netherlands and, to a much smaller extent, also from Belgium and Poland. There were no seizures of larger quantities of amphetamine destined for Scandinavia in 2007. Crystalline methamphetamine ("Crystal") is smuggled from the Czech Republic into Germany, especially into Bavaria, Saxony (79% of the total quantity were seized in these two Länder) and also Thuringia (Bundeskriminalamt 2008a; Thoms 2008).

As in previous years, the Netherlands was also in 2007 the most important country of origin and departure for cannabis products seized in Germany. There are large cannabis plantations in the Netherlands which serve the German drug market by supplying mainly marijuana. Hashish smuggled into Germany in contrast, mainly stems from Morocco. It is transported by lorry to the coast and from there by ships, speed boats or regularly operating ferries to the coasts of the Atlantic and the Mediterranean area. Important gateways are, apart from Spain, also the ports of Antwerp and Rotterdam. From there, the route to Germany leads mainly over distribution centers in the Netherlands. In the year 2007, several cases were recorded in which smuggling routes led from Italy over the southern neighbours of Germany or from the Czech Republic into the Federal Republic of Germany (Bundeskriminalamt 2008a).

The role of South-West-Asia as a supply source for hashish for the Western European markets has increased as a result of the recent considerable expansion of cannabis cultivation areas in Afghanistan; for transportation, the established (heroin) smuggling routes or container ships departing from Pakistan are used. In 2007, Germany too was affected by a delivery of hashish of a ton from this region (Bundeskriminalamt 2008a).

The extent of marijuana cultivation in Germany is difficult to assess because the number of seizures of plants is subject to strong variations. A clear trend is not recognizable. However, criminal police have detected increased cultivation of cannabis in large indoor-plantations close to the border with the Netherlands (especially in North Rhine-Westphalia) (Patzak et al. 2007a, b). A possible reason for this development could be the intensified criminal prosecution in the Netherlands. In 2007, a total of 21 professional indoor plantations, 93 large indoor-plantations and 223 small indoor plantations were detected. Furthermore, one professional outdoor plantation, 14 large outdoor plantations and 68 small outdoor plantations were impounded in the reporting year. Most of them were in Bavaria and the Rhineland-Palatinate (Bundeskriminalamt 2008A).

The number of larger seizures (>10kg) of marijuana stemming from the Netherlands decreased to 11 cases in North Rhine-Westphalia in 2007 (2006: 19). Since the overall quantity seized increased during this period of time, this could be an indicator for marijuana being produced in NRW itself (Landeskriminalamt Nordrhein-Westfalen 2007).

In 2004, the Land Office of Criminal Investigation of North Rhine-Westphalia launched the project "Cannabis plantations" involving all police authorities of North Rhine-Westphalia, to

combat indoor cannabis plantations (cf: <http://pol.duesseldorf-lka.polizei.nrw.de/cannabis.htm>). The enhanced awareness resulting from the project would be a reason for the two-digit increase rates of the offences registered in the illicit cultivation of narcotic drugs (illicit cultivation of narcotic drugs: +43.8%; cultivation of narcotic drugs, production and trafficking as a gang member: +25.0%) (Landeskriminalamt Nordrhein-Westfalen 2008).

Germany also serves as a transit country for the transport of khat. Cultivated in East-Africa, khat is legally transported by air into the Netherlands where it does not fall under the Dutch Narcotics Law. From there, it is mostly transported in small transport vehicles or cars through Germany to Scandinavia. 2007 and the first half of the year 2008 saw several seizures of larger quantities of khat – in one case of more than a ton - on the roads between the German-Dutch and the German-Danish border.

### 10.3 Seizures of narcotic drugs

Table 10.1 gives an overview of the quantities of illicit drugs seized in the years 2006 and 2007.

**Table 10.1** Quantities of illicit drugs seized in Germany in 2006 and 2007

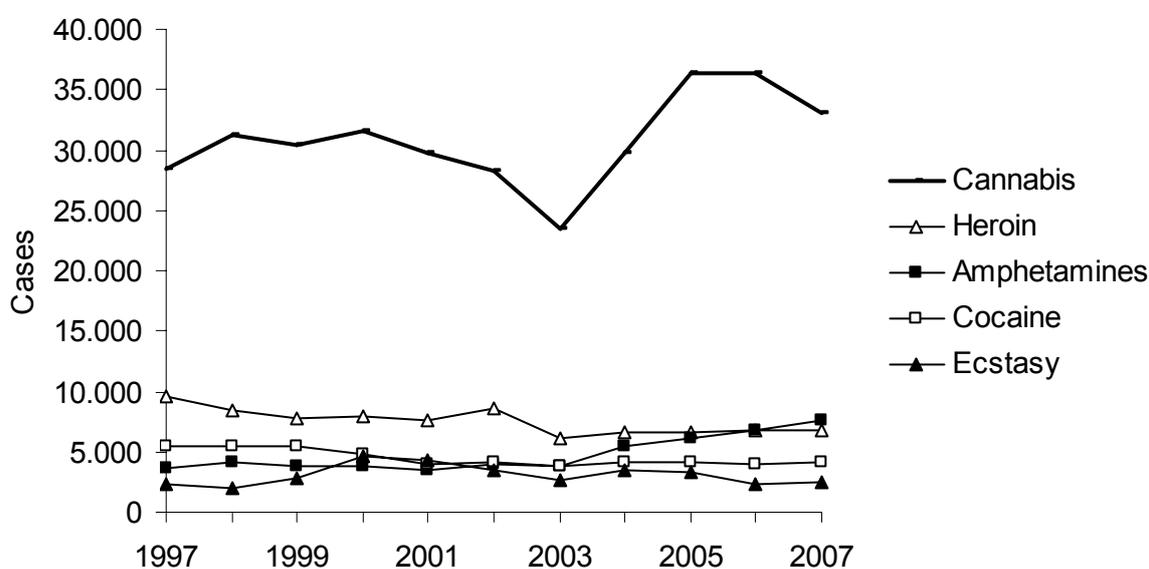
Substance	2006	2007	Change
Heroin	878.9 kg	1,073.5 kg	+22%
Cocaine	1,716.6 kg	1,877.5 kg	+9%
Crack	3.9 kg	4.8 kg	+23%
Amphetam. (thereof Crystal)	723.2 kg (10.7) kg	820.1 kg (10.0) kg	+12% (-7%)
Ecstasy	1,082,820 KE	985,218 KE	-9%
Hashish	5,606.1 kg	3,677.5 kg	-34%
Marihuana	2,954.1 kg	3,769.8 kg	+28%
LSD	12,488 Tr.	10,525 Tr.	-16%
Khat	15,985.1 kg	13,485.3 kg	-16%
Mushrooms	99.7 kg	55.8 kg	-44%

(Bundeskriminalamt 2008a)

The seized quantities of cocaine and amphetamines increased slightly and the ones of heroin, marijuana and crack considerably (at a relatively low overall level though), whereas the seized quantities of ecstasy, crystal, LSD and khat fell slightly below previous year's figures. Compared to 2006, there were significantly fewer seizures of hashish and mushrooms in 2007. The smaller quantity of hashish seized is partly compensated by the larger quantity of marijuana seized.

Since the annual quantities seized may considerably vary depending on individual large seizures, the number of seizures is investigated too. The total figure of seizures with respect

to the above mentioned most important drugs slightly fell (-4.5%) in 2007 (54,914 cases) compared to 2006 (57,485 cases) since the number of cannabis seizures declined by 9.2% (3,335 cases). As for all other substances, with the exception of crack (-8.1%), opium (-24.4%) and mushrooms (-4.7%), the number of seizures slightly (<+10%) increased, the increases found for amphetamines (+12.1%) and LSD (+15.1%, in only 236 cases) however, were somewhat more pronounced. Figure 10.1 shows a long-term increase in the number of seizures of cannabis and amphetamines whereas the values for heroin tend to decline in the 10-year-comparison despite a slight increase observed since 2003. After having continually declined since 2004, the number of seizures of ecstasy stabilized in the last year while the seizures of cocaine have hardly shown any variations since 2001 (Bundeskriminalamt 2008a).



(Bundeskriminalamt 2008b)

**Figure 10.1** Number of seizures of narcotic drugs in the Federal Republic of Germany, 1997 - 2007

When looking at the quantities seized and the number of seizures, one notices a marked increase especially in amphetamines since the year 2000 (Table 10.2).

**Table 10.2** Changes in number and quantity of illicit drugs seized since 2000

	2007 vs.	Heroin	Cocaine	Amphetamine	Ecstasy	Cannabis	Mushrooms	Khat
Cases	2006	1%	6%	12%	5%	-9%	-5%	4%
Amount	2006	22%	9%	13%	-9%	-13%	-44%	-16%
Cases	2000	-14%	-13%	106%	-47%	5%		
Amount	2000	35%	106%	202%	-40%	-48%		

Note: Increases >10% framed, decreases >10% durch Schattierung shaded

(Bundeskriminalamt 2008a)

The case figures recorded for heroin and cocaine in 2007 hardly differ from the ones of the year 2006 despite the increase in the seized quantities and rather tend to decline in respect of the year 2000. The larger quantity of heroin seized in 2007 compared to 2006 results mainly from two individual seizures during which more than 300kg and 150kg were impounded. As for cannabis or cannabis products respectively, both the overall figure of cases and the total quantity seized declined in comparison with the previous year. It needs however to be taken into account that the more than two tons of hashish impounded during three seizures in 2006 considerably influenced the value of that year (table 10.2).

In the year 2007, 135,252 cannabis plants were seized, this corresponds to a decline of 28.9% compared to the previous year. The seizures made in 2006 however comprise approx. 75,000 plants which stem from the sowing of 5 kg hemp seeds which were probably grown as agricultural crop. The number of seizures strongly increased (compared to 2006 by 30.5%) in line with trend that the demand is increasingly met by cannabis cultivated in Germany (table 10.3).

**Table 10.3** Seizures of cannabis plants

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Amount in pieces	81,097	168,833	25,277	68,698	29,352	35,863	68,133	93,936	190,241	135,252
	1,661	1,254	1,048	785	887	750	1,008	1,035	1,121	1,463

(Bundeskriminalamt 2008a)

Like in previous years, large quantities of khat were repeatedly impounded on German roads in 2007 (see above). Noteworthy are the seizures made on the motorways A1 and A7, where about 6,000 kg were impounded in 2007 (Hamburger Abendblatt, 04.04.2008). Local press reported on further large-scale seizures of khat in 2008, especially in Schleswig-Holstein, where quantities >1,000kg were seized at several occasions (Bundespolizeiinspektion Flensburg 2008; Hamburger Abendblatt, 04.04.2008).

For the second time after 2006, the cases involving “crystal” - methamphetamine transformed into free base - were recorded in a discriminating manner (as a subset of the data on amphetamine). The quantity seized declined by 6.5% whereas the number of seizures increased by 12%.

In the year 2007, a total of 10 illicit drug laboratories were uncovered – three more than in 2006. Eight laboratories produced ATS (amphetamine-type-stimulants), one GHB (gamma hydroxybutyrate, “liquid ecstasy”) and another one fentanyl. All laboratories had production capacities sufficient to meet the operators’ own demands and to supply a limited circle of buyers. Large laboratories were not detected.

An overview of recent seizures can be found in standard table 13.

## 10.4 Price and purity of drugs

### 10.4.1 Price

Drug prices have hardly changed between 2006 and 2007. Retail prices of all drugs, apart from LSD and cocaine, declined slightly or remained stable. Wholesale prices of cocaine and amphetamine fell slightly, the ones of marijuana dropped considerably. In 2007, amphetamine and heroin were somewhat more expensive at wholesale level than in 2006. That price developments at retail and wholesale level do not necessarily correlate can be seen very well from the example of heroin. While the wholesale price of heroin increased by 9% from 2006 to 2007, street heroin was cheaper by 3%. Compared to the situation between 2005 and 2006, it is now exactly the other way round (table 10.4). For 2007, the BKA has supplied for the first time an estimation on crystal. The average street price for one gram crystal is estimated at € 50.6 in 2007.

The overview of the current figures on drug prices can be found in standard table 16.

**Table 10.4** Drug prices, 2006 - 2007 (all prices in €)

		Heroin	Cocaine	Crack	Ecstasy	Amphe- tamine	Mari- huana	Canna- bis raisin	LSD
Small quantities <sup>1)</sup>	2007	35.6	63.3	55	6.2	12.6	8.1	5.8	8.8
	2006	36.7	59.1	55	6.6	12.9	8.2	6.4	8.6
	Change	-3%	7%	0%	-6%	-2%	-1%	-9%	2%
Large quantities <sup>2)</sup>	2007	19,465	35,483	--	1,826	4,303	3,200	2,367	--
	2006	17,938	36,120	--	1,942	4,109	3,739	2,377	--
	Change	9%	-2%	--	-6%	5%	-14%	0%	--

(Bundeskriminalamt 2008a)

### 10.4.2 Purity

The figures presented on the active substances contained in amphetamine, ecstasy, heroin and cocaine are based on the "Statistical Evaluation Programme on Narcotic Drugs" (Zerell & Thalheim 2008).

Table 10.5 gives an overview of the development of the levels of active substances in amphetamines, cocaine and heroin since 1997. The concentration of active substance contained in amphetamine has continually declined since 2003. While the content of active substance in cocaine at wholesale level has been relatively stable for the last ten years, the one in street cocaine has been on a continual decline. The purity of heroin at retail level has – even more than at wholesale level – increased significantly since 1997, apart from a few outliers.

Current values are presented in standard tables 15 and 16.

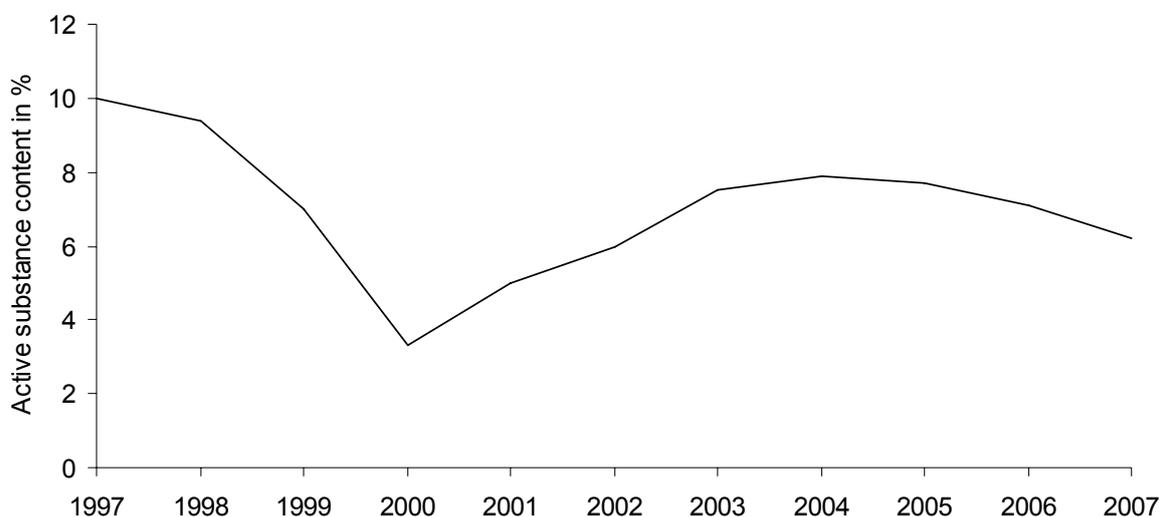
**Table 10.5** Levels of active ingredient - various drugs 1997 - 2007 (median) in percent

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Amphetamines	10.0	9.4	7.0	3.3	5.0	6.0	7.5	7.9	7.7	7.1	6.2
Cocaine street trafficking	50.7	40.2	49.4	35.5	42.6	38.5	32.0	34.5	34.2	24.6	32.0
Cocaine wholesale	79.4	74.3	69.1	69.1	73.0	73.9	76.7	75.0	68.8	72.2	75.3
Heroin street trafficking	9.0	9.0	9.4	11.1	12.0	9.9	17.0	19.9	15.0	15.6	20.3
Heroin wholesale	31.9	20.0	29.2	35.1	45.8	27.0	7.3	48.8	36.5	38.1	46.5

(Zerell &amp; Thalheim 2008)

### Amphetamine

In the year 2007, a total of 2,497 (2006: 2,362) amphetamine samples were analyzed for their content of active substances which averaged 6.2% (2006: 7.1%) (figure 10.2). As the content of active ingredient in amphetamine does not depend on the quantity seized, no differentiation was made between street and wholesale level (Zerell & Thalheim 2008).



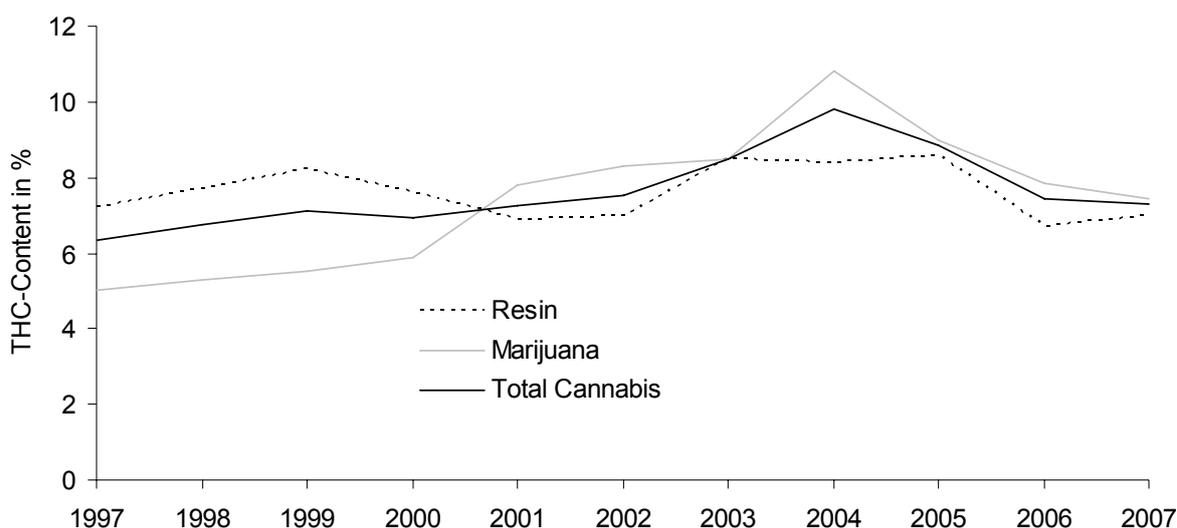
(Zerell &amp; Thalheim 2008)

**Figure 10.2** Content of active substance in amphetamine 1997 bis 2007

The most common adulterants found in 2,356 (2006: 2,087) analyzed samples was caffeine (78%) and salicylic acid; among the diluents were lactose (49%), creatine (4.7%), glucose (2.9%), creatinine (2.5%), mannitol (2.2%), starch/flour (1.6%) and saccharose (1.1%).

## Cannabis

The contents of active substance<sup>33</sup> are separately recorded and evaluated for each cannabis preparation. In 2007, the THC-content was determined on the basis of the seizures of 2,453 marijuana samples, 4,760 inflorescences samples and 2,840 hashish resin samples by the BKA, LKA and customs authorities' laboratories. The average THC-content of marijuana has been on a continual decline since 2004. The average THC-content of hashish went slightly up from 2006 to 2007 but is still clearly below the values of the years from 2003 to 2005 (figure 10.3). Since 2006, all participating laboratories have been reporting their data differentiating between cannabis leaves and inflorescences, since the more potent flowering tops without the leaves have increasingly been emerging on the illicit drug market. The inflorescences had a content of active substance of 2.4%. Compared to the figures of the year 1997, there were only slight changes observed. The content of active substance in cannabis resin slightly decreased whereas the one of marijuana slightly increased (Zerell & Thalheim 2008).



(Zerell & Thalheim 2008)

**Figure 10.3** THC-content of marijuana and cannabis resin 1997-2007

## Ecstasy

In the year 2007, a total of 960,602 pills and capsules (2006: 795,657) were analyzed. Out of these, 99.97% (2006: 98.5%) of them were monopreparations, 0.03% (2006: 1.6%) a combination of two or three addictive substances. With that, the portion of combined preparations decreased as in previous years approximating to the initial value.

<sup>33</sup> In the reported concentrations of active substances, tetrahydrocannabinol (THC) additionally formed under thermal load is also taken account of.

98.6% of the analyzed monopreparations (2006: 98.5%) contained MDMA. The remaining 1.4% contained 1-(3-chlorophenyl)-piperazine (m-CPP), amphetamine, metamphetamine and 3,4-methylenedioxyamphetamine (MDA). Levels of active substances are presented in table 10.6.

Combination preparations reported were mixings of MDMA/MDA (50.0% of the reported combination preparations), MDMA/MDE (41%), MDMA/metamphetamine (5%) and MDMA/amphetamine (4%). The most frequently reported MDMA/MDA-preparations contained on average 57 mg MDMA and 2.5 mg MDA per unit (table 10.6).

As described above, combination preparations accounted for only a small portion of the overall volume which continued to decline between 2006 and 2007. The MDA content of ecstasy impounded during one seizure showed an increase for the first time since 2004. After having dropped below 50 mg per consumption unit in 2006, the content of active substance of MDMA approximated again to the values of 2003-2005.

**Table 10.6** Content of active substance of ecstasy in mg per pill/capsule

Active substance	Amount				Median			
	2004	2005	2006	2007	2004	2005	2006	2007
MDA	15-57	13-47	0.6-30	27 <sup>1)</sup>	40	22	17	27 <sup>1)</sup>
MDE	59-65	1-50	11*	--	62	11	11*	--
2-C-I	10	--	--	--	10	--	--	--
MDMA	3-205	1-441	0.8-141	0.5-215	60	57	48	55
Amphetamine	4-207	1-45	0.6-51	3-33	8	14	15	13
Methamphetamine	20-21	5-14	--	27*	21	10	--	27*
m-CPP				26-76				39

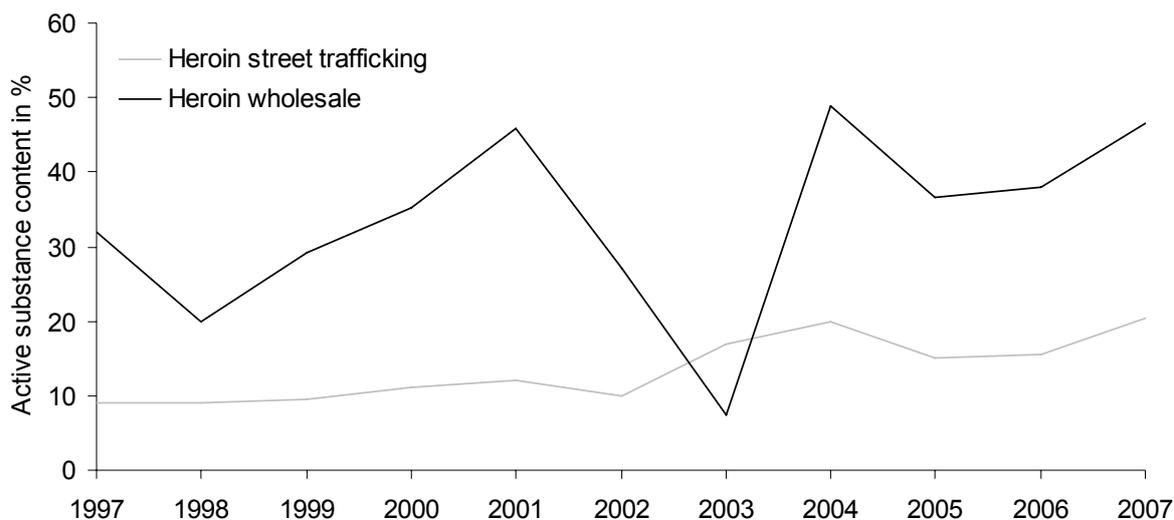
1) Only one seizure.

Note: Contents of active substance were calculated as base.  
(Zerell & Thalheim 2008)

## Heroin

In 2007, 5,099 (2006: 5,227) heroin samples were analyzed for their content of active substance. While the purity of the seizures on the wholesale market has been considerably oscillating between 20% (exception 2003: 7.3%) and almost 50% (2007: 46.5%) over the last years, the level of active ingredients at street level has been rising slightly since 2003, amounting to an average of 20.3% in 2007 (figure 10.4).

Among the 4,649 analyzed samples, the most commonly found adulterants were caffeine (98%) and paracetamol (97%). Lactose (2.0%) was the most common diluent used.



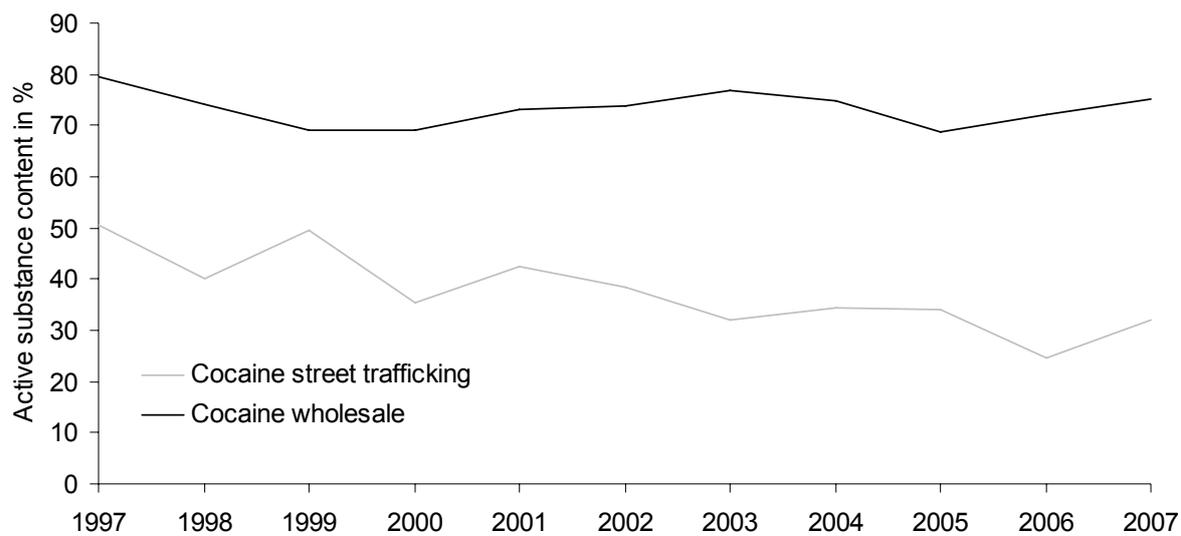
(Zerell & Thalheim 2008)

**Figure 10.4** Content of active ingredient of heroin 1997-2007

## Cocaine

In the year 2007, 3,608 (2006: 3,770) 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 which was found in only 220 of the reported seizures (6% of the samples).

Between 2000 and 2005, the content of active substance at street level was at around 40% with slightly declining tendencies. After having reached in 2006 the lowest level (24.6%) since 1997, the average content of active ingredient increased again to 32% in 2007. As for large quantities, the content of active ingredient has been varying only slightly since 1997 (figure 10.5). The most common adulterants found in the 2,759 samples (2,006: 3,043) in 2007 were phenacetin (42%), lidocaine (20%), diltiazem (18%), caffeine (11%), procain (7%), hydroxyzin (6%) and tetramisol (4%). Blended into the drugs were also lactose (51%), mannitol (12%), glucose (7%), inositol (3.2%) and saccharose (2.5%).



(Zerell & Thalheim 2008)

**Figure 10.5** Content of active ingredient in cocaine 1996-2006

## **PART B: SELECTED ISSUE**

### **11 Sentencing Statistics**

#### **11.1 Summary**

The Narcotics Act (Betäubungsmittelgesetz, hereinafter BtMG), the basic legal instrument regulating the institutional response to drug related offences in Germany, foresees a variety of sanctions according to the severity and the type of the act ranging from administrative fines to custodial sentences. Mere consumption of substances, which fall under the narcotics act, is not subject to sanctions following the principle of the German criminal law, which states impunity for self-injury. Moreover, the German law following the principle “treatment instead of punishment” (Therapie statt Strafe) allows for a deferment of the punishment if the (drug addict) offender undergoes treatment instead of imprisonment.

The main data sources regarding drug criminality and the respective responses are the Police Criminal Statistics (Polizeiliche Kriminalstatistik, PKS) and the nationwide data network Drugs Data File (Falldatei Rauschgift, FDR), as well as the Criminal Prosecution Statistics of Justice. All aforementioned data sources refer to federal and federal state (Länder) level. There seems to be a variety of data available referring to the various stages of the justice system, nonetheless there is a lack of connection between the different statistics. The main obstacles in sequencing and comparative analysis are the different procedures of data recording and classification (i.e., different variables), as well as the differentiation in the level of the detail provided (Paoli 2008). By way of illustration, the police statistics provide information also on the substance type, whereas the prosecution statistics do not.<sup>34</sup>

#### **11.2 Options available in the country**

##### **11.2.1 Legislative framework**

Any state interference with individual rights must by statutory law be based on a regulation. This constitutes a fundamental principle of the Federal Basic Law of Germany, and thus, all restrictions on drug use or other drug related offences have to be provided for by federal law (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2002b). The main legislation concerning illegal drug consumption offences is the BtMG. A list of “controlled substances” is provided in three annexes (Anlagen I-III); nonetheless no legal differentiation

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<sup>34</sup> The following experts have provided information for the compilation of the present chapter: Prof. L. Paoli (Leuven Institute of Criminology of the K.U. Leuven Faculty of Law), Ms. K. Ordnung (Federal Ministry of Health, BMG), Mr. H. Hergenbahn (Federal Criminal Police Office), Ms. H. Biniok, Ms. C. Claus (Public Prosecution Service, District Court of Appeal, Frankfurt/Main, Zentralstelle für die Bekämpfung der Betäubungsmittelkriminalität, ZfB), Prof. L. Böllinger (University of Bremen) and J. Patzak (Public Prosecution Service Trier).

depending on the severity of the danger posed by different drugs is foreseen (for instance, the statute does not differentiate between cannabis and other drugs). Thus, the legislature leaves it to the courts to determine a hierarchy of drugs based on an empirically graded scale of “danger of public health” (EMCDDA 2002b). The BtMG is primarily a regulatory and administrative law with the aim to regulate the trade of listed substances and includes also legal provisions concerning import, export and prescription modalities. Regulatory law breaches of the narcotics act can be sanctioned by administrative fines of up to approximately EUR 25,000. On the other hand, possession of and dealing (especially trafficking) in listed substances are classified as criminal offences according to the sections 29–30a of the BtMG. The interpretation and methodological application of these norms adheres to the system of the German Criminal Code (Strafgesetzbuch, hereinafter StGB) (EMCDDA 2002b).

Other legal provisions concerning drug related offences include the Ordinance on prescription of Narcotic drugs (Betäubungsmittel-Verschreibungsverordnung), the Precursors Control Act (Grundstoffüberwachungsgesetz, GÜG) and the Drug Law (Arzneimittelgesetz, AMG), which also regulates offences related to designer drugs.

Mere consumption of controlled substances is not subject to sanctions. However, the acquisition and possession that normally precede the act of consumption are punishable, since they are associated with the danger of the spread of the drug use phenomenon. Nevertheless, there are various possibilities within the law to abstain from prosecution if only small quantities of narcotic drugs are under possession for personal use. Important criteria for such a decision are the amount and type of drugs, involvement of others, personal history, previous convictions and public interest in prosecution. When a sentence is given, the main principle governing the German legislation towards addicted users is the so-called “treatment instead of punishment”: this allows for a deferment of the enforcement of the final sentences under the condition that the criminal with substance use disorder undergoes treatment (§ 35 BtMG). It is also possible to defer the enforcement of imprisonment up to 2 years to provide drug addicts with a chance to undergo therapy (§56 StGB).

With regard to the outcome of being stopped for drug related offences at the various stages of the justice procedure, it should be noted that the police has no discretionary power and thus all cases of suspected offenders are to be reported to the public prosecutor. Investigations carried out by the police are thus under the public prosecutor’s supervision. The public prosecutor is principally responsible for the proceeding. In the following sub-sections, the various outcomes applied are described with regard to the justice system stage and the three given BtMG offence types; in Table 11.1 an overview is presented.

**Table 11.1** Overview of options available for the various offence types

Offence types	Procedural method at ... level		
	Police	Prosecution	Court
<b>Personal possession</b>	<ul style="list-style-type: none"> <li>• Simplified complaint/Referral to the prosecutor</li> <li>• Complaint/Referral to the prosecutor (common practice)</li> </ul>	<ul style="list-style-type: none"> <li>• Case dismissal with/without accordance of the court</li> <li>• Case dismissal with injunctions and directives with/without accordance of the court</li> <li>• Suspension of prosecution (§ 31a BtMG)</li> <li>• Suspension of prosecution following juvenile law (legal regulation on diversion between adolescents and young adults)</li> <li>• Suspension of public accusation with accordance of the court (§37 BtMG)</li> <li>• Application for a penal order at court</li> <li>• Public accusation</li> </ul>	<ul style="list-style-type: none"> <li>• Case dismissal with accordance of the prosecutor</li> <li>• Case dismissal with injunctions and directives with accordance of the prosecutor</li> <li>• Suspension of prosecution (§31a BtMG) in accordance of the prosecutor</li> <li>• Acquittal</li> <li>• Penal order</li> <li>• Monetary fine or imprisonment</li> <li>• Release on license</li> <li>• Referral to detoxification/treatment</li> </ul>
<b>Cultivation, production and/or commercial trafficking</b>	<ul style="list-style-type: none"> <li>• Complaint/Referral to the prosecutor</li> <li>• (Temporary) arrest</li> </ul>	<ul style="list-style-type: none"> <li>• Case dismissal with/without accordance of the court</li> <li>• Case dismissal with injunctions and directives with/without accordance of the court</li> <li>• Suspension of public accusation with accordance of the court (§37 BtMG)</li> <li>• Application for arrest warrant</li> <li>• Application for a penal order at court</li> <li>• Public accusation</li> </ul>	<ul style="list-style-type: none"> <li>• Case dismissal with accordance of the prosecutor</li> <li>• Case dismissal with injunctions and directives with accordance of the prosecutor</li> <li>• Order of arrest warrant</li> <li>• Acquittal</li> <li>• Penal order</li> <li>• Monetary fine or imprisonment</li> <li>• Conviction to imprisonment (and monetary fine)</li> <li>• Release on license</li> <li>• Referral to detoxification/treatment</li> </ul>

Offence types	Procedural method at ... level		
	Police	Prosecution	Court
<b>Driving after taking drugs</b>	<u>Administrative offences:</u> <ul style="list-style-type: none"> <li>• Caution</li> <li>• Initiation of administrative action (fine)</li> <li>• Fine up to 1,500 Euro</li> <li>• Driving ban from 1 to 3 months</li> </ul> <u>Criminal offences:</u> <ul style="list-style-type: none"> <li>• Referral to the prosecutor</li> </ul>	<u>Criminal offences:</u> <ul style="list-style-type: none"> <li>• Case dismissal with/without accordance of the court</li> <li>• Application for a penal order</li> <li>• Public accusation</li> </ul>	<ul style="list-style-type: none"> <li>• Case dismissal with accordance of the prosecutor</li> <li>• Acquittal</li> <li>• Monetary fine or imprisonment</li> <li>• Release on license</li> <li>• Referral to detoxification/treatment</li> <li>• Driving ban</li> <li>• provisional) Withdrawal of driving license (from 6 months to 5 years or lifetime)</li> </ul>

### 11.2.2 Types of response at the police stage

#### Personal possession or use

Personal possession of illegal substances is subject to punishment regardless of the type and quantity of the substance. Due to the applied legality principle (§§ 152, Para. 2, 160 Para. 1, 163 Criminal Procedure Code, [Strafprozessordnung, StPO]), the police is obliged to investigate any suspicion of a criminal act and to refer it to the respective prosecutor, even in cases of small quantities. This means that the discretionary power of the police when dealing with suspected offenders is limited. There is a considerable degree of heterogeneity in the handling of consumption-related offences (possession of small quantities for personal use - especially of cannabis) across the various federal states (EMCDDA 2002b; Schäfer & Paoli 2006). This is related to the fact that among the federal states there is differentiation in the interpretation of “small amount”. Further details can be found under 11.2.3.

During the last two years there has been a move to greater convergence of the definitions of limit values for “small amount” of cannabis up to which the prosecutor suspends from further prosecution. 14 federal states have already introduced a limit value of 6g (upper/lower limit). Further information on the legal framework can be found in 1.2.2.

Moreover, another aspect of differentiation in the federal states is that below the given maximum amounts, discontinuation of proceedings is obligatory, in some federal states, whereas in others it is subject to a case-by-case approach also taking into account for example repeat offences.

The possession of only a small quantity for personal use is considered a consumption offence and the police actions, in the more “liberal” federal states, are regularly limited to a so called simplified complaint of an offence comprising weighting of the substance, which is also confiscated, administration of drug test and interrogation of the suspect (so called simplified complaint).

In order to disperse open drug scenes, the police and the responsible administrative authorities based on the federal police legislation apply barring and restraining orders to the participants attracted to such scenes.

### **Production, dealing or trafficking**

The usual reaction in the cases of production and/or dealing and trafficking is a (temporary) arrest and the referral of the case to the public prosecutor. Additionally to the drug confiscation, any production facility is also seized, as well as any property assets with the aim of skimming unlawful profits.

### **Driving after taking drugs**

When the police suspect of driving under the influence of illegal drugs, a blood sample test is usually ordered. In this case, the police forward all the information related to the driving aptitude and the drug consumption to the responsible driving license authority (Berr et al. 2007).

It should be mentioned that, unlike alcohol, up to now no minimum threshold quantity for illegal substances is defined, which is judicially accepted. This means that, in principle, even the slightest dosage is subject to a fine (Böllinger & Quensel 2002). But according to a Supreme Court decision, a THC-content of below 1.0 ng/ml in the blood does not constitute an acute impairment of the fitness to drive (Az. BvR 2652/03 dd. 21.12.2004). Moreover, according to a sentence of the Federal Constitutional Court (Bundesverfassungsgericht, 08/07/2002), the Driving License Authorities are allowed to withdraw the offender/suspect's driving license only when there are concrete reasons to suspect that the respective individual cannot/ is not willing to keep cannabis consumption and active participation in road traffic separated (Annex 4, §§ 11, 13 and 14 FeV<sup>35</sup> – Nr. 9.2.2).

Additionally, the limit value for the THC concentration in the blood in road traffic setting has been the subject of several studies that provide potential approaches to and recommendations for developing per se limits for cannabis (Berghaus & Krüger 1998; Böllinger & Quensel 2002; Grotenhermen et al. 2005). In this vein, experts have worked on a grid to measure intoxication caused by THC analogously to the blood alcohol concentration. By way of illustration, a recently published study based on a comparison of meta-analyses of experimental studies on the impairment of driving-relevant skills by alcohol or cannabis suggests that a suitable numerical limit for THC in serum may fall in the range of 7-10 ng/ml, since these figures may correlate with an impairment comparable to that caused by a blood alcohol concentration (BAC) of 0.005% (Grotenhermen et al. 2007).

The German legislation provides for a dual sanction approach with regard to car driving under the influence of psychoactive substances. If the case is considered an administrative offence, the outcome ranges from caution, initiation of administrative action, fining of an

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<sup>35</sup> FeV: Fahrerlaubnisverordnung (Driver's License Regulation)

amount up to 1,500 Euro to a driving ban; whereas when the case is classified as a criminal offence, it is referred to the public prosecutor.

### 11.2.3 Types of response at the prosecution stage

#### Personal possession or use

According to the principle of legality which governs the German Criminal Proceedings Law, all cases of infringement of the laws in effect and on the bases of a substantial primary suspicion lead to the public prosecutor, who on the grounds of suspicion opens preliminary proceedings. Nonetheless, under specific conditions, the prosecutor has the discretion to dismiss the case (principle of expediency). When the quantity is insignificant and for personal use only and if there is no public interest for prosecution, the public prosecutor may abstain from referring the case to trial (§ 31 a, Section 1, BtMG) (EMCDDA 2002b).

This provides the public prosecutor with an instrument to stop proceedings for consumption-related offences without court approval. All federal states have regulated details of the application of § 31a BtMG through recommendations or guidelines. The finding of a study conducted by Schäfer and Paoli (2006) indicated that these regulations diverge in crucial points such as for example the definition of “small amount”. For instance, by the time of the study of Schäfer and Paoli (2006), maximum quantities providing for a discontinuation of prosecution varied between 6 and 30 g of cannabis from one federal state to another. Findings of the study illustrating differences in practice are provided in paragraph 11.5. Nonetheless, meanwhile – due to the jurisprudence of the BVerwG - the vast majority of the federal states have aligned their definition regarding “small amount” of cannabis (cf. Chapter 1.2.2 and 11.2.2).

As the substance type is not specified in the respective sections of the BtMG, the aforementioned consumption-related offences refer to all drug types and the proceedings could be closed without accordance of the court. Nonetheless, in practice they are applied mainly for cannabis (EMCDDA 2008).

According to sections of 153-154 StPO the prosecutor has the power to dismiss the case with or without injunctions and directives when the act is considered petty and when there is no public interest in prosecution. This may be done with or without imposing injunctions and directives. In certain cases the dismissal may be provisional as long as injunctions and directives are fulfilled.

A penal order is another possible outcome in cases which in the view of the prosecutor –do not require a hearing by the court. However, the possession of larger quantities usually results to referral to trial as in principle by penal order only fines and accompanying measures (such as asset forfeiture) may be imposed.

Adolescents<sup>36</sup> and young adults<sup>37</sup> may fall under Juvenile Law (Jugendrecht) and in this case diverging diversion provisions of the Juvenile Offenders Act (Jugendgerichtsgesetz, JGG, §§ 45 and 47) could be applied. This is often applied in cases having to do with small quantities of cannabis use up to 6 grams.

In some federal states, local prevention programmes are applied to avoid court hearings – for example the widely used programme "Early Intervention with First-Offence Drug Consumers - FreD". They also represent 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 police for the first time due to their consumption of illegal drugs. The evaluation results of this programme have shown that the content and implementation of the FreD treatment offer in terms of the central features, i.e., participation, participant orientation, character of groups, organisational structure and time scale was "youth orientated" and was perceived by the participants as "effective and helpful" (Landschaftsverband Westfalen-Lippe (Ed.) 2003). Recent data on the implementation of the programme in Chapter 3.3.3.

### **Production, dealing or trafficking**

The trafficking, cultivation and manufacture of illicit drugs are considered serious offences. In this sense, often an order for an arrest warrant is issued and the offender is referred to trial, however several elements are taken into consideration such as the type and quantity of the illegal substance, the level of professionalism of the act and the involvement in (organised) groups or gangs defining the selection of the court of first instance and the following penalty proposal. Under certain conditions, such as cultivation and manufacture of very small quantities only for personal use, prosecutors could dismiss criminal proceedings.

### **Driving after taking drugs**

Under the suspicion that the driver was under the influence of illegal drugs while driving, his driving license may be withdrawn.

Administrative offences are in principle not being handled by the prosecutor but by the respective administrative authorities.

Criminal offences are usually referred to the court for trial. The power of the prosecutor to dismiss proceedings is limited as driving offences always entail a public interest in prosecution. Furthermore a dismissal of the offence would hinder the withdrawal of the driving licence to be imposed.

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<sup>36</sup> Adolescents refers to 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 adolescent offenders.

<sup>37</sup> Young adults refers to 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.

### 11.2.4 Types of response at the court stage

#### Personal possession or use

In general, dismissals at this stage and primarily in the cases of illegal possession are very rare. For consumption-related offences, though, a dismissal of the proceedings can be considered also at the court stage (§§ 31 a para. 2 BtMG). The same suspension is also possible with or without imposing injunctions and directives by Section 153, para 2 and 153 a, para 2 in case of minor guilt and lack of public interest to prosecute. Moreover, according to § 29, Section 5 of the BtMG the court has the power to refrain from imposing punishment if the quantity is not significant and for personal use.

A repeat offence or illegal possession of a larger quantity is in principal sanctioned according to § 29 of the BtMG with incarceration of up to five years or a fine.

Cases of personal possession of larger illegal drug quantities of a drug with an active substance content exceeding the content defined by the law are considered to be a felony punished with a custodial sentence of one year minimum (§29 a, Section 1, No 2 of the BtMG).

Additionally, the illegal substance and any consumption paraphernalia are subject to confiscation (§33 BtMG) and thus they are seized.

With regards to addicted users who have received an imprisonment conviction of up to 2 years, it is possible to implement a release on license (§ 56 StGB) or to suspend execution of punishment (§ 35 BtMG), when the offender is already attending a therapeutic programme or is prepared to enter treatment shortly (according to the principle of “treatment instead of punishment”).

#### Production, dealing or trafficking

Production, cultivation and dealing of large quantities (so called not small quantities) of illegal substances as well as professional trafficking or dealing by a criminal organisation are punished with an imprisonment sentence, which cannot be diverted to probation (§§ 29a, 30 BtMG).

The spectrum of punishment in these severe cases consists of imprisonment of up to 5 years or a fine. In particular serious cases, such as for actions on a commercial basis, danger for health of several persons, involvement of minors, trade or import of significant quantities the penalty of imprisonment could vary from one to 15 years. However, in the cases of convicted persons who are addicted and willing to undergo treatment for the addiction problem, the execution of the given sentence could be deferred (principle “treatment instead of punishment”) (EMCDDA 2008).

In many cases, cash is also confiscated and/or profits are skimmed.

## **Driving after taking drugs**

A driver can be punished with a penalty of up to 1 year imprisonment or with a criminal fine for driving under the influence of alcohol or other intoxicating substances and for his consequent inaptitude to drive safely (Section 316 StGB). If the driver has in addition endangered other persons or valuables the sentence of up to 5 years of imprisonment may be imposed (Section 315c StGB). An unfitness to drive exists, if there is proof that documents the inappropriateness of the driving condition. The unfitness could be documented by the presence of physical or mental defects or the detection of driving a vehicle under the influence of drugs. The criminal court can also order a driving ban and temporary withdrawal of the driving license or a complete revocation. After a minimum time lapse for re-acquiring a new driving license, one could be provided, after passing an exhaustive medical-psychological test, which has to be paid by the traffic offender (Böllinger & Quensel 2002).

Moreover, driving under the influence of drugs could be classified as an administrative offence and thus can be punished with a fine taken into account the breach intensity and the offender's income (§ 24a Sect. 2 of the Road Traffic Law [Strassenverkehrsgesetz, StVG]). Another option is that the offender can receive a driving ban for up to three months.

## **11.3 Data collection systems**

### **Introduction**

The main data sources regarding drug criminality and the respective responses in Germany are the Police Criminal Statistics (Polizeiliche Kriminalstatistik, PKS) and the data network Drugs Data File (Falldatei Rauschgift, FDR) as well as the Criminal Prosecution Statistics of Justice. All aforementioned data sources refer to federal and federal state level.

Mainly the various information sources register data according to different variables and thus different type of data are available for each stage of the justice system. To date no direct link between different databases of the justice system could be identified, since the data are analysed separately and independently. It is assumed that the possibility of establishing a perspective link among the various databases is quite limited, taken that each of the existing data collection systems are well established and the interest to ensure coherence of the recorded data among years would prevail over the introduction of changes with the aim of harmonizing the existing information systems.

Additionally, data protection reasons might be an obstacle in establishing a register following the course of a suspect/accused person during all the stages of the justice system.

Moreover, the comparison among the data deriving from the different information sources would be problematic or even not feasible, as the data of the Criminal Prosecution Statistics refer in most cases to offences committed in the past, whereas the police statistics refer as a rule to law breaches of the reporting year (Regierungspräsidium Karlsruhe 2008). This means that no temporal sequencing is strictly possible; however, given the fact that the German police have no authority to dismiss cases independently and the differences of

cases dealt with by the police and opened by the Prosecution services each year is relatively small, an attempt of sequencing could be attempted even if it is not 100 percent methodologically sound. A major limitation is however represented by the fact that prosecution statistics do not provide detail on the type of drugs, whereas police statistics do (Paoli 2008).

### **11.3.1 Data collection system at the police stage**

All federal states run police criminal statistics records. Then they submit their data in a predetermined form as tables (aggregated data) to the Federal Criminal Police Office which compiles them to create the Police Crime Statistics for the Federal Republic of Germany (Bundeskriminalamt 2007a). Basic instrument of the police information system is INPOL, which gathers and connects all data recorded on federal and federal state level.

With regard to Police Criminal Statistics, the following methodological information should be taken into account. The unlawful (criminal) acts dealt with by the police, including attempts subject to punishment, are recorded in the Police Crime Statistics. This also includes the drug offences handled by the customs authorities. Breaches of regulations and road traffic offences are not covered (however, the offences described in Sections 315 and 315b of the German Penal Code as well as Section 22a of the Road Traffic Act - which are not regarded as road traffic offences in the sense of the guidelines - are covered) (Bundeskriminalamt 2007b).

According to the current national framework, the judicial authorities, and not the police, decide the question of guilt. Furthermore, when cases are not cleared up, the age and the criminal responsibility of the perpetrators are usually not known anyway. Collection of statistics is based on a catalogue of criminal offences compiled under both penal and criminological aspects. "Outgoing statistics" have been kept in a uniform manner throughout Germany since 1 January 1971, i.e. the criminal offences that come to light are not recorded until the police investigations have been concluded and the respective files can be handed over to the public prosecutor's office or the court (Bundeskriminalamt 2007b).

The State Criminal Police Offices send the figures to the Federal Criminal Police Office. The extent to which crime goes unreported depends on the type of offence, and this can vary over the course of time in response to a variety of factors (e.g. public willingness to report offences, the intensity of crime detection efforts). Therefore it could not be assumed that there is a fixed ratio between the number of offences committed and the offences recorded in the statistics (Bundeskriminalamt 2007a). Factors, such as the extent to which crime is reported, the crime detection efforts of the police, the collection of data for statistical purposes, amendments to criminal law as well as changes in crime influence statistical developments in the Police Crime Statistics. Thus the Police Crime Statistics do not provide an exact reflection of crime, but rather one that is more or less accurate depending on the specific type of offence. Nevertheless, the available data could provide indicative information about the frequency of the cases recorded as well as about forms of crime and development trends (Bundeskriminalamt 2007b).

For the recording of drug offences in connection with the drug type, in the cases where several types of drugs are involved, the following priority is applied: 1<sup>st</sup> heroin and cocaine, 2<sup>nd</sup> amphetamine/methamphetamine and derivatives of these in powder or liquid form, 3<sup>rd</sup> amphetamine/methamphetamine and derivatives of these in the form of tablets or capsules (ecstasy), 4<sup>th</sup> LSD, 5<sup>th</sup> cannabis and 6<sup>th</sup> other drugs (Bundeskriminalamt 2007b).

Moreover, police statistics distinguish between “soft” and “hard” drug users<sup>38</sup>.

The Federal Office of Criminal Investigation differentiates in its statistics on drug-related crimes between punishable acts in terms of violations of the BtMG and cases of direct economic compulsive criminality. The first ones are subdivided into four different groups of offences: a) General offences in terms of §29 BtMG (especially possession, purchase and distribution, so-called consumption-related offences), b) Illegal trafficking and smuggling of narcotic drugs in terms of §29 BtMG, c) Illegal import of narcotic drugs in non negligible quantities in terms of § 30 BtMG and d) other offences against the BtMG. Prosecution of economic compulsive crimes is mainly related to theft and robbery.

The statistical unit in the records is number of offences. Only one case is recorded if the trafficker/s, or groups of traffickers, have sold drugs for a long period of time, or when one person has procured drugs over a long period of time (Bundeskriminalamt 2007b). Multiple offences are counted as one offence and specifically according to the most serious one (in the case of various acts). When different substances and different acts are involved priority is given to the seriousness of the act (Bundeskriminalamt 2007a). With regard to the data of this stage breakdowns by drug are available. Nonetheless, no information on outcomes is available taken that all cases are supposed to be referred to the prosecutor who has the power to decide on the response. Namely the police is considered to be a supporting institution to the public prosecutor.

The special database FDR, which constitutes only a small extract of the PKS, has the main aim to describe the situation as well as to detect trends. Data regarding personal possession and dealing are included in the aforementioned Criminal Police Statistics.

As for the system regarding the road traffic setting, the outcome data regarding driving under the influence of drugs are part of the Justice Statistics (see paragraph 11.3.3). However, since 2003 the Federal Statistics Office in its statistical report on road accidents 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 other intoxicating substances than alcohol. These data refer to the police stage however they are limited to the recording of heavy accidents (Statistisches Bundesamt 2008d). It should be taken into account, though, that since alcohol

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<sup>38</sup> “Hard” drug users are considered users of substances and preparations listed in Annexes I-III of the Narcotics Act including manufactured pharmaceuticals that are subject to the provisions of narcotics legislation - with the exception of those persons who use only cannabis products (hashish, marijuana, hashish oil) or psilocybin (mushrooms) and of “exempted preparations”. To the extent that persons known as “hard” drug users consume alternative substances - “exempted preparations” or other medications or substances not covered by the Narcotics Act - this must also be considered as hard drug use (Bundeskriminalamt 2007b).

is easier to detect than other intoxicating substances, it is to be assumed that drug-related cases are underrepresented in the road traffic statistics.

### **11.3.2 Data collection system at the prosecution stage**

Prosecution data are routinely collected through an information system which includes information on the outcome of the proceedings as well as on the offender (Verfahrensregister). The data of all closed cases are sent to the Federal Statistics Office, which has the responsibility to produce the respective statistics.

The information system on convictions is updated on annual basis and the statistical unit in the records is the person.

A problem that was identified with regard to the operation of this information system is that until recently there was no link among the Public Prosecution Services across the country. The introduction of the new central public prosecutor procedure register (Zentrales Staatsanwaltschaftliches Verfahrenregister, ZStV) by the Ministry of Justice on January 1, 2007 aims to solve this problem by connecting the data recorded at the various services and thus facilitating effective criminal prosecution. In this register all data regarding preliminary proceedings are being reported.<sup>39</sup>

### **11.3.3 Data collection system at the court stage**

At the court stage data are recorded regarding all proceedings, which are then submitted to the statistical services of the court statistics (Gerichtsstatistik).

Regarding the judicial process, all final verdicts of the courts are inserted in the Federal Central Register and are also included in the national prosecution statistics. These statistics are published in volumes of annual reports in which the offences are given with their nature and scale. The judgements listed there, are classified according to the main groups of offences, in conformity with the current laws (StGB and associated legislation). Convictions are classified following a distinction between traffic offences, possession of or trafficking drugs prosecution for offences connected with obtaining drugs (EMCDDA 2002a).

In the data collection system, the statistical unit is the offender.

The main sanction with regard to the offence type is recorded, whereas data are also collected on perspective secondary sanctions and measures given additionally to the main sanction according to StGB. From the various options for secondary sanctions the following are only recorded: driving ban, deprivation of civil rights and asset forfeiture. As for the measures, they refer to ordered measures with the aim of improvement and safety and namely withdrawal of driving license, placement in psychiatry, detoxification unit and preventive detention. Data in terms of secondary sanctions are also provided on the persons incapable as well as with reduced capability of crime. The aforementioned data are recorded and published systematically only with regard to the old federal states; as for the new federal

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<sup>39</sup>[http://www.bundesjustizamt.de/cln\\_049/nn\\_257944/DE/Themen/Strafrecht/ZStV/ZStV\\_\\_node.html?\\_\\_nnn=true](http://www.bundesjustizamt.de/cln_049/nn_257944/DE/Themen/Strafrecht/ZStV/ZStV__node.html?__nnn=true)

states, there is no comprehensive/systematic recording and thus the respective data are not published.

The Federal Motor Transport Authority (Kraftfahrtbundesamt, KBA) publishes an annual report with data from the Central Register of traffic offenders and of driving licences (Verkehrszentralregister, VZR) including entries for alcohol and drug offenders. Moreover, it provides driving licence statistics regarding withdrawals and refusals of driving licences, driving bans broken down by federal state, gender, age and reasons for decisions taken. However, outcomes regarding punishable acts involving alcohol and drugs are recorded together and cannot be distinguished.

#### **11.4 Data collected**

##### **Police stage**

Police data are very detailed and include information on the socio-demographic characteristics of the suspect (gender, age, nationality) as well as on the offence type, the drug type and the geographical area. Additionally, the statistics of the Federal Criminal Police Office include data on first-notified offenders, that is users of hard drugs who come to police notice for the first time.

As stated above, the focus of these data is not to provide information on the outcome, since the police cannot dispose of a criminal case.

##### **Prosecutor stage**

The data available corresponding to the prosecution stage and providing information on the disposition of the prosecutor include fewer information and breakdowns compared to those available for the previous stage of the justice procedure. Specifically, they present all offences in terms of the BtMG together, providing no breakdowns by specific offence types. Moreover, there is no distinction by drug type, neither is any information given on information on the suspects' characteristics, such as gender, age, nationality, criminal records and drug career is provided (Paoli 2008). Breakdowns are nonetheless available by geographical area and namely by federal states, as well as by old and new states.

##### **Court stage**

The data of the court stage are broken down by general offence types, whereas regarding offences of the BtMG the information is broken down also by its various paragraphs. The data are more detailed regarding the distinction between convicted persons (all conviction types together) and total number of persons who were sentenced (all offenders who were prosecuted regardless of the trial's outcome, including acquittals). With regard to this distinction information is recorded on gender and age groups of the offenders, type of the decision, type of the law applied (e.g. general or juvenile), geographical area (federal state), primary and secondary sanctions.

Additionally, for the convictions data information is also provided on the time difference between the offence commitment and the conviction, duration of foreseen incarceration, number of young adults and adults by federal state, amount of monetary fine, nationality of the offender and the criminal records.

Specifically, for the different type of outcomes given, data is provided on gender of the accused persons.

Data regarding outcomes of the public prosecutors with regard to the application of the § 35 of the BtMG, which is related to the principle of “treatment instead of punishment” and specifically the postponement of a sentence execution as well as the revocation of this postponement are not systematically recorded.

## 11.5 Results available

### Police stage

Data regarding the official police crime statistics are accessible at the website of the Federal Criminal Police Office ([www.bka.de](http://www.bka.de)) as well as of the Federal Ministry of Interior ([www.bmi.bund.de](http://www.bmi.bund.de)). The respective statistics (*PKS*) is produced annually. Additionally, with regard to the drug situation in the Federal Republic of Germany the reports *Narcotic Drugs – Annual Report (Abridged Version) (Rauschgift - Jahreskurzlage)* and *Narcotic Drugs Criminality – Federal Situation Report (Rauschgiftkriminalität - Bundeslagebild)* provide also on annual basis the overall situation in the country. The information presented in these reports is based on analyses of the Drugs Data File, regarding the Federal Situation Report also data of the Criminal Police Statistics is included. Annual reports are produced by the Criminal Police Offices of the federal states as well, and in most cases these documents can be also accessed at the websites of the corresponding services.

The data on drug related crime, that is offences reported at the police level separated by offence type (i.e., the classification applied in German police crime statistics) and by drug type is presented in detail in Chapter 8. In summary, in 2007 a total of 248,355 offences were recorded related to BtMG, out of which 171,496 were general offences under §29 BtMG (that is, possession offences), 64,093 were illegal trafficking and smuggling of narcotics under §29 BtMG and illegal import under § 30 para 1 no. 4 BtMG, and 12,766 were other type of offences (such as illicit cultivation of narcotic drugs, cultivation, production or trafficking of narcotic drugs as a member of a gang, allocation of money or assets, etc.) (Bundesministerium des Innern 2008).

The data on road accidents referring to the police stage are included in a volume compiled by the Federal Statistics Office (series 8, part 7), which can be accessed at its website (<http://www.destatis.de/>). In the year 2007, 336,002 accidents occurred on German roads with 409,641 operators of vehicles being involved. Out of these, 1,354 (0.3%) were under the influence of “other intoxicating substances” (Statistisches Bundesamt 2008d).

### Prosecutor stage

Prosecution statistics are published on annual bases and are accessible at the website of the Federal Statistics Office (series 10, part 2.6). The most recent data available are from year 2006. According to Table 11.2, out of a total of 280,877 proceedings related to application of drug law that were disposed of by the public prosecutor, in 174,276 the outcome was dismissal, whereas 50,707 cases were referred to trial and 23,096 were sentenced with a penal order.

**Table 11.2** Type of outcomes for drug related offences deriving from prosecutions statistics in year 2006

Type of outcome	N	%
Charges	50,707	18.1
Penal order	23,096	8.2
Conditional dismissals	5,951	2.1
Unconditional dismissals	102,257	36.4
Dismissals due to lack of evidence	66,068	23.5
Other outcome	32,798	11.7
Total	280,877	100.0

(Statistisches Bundesamt 2007c)

Additional data on this stage derive occasionally from respective studies. By way of example, the legal practice of the departments of public prosecution with regard to the application of § 31a of the BtMG, which offers the possibility to discontinue prosecution, was evaluated in the context of other regulations on the discontinuation of prosecution as part of a study comparing laws on the topic “Drug use and practice of criminal prosecution“ (Schäfer & Paoli 2006). A random sample of over 300 proceedings on consumption-related offences in each of six different federal states was taken. Out of these proceedings, files of a total of 2,011 individual cases were analysed and a large number of experts interviewed (policemen, public prosecutors, criminal court judges and counsels at the criminal bar) in eleven selected cities. Furthermore, the study was to find out whether the suspension of prosecution would ease the work load of criminal prosecution authorities, whether it would promote the principle of “treatment instead of punishment“ and whether there was a correlation between prevalence of drug use and practice of criminal prosecution in the individual federal state. The regional differences found in the application of the drug law were substantial. The insufficiently defined term of “occasional consumption“ which is regarded as a criterion for absent “public interest“ in prosecution, was identified as one of the core problems by the authors of the study. Due to the differences regarding maximum cannabis quantity providing for a discontinuation of prosecution from one federal state to the other, the quota of discontinued proceedings ranged between 20% and 80%. Critical was the question whether prosecution should be generally discontinued or only under certain conditions (first offender, occasional or habitual consumption). After the opening of proceedings, charges were filed or summary

awards of punishment requested in 4.9% (Schleswig-Holstein) to 40.7% (Bavaria) of the cases. The practice of stopping prosecution concerning § 31a BtMG has led to the intended decrease of workload for the prosecution authorities. Courts by contrast, have seen their workload rising in respect of drug-related offences. According to Schäfer and Paoli, §31a cannot contribute anything substantial to turning the concept “Treatment instead of punishment” into practice.

### **Court stage**

Data on convictions are also accessed at the website of the Federal Statistics Office (series 10, part 3) and are published on an annual basis.

As in the case of the prosecution statistics, the most recent data available refer to 2006. Specifically, a total of 58,892 persons were tried for offences committed against the Narcotics Act, out of which 47,161 under General Criminal Law and 11,731 under Juvenile Law. A total of 6,727 person received non-conviction decisions (4,098 General Criminal Law and 2,629 Juvenile Law). Table 11.3 presents in detail data on the various decisions also with regard to the various drug related offence types.

With regard to the distinction by offence type, total refers to all offences committed against the Narcotics Act; whereas “Other §29 Abs.1” are general consumption related offences, “Trafficking §29a Abs.1 Nr.2” refer to illegal trafficking and smuggling of narcotic drugs and “Import §30 Abs. 1 Nr.4” refer to import of narcotic drugs in non negligible quantities. The aforementioned division coincides with the classification of the BKA.

**Table 11.3** Accused persons for offences against the Narcotics Act subject to a court decision in year 2006<sup>1)</sup>

Sanctions	Total	Other §29 Abs. 1	Trafficking §29a Abs.1 Nr. 2	Import §30 Abs. 1 Nr.4
<b>Under General Criminal Law</b>				
Convicted (See Table 11.4)	43,063	33,230	4,968	2,326
Other court decisions	4,098	3,544	214	100
<i>Out of which:</i>				
<i>Conditional discharge</i>	4	2	2	0
<i>Acquittal with conditions</i>	0	0	0	0
<i>No punishment</i>	57	52	1	0
<i>Closing of the proceedings</i>	2,958	2,734	72	40
<i>Acquittal</i>	1,079	756	139	60
<b>Total</b>	<b>47,161</b>	<b>36,774</b>	<b>5,182</b>	<b>2,426</b>
<b>Under Juvenile Law</b>				
Convicted (See Table 11.4)	9,102	7,542	873	197
Other court decisions	2,629	2,512	48	9
<i>Out of which:</i>				
<i>Closing of the proceedings</i>	2,420	2,331	33	2
<i>Acquittal</i>	209	181	15	7
<b>Total</b>	<b>11,731</b>	<b>10,054</b>	<b>921</b>	<b>206</b>
<b>Total (General Criminal &amp; Juvenile Law)</b>	<b>58,892</b>	<b>46,828</b>	<b>6,103</b>	<b>2,632</b>

1) The data refer only to the old states. The data on new federal states are not available.

(Statistisches Bundesamt 2007b)

Moreover, 52,165 persons were convicted for offences against the Narcotics Act, out of which 43,063 convictions were rendered under the general criminal law relating to adult offenders and 9,102 relating to juvenile offenders. Regarding the conviction rendered in respect of the general criminal law, 17,546 custodial sentences (with or without fine) - out of these 10,935 were suspended on probation – and 25,517 fines were imposed (Statistisches Bundesamt 2007b) (Table 11.4).

**Table 11.4** Convictions for offences committed against the Narcotics Act in year 2006<sup>1)</sup>

Sanctions	Total	Other §29 Abs. 1	Trafficking §29a Abs.1 Nr. 2	Import §30 Abs. 1 Nr.4
<b>Under General Criminal Law</b>				
Custodial sentence	17,515	7,940	4,894	2,292
Custodial sentence with fine	31	12	15	0
Fine	25,517	25,278	59	34
Imprisonment and/or fine without injunctions/directives	34,132	28,869	2,528	1,377
Imprisonment and/or fine with injunctions/directives	8,931	4,361	2,440	949
Suspension on probation	10,935	5,541	2,986	993
Total <sup>2)</sup>	43,063	33,230	4,968	2,326
<b>Under Juvenile Law</b>				
Prison sentence	2,120	985	689	168
Corrective measures <sup>3)</sup>	6,404	6,009	172	29
Educational measures <sup>4)</sup>	578	548	12	0
Total <sup>2)</sup>	9,102	7,542	873	197
<b>Total (General Criminal &amp; Juvenile Law)</b>	<b>52,165</b>	<b>40,772</b>	<b>5,841</b>	<b>2,523</b>

1) The data refer only to the old states. The data on new federal states are not available.

2) Counted according to the most severe sanction.

3) Such as warning, with injunctions/directives, youth custody.

4) Such as community work, obligation to acquire a job or vocational training.

(Statistisches Bundesamt 2007b)

Table 11.5 provides information on the supplementary sanctions given for offences against the Narcotics Act in 2006. It is evident that the sanction of asset forfeiture is widely applied additionally to the main sanction (16,583 persons).

Comparing the figures with the ones referring to the previous stage of the justice procedure - although it should be kept in mind that no temporal sequencing is possible as stated above- it becomes obvious that the total of cases disposed by the prosecutor is high, whereas the figures referring to cases brought before a court tend to be low (Killias et al. 2003).

**Table 11.5** Secondary sanctions and measures for offences committed against the Narcotics Act in year 2006<sup>1)</sup>

	Total	Other §29 Abs. 1	Trafficking §29a Abs.1 Nr. 2	Import §30 Abs. 1 Nr.4
<b>Secondary sanctions</b>				
Deprivation of civil rights	0	0	0	0
Asset forfeiture	16,583	14,184	1,117	808
Driving ban	296	261	23	9
<b>Measures for amelioration and safety</b>				
Withdrawal of driving license	263	171	43	32
Placement in psychiatry	4	1	3	0
Placement in detoxification unit	337	54	141	80
Preventive detention	2	0	1	1
Other measures	17	12	3	0
<b>Incapability of crime</b>				
Without referral	1	0	0	1
Placement in psychiatry	2	1	1	0
Placement in detoxification unit	2	1	1	0
<b>Reduced incapability of crime</b>				
Without referral	570	325	129	38
Placement in psychiatry	2	0	2	0
Placement in detoxification unit	110	20	37	31

1) The data refer only to the old states. The data on new federal states are not available.

(Statistisches Bundesamt 2007b)

As far as the road traffic statistics related to substance consumption are concerned, the data of the Federal Motor Transport Authority can be downloaded free of charge on its website and are supplemented by annual reports. In 2007, a total of 27,600 drug related driving offences (excluding alcohol) were recorded, representing 12.4% of the cases related to substance use (Table 11.6). This relatively low rate though compared to the alcohol related offences might be possibly linked with the difficulty to detect other intoxicating substances.

**Table 11.6** Drug related driving offences (including alcohol) 2002 – 2007

		2002	2003	2004	2005	2006	2007
All substance related offences (incl. alcohol) <sup>1)</sup>	N	238,100	236,100	243,400	241,900	225,300	222,600
Drug related offences (excl. alcohol) <sup>1)</sup>	N	12,800	17,000	24,700	27,900	27,400	27,600
	%	5.4	7.2	10.1	11.5	12.2	12.4

1) Absolute numbers of offences are rounded to 100.

(Krafftahrtbundesamt 2008a)

According to the 2007 data, the most typical driving license sanction related to the consumption of substances (alcohol or drugs) is the withdrawal of the driving license (97,339 cases) and the driving ban with administrative fines (86,016 cases). Less frequently applied sanctions are the ban on granting a driving permit or refusal to grant a driving permit (15,028), the disqualification which is applied on holders of foreign driving licenses, that could not be withdrawn by the German authorities (5,802) and the driving ban in the framework of the criminal procedure (Table 11.7).

**Table 11.7** Type of driving license sanctions involving alcohol or drugs in year 2007

<b>Driving license sanction</b>	<b>Total punishable acts</b>	<b>Punishable act involv. alcohol or drugs</b>
Withdrawal of driving license	132,016	97,339
Ban on granting a driving permit or refusal to grant a driving permit	29,370	15,028
Disqualification for holders of foreign driving licenses	7,230	5,802
Driving ban in criminal procedure	33,460	6,203
Driving ban with administrative fines	469,832	86,016

(Krafftahrtbundesamt 2008b)

All in all, the information and reports presented in this chapter are published regularly and in most cases could be easily accessed. As for their use, by way of illustration, in the section regarding the quality characteristics of the statistics of the Federal Statistics Office it is stated that the target audience of these reports are in principal the bodies of the justice and legislation authorities on national and federal state level. These data are furthermore used in justice practice, scientific research, as well as to a lesser extent by information providers and media (Statistisches Bundesamt 2007b, c, 2008d).

## PART C: BIBLIOGRAPHY AND ANNEXES

### 12 Bibliography

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## 12.2 Websites

### Important institutions

Website	Inhalt
<a href="http://www.bmg.bund.de">www.bmg.bund.de</a>	Bundesministerium für Gesundheit (BMG) Federal Ministry for Health
<a href="http://www.bzga.de">www.bzga.de</a>	Bundeszentrale für gesundheitliche Aufklärung (BZgA) Federal Centre for Health Education (FCHE)
<a href="http://www.dbdd.de">www.dbdd.de</a>	Deutsche Referenzstelle für die Europäische Beobachtungsstelle für Drogen und Drogensucht (DBDD) German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction
<a href="http://www.dhs.de">www.dhs.de</a>	Deutsche Hauptstelle für Suchtfragen (DHS) German Centre for Addiction Issues
<a href="http://www.drogenbeauftragte.de">www.drogenbeauftragte.de</a>	Drogenbeauftragte der Bundesregierung Federal Government Commissioner on Narcotic Drugs
<a href="http://www.drugcom.de">www.drugcom.de</a>	BZgA Informationen für junge Leute und Partygänger FCHE information for young people and party goers
<a href="http://www.drugscouts.de">www.drugscouts.de</a>	Landesprojekt in Sachsen für junge Leute Land project of Saxony for young people
<a href="http://www.emcdda.europa.eu">www.emcdda.europa.eu</a>	Europäische Beobachtungsstelle für Drogen und Drogensucht (EBDD) European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
<a href="http://www.prevnet.de">www.prevnet.de</a>	"PrevNet" serves to network players in the field of prevention facilitating the access to information and material
<a href="http://www.psychologie.tu-dresden.de/asat/">www.psychologie.tu-dresden.de/asat/</a>	Technische Universität Dresden Institut für Klinische Psychologie und Psychotherapie Dresden University of Applied Sciences Institute for Clinical Psychology and Psychotherapy
<a href="http://www.psychologie.tu-dresden.de/bmbf/">www.psychologie.tu-dresden.de/bmbf/</a>	Technische Universität Dresden Institut für Klinische Psychologie und Psychotherapie Dresden University of Applied Sciences Institute for Clinical Psychology and Psychotherapy Deutsches Suchtforschungsnetz German Addiction Research Network
<a href="http://www.rki.de">www.rki.de</a>	Robert Koch-Institute (RKI), Berlin

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 which exist in this field.

### Websites of research institutions

The websites of the research associations provide further information on individual research projects, network structures and cooperation partners as well as research reports and literature references:

- Suchtforschungsverbund Baden-Württemberg: [www.bw-suchtweb.de/](http://www.bw-suchtweb.de/)
- Suchtforschungsverbund Bavaria/Saxony: [www.psychologie.tu-dresden.de/asat/](http://www.psychologie.tu-dresden.de/asat/)
- Suchtforschungsverbund Nordrhein-Westfalen: [www.suchtforschungsverbund-nrw.de/](http://www.suchtforschungsverbund-nrw.de/)
- Suchtforschungsverbund Nord-Ost ("Early intervention in substance-related disorders" (EARLINT)): [www.medizin.uni-greifswald.de/epidem/forschung/intervention/earlint.html](http://www.medizin.uni-greifswald.de/epidem/forschung/intervention/earlint.html)
- Deutsche Gesellschaft für Sucht: [www.dg-sucht.de](http://www.dg-sucht.de)
- German Heroin Study: [www.heroinstudie.de](http://www.heroinstudie.de)
- Premos-Study: [www.premos-studie.de](http://www.premos-studie.de)
- Addiction research funded by the Ministry for Education and Sciences: [www.gesundheitsforschung-bmbf.de/en/137.php?PHPSESSID=d0a4c0911d2d3f8182463a3536a75789](http://www.gesundheitsforschung-bmbf.de/en/137.php?PHPSESSID=d0a4c0911d2d3f8182463a3536a75789)

### Websites of other relevant institutions and working groups

- Fachstelle für Arbeitsmarktintegration und Reintegration Suchtkranker: [www.fachstelle-faire.de](http://www.fachstelle-faire.de)
- Zentrum für interdisziplinäre Suchtforschung Hamburg: [www.zis-hamburg.de](http://www.zis-hamburg.de)
- Zentrum für Drogenforschung der Johann Wolfgang von Goethe-Universität Frankfurt/M.: [www.uni-frankfurt.de/fb/fb04/forschung/cdr/index.html](http://www.uni-frankfurt.de/fb/fb04/forschung/cdr/index.html)
- Institut zur Förderung qualitativer Drogenforschung, akzeptierender Drogenarbeit und rationaler Drogenpolitik Münster: [www.indro-online.de](http://www.indro-online.de)
- Zentralinstitut für seelische Gesundheit Mannheim: [www.zi-mannheim.de](http://www.zi-mannheim.de)
- Institut für Suchtforschung der Fachhochschule Frankfurt/Main: [www.fh-frankfurt.de/de/forschung](http://www.fh-frankfurt.de/de/forschung)
- Institut für Sozialarbeit und Sozialpädagogik Frankfurt/M.: [www.iss-ffm.de/](http://www.iss-ffm.de/)
- Institut für Klinische Psychologie und Psychotherapie der Technischen Universität Dresden: [www.psychologie.tu-dresden.de/klinische/](http://www.psychologie.tu-dresden.de/klinische/)
- Kompetenzplattform Suchtforschung an der katholischen Fachhochschule NRW: [www.addiction.de](http://www.addiction.de)
- Suchtforschungsverbund an Fachhochschulen (SFFH) mit den Standorten Frankfurt/M., Köln, Aachen und Mainz: [www.suchtforschungsverbund.de](http://www.suchtforschungsverbund.de)

- Institut für Therapieforschung München: [www.ift.de](http://www.ift.de)
- Institut zur Förderung qualitativer Drogenforschung, akzeptierender Drogenarbeit und rationaler Drogenpolitik Münster: [www.indro-online.de](http://www.indro-online.de)

### **Specific Cannabis projects**

- The project “AVerCa” aims at setting up an effective care structure for the early recognition of and early intervention in cannabis abuse among children and adolescents: [www.dhs.de/web/projekte/cannabis.php](http://www.dhs.de/web/projekte/cannabis.php)
- Modular therapy of cannabis-related disorders: [www.candis-project.de](http://www.candis-project.de)
- The group training “Can Stop” was developed on behalf of the BMG by the German Centre for Addiction Problems among Children and Adolescents (Deutsches Zentrum für Suchtfragen des Kindes- und Jugendalters, DZSKJ). The training is based on a manualized treatment programme for young people with cannabis problems.
- The cannabis cessation programme “Quit the Shit” has been online available since 2004 at [www.drugcom.de](http://www.drugcom.de). It addresses people with regular cannabis consumption.
- International Cannabis Need of Treatment Study: <http://www.incant.de>
- Counselling project for cannabis consumption carried out in Germany and Switzerland: [www.realize-it.org](http://www.realize-it.org)
- Cannabis campaign launched by the city of Frankfurt: [www.be-u-online.de](http://www.be-u-online.de)

### **Party projects**

- Drogenhilfe Köln e.V.: [www.partyack.de](http://www.partyack.de)
- SZL Suchtzentrum gGmbH Leipzig: [www.drugscouts.de](http://www.drugscouts.de)
- Verein zur Förderung der Partykultur und Minderung der Drogenproblematik e.V. Berlin: [www.eve-rave.net](http://www.eve-rave.net)
- Party Project e.V. Bremen: [www.party-project.de](http://www.party-project.de)
- chill-out - gemeinnütziger Verein zur Förderung der Kommunikationskultur e.V. Aachen: [www.chill-out.de](http://www.chill-out.de)
- Alice projekt - Frankfurt : [www.alice-project.de](http://www.alice-project.de)
- Jugend- und Suchtberatungszentrum/ Psychosoziale Beratungs- und Behandlungsstelle Hannover: [www.drobs-hannover.de](http://www.drobs-hannover.de)



## PART D: LISTS OF TABLES AND FIGURES

### 13 Tables

Table 2.1	Prevalence of illicit drugs in Germany.....	28
Table 2.2	Lifetime-prevalences for illicit drugs.....	29
Table 2.3	Trends in the lifetime and 12-month-prevalences of the consumption of illicit drugs broken down by substances (age group 18-24 years), 1990-2006 <sup>1)</sup> .....	30
Table 2.4	Prevalences of the consumption of illicit drugs among children and adolescents – various studies.....	40
Table 2.5	Prevalences of the consumption of cannabis among children and adolescents – various studies.....	41
Table 4.1	Prevalence estimates of problem opiate consumption from 2004 to 2007 .....	66
Table 4.2	Socio-demographic data broken down by main drug (outpatient) .....	69
Table 4.3	Drug administration routes in outpatients 2004-2007 .....	70
Table 4.4	Main diagnoses in outpatient treatment.....	71
Table 4.5	Inpatients with addiction diagnoses .....	77
Table 5.1	Inpatient treatment of addiction-related problems in hospitals 2003-2006.....	86
Table 5.2	Rehabilitation therapies for addiction problems (Withdrawal treatments).....	87
Table 5.3	New admissions to outpatient treatment 2007 .....	89
Table 5.4	Type and percentage of substitution substances reported to the substitution register.....	91
Table 6.1	Drug-related deaths 2002-2007 broken down by substances .....	103
Table 6.2	Mortality of outpatient opiate addicts - trend .....	107
Table 8.1	Social situation of persons in outpatient therapy broken down by main drug.....	123
Table 8.2	Drug use and road accidents.....	130
Table 8.3	Number of detainees and drug-related crimes.....	131
Table 8.4	Outpatient therapy of drug-related problems in prison.....	132
Table 10.1	Quantities of illicit drugs seized in Germany in 2006 and 2007 .....	142
Table 10.2	Changes in number and quantity of illicit drugs seized since 2000 .....	143
Table 10.3	Seizures of cannabis plants .....	144
Table 10.4	Drug prices, 2006 - 2007 (all prices in €).....	145

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Table 10.5	Levels of active ingredient - various drugs 1997 - 2007 (median) in percent.....	146
Table 10.6	Content of active substance of ecstasy in mg per pill/capsule.....	148
Table 11.1	Overview of options available for the various offence types .....	153
Table 11.2	Type of outcomes for drug related offences deriving from prosecutions statistics in year 2006 .....	165
Table 11.3	Accused persons for offences against the Narcotics Act subject to a court decision in year 2006 <sup>1)</sup> .....	167
Table 11.4	Convictions for offences committed against the Narcotics Act in year 2006 <sup>1)</sup> .....	168
Table 11.5	Secondary sanctions and measures for offences committed against the Narcotics Act in year 2006 <sup>1)</sup> .....	169
Table 11.6	Drug related driving offences (including alcohol) 2002 – 2007 .....	169
Table 11.7	Type of driving license sanctions involving alcohol or drugs in year 2007 .....	170

## 14 Figures

Figure 2.1	Lifetime-, 12 month- and 30-day-prevalence of the cannabis consumption among Frankfurt students aged between 15 and 18 years - 2002-2007 (MoSyD).....	35
Figure 2.2	Lifetime-, 12-month- and 30-day-prevalence of the consumption of illicit drugs (excluding cannabis) among Frankfurt students aged 15 to 18 years - 2002-2007 (MoSyD).....	36
Figure 2.3	Lifetime- and 30-day-prevalence of the consumption of cannabis among adolescents in Hamburg 2004-2007 .....	36
Figure 2.4	Lifetime- and 30-day-prevalence of the consumption of cannabis and other illicit drugs (excluding cannabis) among adolescents in Hamburg 2004-2007 .....	38
Figure 2.5	Cannabis consumption broken down by school type, results of HBSC, North Rhine-Westphalia.....	39
Figure 3.1	Settings of prevention measures (Dot.sys).....	49
Figure 4.1	Long-term changes in the admissions to outpatient addiction treatment broken down by main diagnoses (1994=100%) .....	72
Figure 4.2	Trends (main diagnoses alcohol and sedatives/hypnotics) .....	74
Figure 4.3	Trend in the main diagnosis group opiates; active ingredient: methadone.....	75
Figure 5.1	Duration of inpatient therapy broken down by substances 2007 .....	87
Figure 6.1	Coded causes of drug-related deaths in the General Mortality Registry (1998-2006).....	105
Figure 6.2	Drug-related deaths broken down by age groups 1998-2006.....	106
Figure 6.3	Distribution of the substance categories in the coded direct causes of death, overdose 1998-2006.....	106
Figure 8.1	Development of trafficking crimes.....	125
Figure 8.2	Development of consumption-related offences.....	126
Figure 8.3	Convictions under the Narcotics Act.....	128
Figure 8.4	Trends in the convictions under the Narcotics Act.....	129
Figure 10.1	Number of seizures of narcotic drugs in the Federal Republic of Germany, 1997 - 2007 .....	143
Figure 10.2	Content of active substance in amphetamine 1997 bis 2007 .....	146
Figure 10.3	THC-content of marijuana and cannabis resin 1997-2007 .....	147
Figure 10.4	Content of active ingredient of heroin 1997-2007 .....	149
Figure 10.5	Content of active ingredient in cocaine 1996-2006.....	150