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REPORT TO THE EMCDDA

by the Reitox National Focal Point

GERMANY

DRUG SITUATION 2002

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Abbreviations

	German	English
AMG	Arzneimittelgesetz	Pharmaceutical Law
ANOMO	Anonymes Monitoring in den Praxen niedergelassener Ärzte	Anonymous monitoring of a representative sample of doctors in independent practise
AUB Richtlinien	Richtlinien für Anerkannte Untersuchungs- und Behandlungsmethoden	Guidelines for diagnostic and treatment methods
BfArM	Bundesinstitut für Arzneimittel und Medizinprodukte	Federal Centre for Drugs and Medical Devices
BMJ	Bundesministerium der Justiz	Federal Ministry of Justice
BMGS	Bundesministerium für Gesundheit und Soziale Sicherheit	Federal Ministry for Healthand Social Security
BSHG	Bundessozialhilfegesetz	Federal Law on Social Help
BtM	Betäubungsmittel	Narcotics
BtM-ÄndV.	Betäubungsmittelrechts-Änderungsverordnung	Amendment of Narcotic Law Regulations
BtMG	Betäubungsmittelgesetz	Narcotic Law
BtMG-ÄndG	Gesetz zur Änderung des Betäubungsmittelgesetzes	Amendment of the Narcotic Law
BUND	Bundesstudie	Survey on the Use of Psychoactive Substances in the German Adult Population
BZgA	Bundeszentrale für gesundheitliche Aufklärung	Federal Centre for Health Education (FCHE)
BLV	Badischer Landesverband gegen die Suchtgefahren	
DAS	Drogenaffinitätsstudie	Drug Affinity Study
DBDD	Deutsche Referenzstelle für die Europäische Beobachtungsstelle für Drogen und Drogensucht	German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction
DFB	Deutscher Fußball Bund	German Football Association
DND	Drogennotdienst	Drug Emergency Service

Abbreviations (continued)

	German	English
DSB	Deutscher Sport Bund	German Sports Association
DTB	Deutscher Turner Bund	German Gymnastic Association
EBDD	Europäische Beobachtungsstelle für Drogen und Drogensucht	European Monitoring Centre for Drugs and Drug Addiction
ECDP		European Cities on Drug Policy
EDDRA		Exchange on Drug Demand Reduction Action
EU	Europäische Union	European Union
FAW	Fachverband für Außenwerbung	
GRV	Gesetzliche Rentenversicherungen	Public Social and Pension Insurance
HAART		Highly Activating Antirectroviral Treatment
HBV	Hepatitis B Virus	Hepatitis B Virus
HCV	Hepatitis C Virus	Hepatitis C Virus
IVU	Intravenös applizierende Drogenkonsumenten	Intravenous drug users
KJHG	Kinder- und Jugendhilfegesetz	Law on children and youth help
LAAM	Levoalphaacetylmethadol	
NGOs	Nicht-staatliche Organisationen	Non-governmental organizations
REITOX	Europäisches Informationsnetzwerk zu Drogen und Sucht	Reseau Europeen d'Information sur les Drogues et Toxicomanies
RKI	Robert Koch Institut	Robert Koch Institute
SGB	Sozialgesetzbuch	Code of Social Law
StBA	Statistisches Bundesamt	Federal Statistical Office
StGB	Strafgesetzbuch	General Criminal Code
THC	Tetrahydrocannabinol	
UN	Vereinte Nationen	United Nations
VDR	Verband Deutscher Rentenversicherungsträger	German Association of Pension Insurances
WHO	Weltgesundheitsorganisation	World Health Organisation
ZI	Zentrales Institut der Kassenärztlichen Versorgungen	Central Institute of Panel Doctors
THC	Tetrahydrocannabinol	
UN	Vereinte Nationen	United Nations

Federal States

	Bundesland	**Federal Land**
BW	Baden-Württemberg	Baden-Württemberg
BY	Bayern	Bavaria
BR	Berlin	Berlin
BB	Brandenburg	Brandenburg
HB	Bremen	Bremen
HH	Hamburg	Hamburg
HE	Hessian	Hessia
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
AN	Sachsen-Anhalt	Saxony-Anhalt
SH	Schleswig-Holstein	Schleswig-Holstein
TH	Thüringen	Thuringia

Introduction

The regulation on which the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is based now is existing since 10 years. The national partners – the so-called Focal Points – were determined shortly afterwards by the national governments and play an important role in the activities of this institution since then.

Working mode and working results have consolidated during this period. In the meantime the European Drug Report regularly offers a total view on the situation in Europe and the comparability of much information concerning drug policy in the member states of the EU has increased considerably. With regard to surveys, statistics of treatment and deaths as well as exemplary measures aiming at reduction of demand this European network is of great importance today.

The accession of new member states to the European Union beginning 2004, an improvement of data quality and the filling of existing gaps in reporting are challenges for the future. The desire of widening the topic when facing more and more difficult financing conditions at the same time will demand a high working effort as well as an increased willingness to set priorities.

The national reports sent to the EMCDDA every year serve as basis for the European summary. They have changed their appearance and character during that time. In the beginning there were mainly situational descriptions dealing also with methodical questions concerning comparability of national data. More and more the main emphasis in the reports has been put on changes in the problem area and innovative attempts to deal with them. The restructuring of the European reporting planned for 2004 will continue this trend. With that the reports no more represent a full description of the drug situation and the strategies of intervention in Germany, but show by means of a detailed questionnaire primarily the most important changes to the year before.

Today the European cooperation offers more than ever before possibilities to develop standards and methods which are not available on national level in this manner. In that respect we wish all the best for the EMCDDA and its partners for the coming 10 years. We want to thank all persons involved in this process and wish them staying power also for the future.

Roland Simon

Director of the DBDD

Summary

The present report on the drug situation in Germany has been prepared on behalf of the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) which is an agency of the European Union. The work has been performed by the German Reference Center for the European Monitoring Center for Drugs and Drug Addiction (DBDD) in which the Institute for Therapy Research (IFT), the Federal Center for Health Education and the German Central Office against Addiction cooperate. The German Reference Center for the European Monitoring Center for Drugs and Drug Addiction is funded by the Federal Ministry for Health and Social Affaires and the EMCDDA. The overall report has been structured according to the guidelines provided by the EMCDDA and is available to download from www.dbdd.de .

Political strategies at national and regional level

In the last years, the formerly narrow drug policy concept has gradually evolved into a cross-substance 'addiction' policy which brings the common aspects of psychotropic substances more into the foreground of the interest of drug experts and politicians. The 'Action Plan Drugs and Addiction' which has been presented by the drug commissioner of the German Federal Government in June 2003 and which is supposed to serve as a framework for the national addiction policy for the next five to ten years, makes this approach clearly visible for the first time as part of an overall political concept.

The four pillars on which the addiction policy rests, are prevention, counseling and treatment of drug users, survival aides and harm reduction as well as repression and reduction of the supply especially of illicit drugs. With regard to prevention, the reduction of tobacco consumption forms the top goal. Counseling and treatment services are to be further developed and expanded. Here, quality assurance and development require a permanent effort. The intensification of the cooperation between various institutions involved such as emergency aid, psychosocial counseling but also counseling for young people is to make drug care more effective and efficient. Hereby, the specific needs of female drugs users are to be given special attention.

A series of legal framework conditions with regard to substitution have already been changed in order to facilitate access to these services and secure the quality of these measures. Together with other drug policy measures these changes are to be evaluated in the future with respect to their effectiveness.

While the German federal states support the national Addiction and Drug Plan in general, some however have shifted the focus of the plan or do not lend their support to individual initiatives.

Epidemiological situation

During the reference period, no new national epidemiological studies have been published for Germany. The last REITOX report includes an overview of the situation for the reference year 2000. However, police figures on drug seizures, most recent treatment statistics as well as first results yielded by the HBSC study do give an indication of current trends.

Heroin consumption appears to have stabilized, showing even a slight downward trend. As for cocaine - until a few years ago the secondary drug almost exclusively preferred by heroin users – the drug is meanwhile also on the increase with primary cocaine users. In fact, they tend now to outnumber heroin users in treatment facilities. However, treatment statistics show fewer problematic somatic or social impacts for patients using cocaine without taking any additional drugs than for primary heroin consumers. A more detailed analysis is currently under way. The clearest indications of the increase of the case figures can be found with cannabis. While the expansion of Ecstasy has stabilized, the use of amphetamines too has clearly increased compared to the previous year.

Most drugs are - at least for experienced drug users - relatively easy to procure in the whole of Germany. There are indications however, that cocaine in form of powder was temporarily hard to find on the market in some metropolitan areas leading to an intensified use of crack.

The population survey on the use of psychotropic substances was carried out in 2003; results hereto as well as the results of the national youth survey (drug affinity study), a school survey (ESPAD) and a general health survey among school children (HBSC) carried out in several German federal states will be presented in 2003.

Demand reduction measures

Prevention is given great importance finding its expression also in the Action Plan Drugs and Addiction. Germany has a very developed drug aid system combining medical, social and psychotherapeutic elements. Specialized facilities provide outpatient and inpatient drug-free treatment, detoxification, substitution and rehabilitation measures.

Substitution treatment alone reach an estimated 50 000 heroin addicts per year. About 10.000 rehabilitation measures for drug and poly-drug addicts are financed by the German pension insurance fund. Hereby, outpatient offers gain in importance which has been demanded for content-related and economic reasons for a long time. The easy transfer of clients between the respective facilities as well as the cooperation of other institutions involved are political core demands. Changes to framework conditions have further facilitated access to substitution treatment and have helped to slightly decrease the administrative work of physicians.

Key topics

The monitoring and evaluation of results yielded by new strategies and approaches of drug policy is done more and more systematically. Parallel to the established approach to resort to expert commissions for evaluation, it is also in discussion as part of the action plan to define empirical effectiveness measures. Details are still in the planning.

This year, particular attention is given to people who seek help from counseling and treatment centers because of cannabis use. This group accounts for about 9% of all clients of outpatient counseling centers in the year 2002 ranking third after alcohol (67%) and opiates (14%). A comparison between absolute figures of the admissions per year shows an increase of this group of clients since 1994 by almost 500%. In the same period of time, the number of alcohol clients has risen only by 50% and of opiate users only by 60%.

Approximately one man in four and one woman in five of this group of clients use cannabis daily, 40% of them at least several times a week and a third has not used cannabis at all in the previous 30 days. On the one hand, a not insignificant portion of clients approach the facilities exclusively because of problems with obtaining a driving license or because of obligations imposed by court without having further problems with the drug. On the other hand, a significant number of the clients do have considerable problems with respect to frequency of use, use of additional substances and effects of cannabis use. Treatment specifically geared to cannabis users is rare. A current study on this topic area will provide more detailed information at the beginning of the year 2004. In the population, about 10 million people have made experiences with cannabis while 1,5 million have used the substance at least 10 times during the previous 12 months. By clinical measures (DSM IV), about 200 000 people are dependant on the drug according to current calculations.

The connection between drug use and other psychic disorders was the third central topic of this year. Current studies show the most clear connections to anxiety syndromes, post-traumatic stress syndromes, personality disorders and psychotic illnesses. The type of connection remains very often unclear, i.e. the question ‘what is caused by what’ cannot be satisfyingly answered. In many cases however, drug use appears to have a negative impact on the further development of these disorders.

Treatment possibilities for this group increase only very slowly. On the one hand, common drug treatment procedures are often too ambitious and not flexible enough for this group of clients, on the other hand, psychiatric facilities are often not capable to deal with the specific problems of drug users. Equally important as sufficient treatment capacities are the early detection of psychic disorders by the physician or the consultant and the referral to the respective facilities.

PART I NATIONAL STRATEGIES: INSTITUTIONAL AND LEGAL FRAMEWORKS

1 Developments in Drug Policy and Responses

In Germany the term „Drug Policy" gradually changes its meaning. Till the end of last century it was clearly applied to illegal drugs standing in the main focus of political interest. There was no comparable conception for an alcohol or tobacco policy or for an "addiction"-policy including all substances. Since some years (1) disorders caused by legal psychotropic substances and (2) common aspects of all such substances (i.e. in primary prevention or concerning patients with multiple misuse) are more in the focus of political interest. In order to clarify the situation, more and more the terms "drug and addiction policy" or only "addiction policy" are used. For the annual reports of the DBDD this means that more and more also legal substances and common strategies for legal and illegal substances have to be investigated. In most cases a diversification is no more possible due to political developments. Nevertheless, according to the requested subject of the report only illegal substances are taken into consideration where possible.

1.1 Political framework in the drug field

1.1.1 Objectives and Priorities of the national drug policy

The office of the Federal Drug Commissioner belongs since 1998 to the Federal Ministry for Health and Social Security (BMGS). The Federal Drug Commissioner, Mrs. Caspers-Merk (Secretary of State to the Parliament), is responsible for addiction policy of the Federal Ministry for Health and Social Security and coordinates the drug and addiction policy of the whole Federal Government.

Her work is based on the following four „pillars":

- Prevention of drug consumption
- Advice and treatment offered to consumers
- Surviving aid and harm reduction
- Repression and supply reduction

It is intended to obtain a balance between measures concerning reduction of offer and demand. Addiction policy includes legal addictive substances and their risks and takes into consideration the European development concerning national measures.

Addiction is treated as an illness requiring treatment. The existing measures to combat the illness shall be made available as early and as extensive as possible. Risky consumption, harmful use and addiction of drugs shall be prevented or at least considerably reduced. Prevention of addiction is of outstanding importance. Existing measures and helping offers shall be completed and secured qualitatively.

1.1.2 New initiatives and basic changes

Actual attempts and political positions in relation with drugs on national level are apparent significantly from two papers issued by the Federal Drug Commissioner in 2003. Whereas the "Report on Drugs and Addiction 2003" is showing the yearly statement to the topic, the "Action Plan Drugs and Addiction" is designed for a long-term period. The most important aspects of both texts are shown below.

Report on Drugs and Addiction 2003

In April 2003 the Federal Drug Commissioner presented the actual Report on Drugs and Addiction.

Facing an estimated figure of 40.000 resp. 110.000 persons dying every year through the legal substances alcohol and tobacco, significantly more attention is now paid to this fact than up till now. A number of legislative measures have been taken in order to reduce problems resulting especially from these drugs. For instance the sale of tobacco to children under 16 years is now forbidden, restrictions of advertisements and warnings concerning cigarettes have been intensified. A main objective is the primary prevention of tobacco consumption by young people. Whereas the rate of smokers within this age group is now increasing due to respective surveys, it shall be decreased within the next years from 28% to 20% according to the intention of the Federal Government. This shall be achieved by already passed legislative measures as well as by qualified support of measures of addiction prevention.

Consumption of tobacco is in most cases also the first step for the development of problems with illegal drugs. Thus drug prevention is always at first prevention of tobacco consumption. The here indicated objectives represent therefore in an implicit manner preventive improvements also for people with drug problems. Moreover there are some more specific goals concerning drug problems:

- Considering the actual state of research on the risks of consumption of ecstasy, a more critical view of the substance shall be passed on the party scene. For this the internet has been used more and more as an additional medium during the last years.
- The often extremely difficult situation of drug addicts on the working market shall be improved. Changes in care for this group of people offered by the working offices should increase their chances to get a job and enable a social (re-)integration.

A number of basic attempts within health policy support these activities. A more intense network of different working areas – especially between youth work and addiction aid – shall enable better and more efficient services than up till now. The special needs of female addicts ("gender mainstreaming") shall be taken into consideration by suitable structural and personnel measures.

Due to the orientation of the REITOX report to illegal drugs a number of further aspects in the addiction and drug report relating specifically to alcohol problems are not shown here.

Action Plan Drugs and Addiction

In June 2003 the Federal Cabinet has approved the "Action Plan Drugs and Addiction" presented by the Federal Drug Commissioner. It shall serve as a framework plan of addiction policy for the next 5-10 years and replaces the "Plan to combat drugs" of the year 1990. It shall contribute "to change health awareness and to avoid harmful consumption or at least reduce it". It is based on the four pillars of the national drug and addiction policy (see chapter 1.1.2). Compared to the plan of 1990 it is obvious that legal drugs have been taken more into consideration and that new elements of care (internet offers, consumption rooms) have been included. Besides a number of targets influencing the consumption of illegal drugs indirectly by preventing consumption of tobacco, the plan relates also specifically to drugs. For instance there is a demand to avoid respectively reduce the consumption of illegal drugs by referring to the special risks of infection - especially Hepatitis C - and possible damages to the brain by synthetic drugs. Moreover, special target groups (children of addictive parents, high-risk groups, car drivers, consumers of different drugs) shall be treated specifically.

Prevention

More importance shall be attached to secondary prevention aiming at minimizing harm. This especially concerns poly drug use and other very risky modes of consumption by young people. The basic conditions of prevention work shall be improved through quality assurance. Agreements were made with the tobacco industry, similar agreements with the social insurances are under discussion. The sponsoring of preventive measures through the alcohol and tobacco industry is a matter of controversial debate in Germany.

In order to reach these targets, existing methods and attempts will be developed further (guidelines, competitions, press campaigns). This requires the support by different institutions and their staff: kindergartens, authorities offering support and services to young people, public health departments and registered doctors with own practices. These groups of persons shall be motivated for this support and provided with necessary information and material in order to enable them to fulfil this task better than up till now. There are also plans for an intensified cooperation with sports clubs but also advertising agencies.

Survival aid and harm damage

For drug addicts the risks of consumption shall be minimized as far as possible by information provision and by special offers, especially consumption rooms. Also services for alcohol addicts are using these methods which offer help to survive and harm reduction. In order to reduce deaths and damages to health caused by misuse of alcohol, Case Management and better cooperation between different helping fields (aid for homeless people, addiction aid, medical care) are requested. Meanwhile the concept of harm reduction damage is pursued very obviously also in the field of legal drugs.

Treatment

Access to helping offers shall be improved by a common phone number for the drug hotline. Interfaces between out-patient and in-patient offers shall be improved. Quality assurance shall be guaranteed by certificates of quality, common standards for follow-up and networks of competence. Addictive clients with psychological problems have to be followed very carefully as there exist only few facilities for these people up till now. The special needs of women and migrants shall be considered in a suitable way. Due to new legal regulations there are possibilities of supporting self-help activities financially by health insurances and responsible bodies of rehabilitation. Substitution treatment shall be completed more and more by complementary psychosocial and psychotherapeutic measures. After the evaluation of the demonstration project for heroin supported treatment the results shall be considered in the development of helping offers.

Prosecution

A reduction of offer shall still be obtained by the prosecution of drug trafficking and control of preceding substances, but especially by measures for the development of an alternative cooperation in the producing countries of heroin and cocaine. On the part of prosecution a close cooperation between customs authorities and police on national and federal level is necessary. Also a close cooperation with the EU member states and the neighbour states especially with East and Southeast Europe, is considered as absolutely essential.

Evaluation and further development

The legal frame how to deal with drug problems is set up by regulations. It is planed to pursue and analyse the consequences of individual decisions in their effects.

Concerning substitution treatment the process within BUB-guidelines concerning evaluation of medical examination and methods of treatment by doctors (BUB-guidelines) was considerably simplified beginning 28.10.2002. The group of people being allowed to take part in a substitution treatment was expanded to all manifest opiate addicts without further restrictions. For the beginning of treatment no application of a doctor at a health insurance association is necessary. However, there has to be made a notification to this association which is carrying out spot checks concerning the quality of completed treatments. Moreover;

a notification to the substitution register mentioning name of the patient, means of substitution and name of doctor is necessary.

For a number of targets mentioned in the available programme, measures and indicators for the evaluation of results shall be defined.

In the next years research shall be mainly supported in areas where reasons are especially examined gender-specifically in order to achieve an improvement and efficient organization of secondary prevention, prevention and treatment.

Apart from the special importance of alternative development cooperation between Germany and the countries producing heroin and cocaine, the plan emphasizes the important meaning of cooperation within the European Union (Drug Activity Plan 2000-2004), EMCDDA, Europol and UNDCP.

Demonstration and research projects

A number of regional and local model projects have been supported financially by integration funds of the Federal Ministry of Interior Affairs in order to get easier in touch with young migrants being at risk to become addicts. The project for “Early Intervention for First Notified Drug Users (FreD)” was carried on by the Federal Ministry for Health and Social Security in cooperation with many Federal Laender. The results of the project shall be transmitted into other regions in the course of 2003 and the respective experiences shall be used for future applications.

The preparation of contents of prevention for media coverage is a central subject on the website drugcom.de, offering self-tests as well as access to an individual consultation especially for young people with drug problems. The project is promoted by the Federal Centre for Health Education (FCHE).

The Federal Ministry for Health and Social Security was promoting a number of research projects in 2003 serving especially the improvement of prevention and treatment of drug addicts. Results were published concerning evaluation of drug consumption rooms (ZEUS 2000) and diseases caused by addiction of women (Zenker 2002). Running projects deal with the special health risks of children of addicts and possibilities of help. New attempts concerning treatment of most heavily dependent addicts who could hardly be reached by helping offers, shall be examined and evaluated in the study of “heroin supported treatment of opiate addicts”. The study in which altogether 1.120 patients shall take part, started in March 2002.

Further funds for research have been made available within the project “focal promotion for drug research” by the Federal Ministry for Research and Education, whereas particular attention is paid to the fields of alcohol and tobacco. The development of alliances between science and practice as well as transfer of knowledge are also very important subjects.

1.1.3 Coordination

Within the federal structure of Germany the responsibility including financial affairs for the areas of health and prosecution lies mainly with the Federal Laender. The Federal Government develops in the field of addiction and drugs a common strategy on national level and defines the details of political targets concerning drugs. This is achieved on one hand by establishing national action plans (Action Plan Drug and Addiction) and on the other hand by legislation of the Narcotic Law (BtmG) . Another possibility is the implementation of model projects. They are important for the testing of new methods and forms of organization for a limited time. Prevention is especially promoted in different areas by the Federal Centre for Health Education (FCHE), a subordinated authority of the Federal Ministry for Health and Social Affairs.

Implementation of the Action Plan

Many persons and institutions of the Laender, associations and other social groups were involved in the installation of the Action Plan Drug and Addiction. The implementation of the Action Plan shall be accompanied by a council for drugs and addiction consisting of all social groups and institutions being relevant for the addiction area. These persons shall support the realization of the measures in the respective responsibility areas and the council for drugs and addiction will examine the results. The plan shall become effective mainly by cooperation (with sports clubs, mass media, youth welfare and kindergartens).

The conference of the Laender's Ministers for Health has notified the Action Plan and supported a number of detail targets. Individual Federal Laender made clear that they have a different list of priorities concerning consumption rooms, heroin supported treatment and limitation of advertisements for alcohol and tobacco products. The Federal Laender and the local authorities are to a large extent responsible for the realization of the plan. However, an extension of the offers is very unlikely due to extremely financial problems. In single cases helping offers have rather been reduced already.

1.2 Legal framework

1.2.1 Basic changes of the legal situation concerning reduction of demand

The Narcotic Law (BtmG) contains all basic regulations to deal with these substances. It takes into consideration UN conventions for this area. Substances regarded as narcotics (Btm) according to the German Narcotic Law (BtMG) are listed in three schedules containing all substances mentioned in the international conventions on addictive substances.

- Schedule I: Narcotics which are forbidden generally, no trade allowed (for example MDMA, heroin)
- Schedule II: Narcotics, for which trade is allowed, but which cannot be prescribed (for example Delta-9-tetrahydrocannabinol (THC), dexamphetamine)
- Schedule III: Narcotics, for which trade and prescription are allowed (for example amphetamines, codeine, dihydrocodeine, cocaine, methadone, LAAM, morphine and opium).

The prescription of narcotics (from schedule III) as part of a medical treatment has to follow the special rules of the regulation on the prescription of narcotics (Betäubungsmittel-Verschreibungsverordnung (BtMVV) . So special narcotics-form-sheets have to be used.

There was no essential revision of the Narcotic Law (BtmG) during the period under review. The last changes in the regulation on the prescription of narcotics (BtMVV) have been collected in table 1.

Table 1: Current changes concerning the Narcotic Law

Law came into effect	Amendments	CHANGES
01.07.2002	15th Amendment of the Narcotic Law	Qualification (addiction therapy) of general practitioner practising substitution is determined Introduction of a central reporting system for the prescription of substitution substances Buprenorphine and levacetylmethadone are added to the list of substitution substances
28.11.2002	16th Amendment of the Narcotic Law	Isocodeine is added to the schedule II of the Narcotic Law zolpidem and gamma-hydroxy-butyric acid are added to schedule III of the Narcotic Law, each in a restricted form depending on the amount of active substance and how the substance is administered
12.02.2002	17th Amendment of the Narcotic Law	ester and ether of GHB have been cancelled in schedule II

1.2.2 Legal framework concerning reduction of demand

The Codes of Social Law are defining the legal framework for the agreement to cover costs concerning treatment of addiction. These costs (for weaning) are born by the pension scheme. Costs for physical weaning (detoxification) and for substitution-supported treatment are born by the legal health insurance companies. By passing the Ninth Book of the Code of Social Law (SGB IX) “Rehabilitation and participation of disabled persons” and its entry into force on July 1st, 2001, additional rights were granted to addictive people and responsibilities of health insurances and the pension scheme could be better cleared up and coordinated. Moreover, the demands placed on institutions offering treatments were partly revised and the crossing points between form of performance (out-patient, partly out-/partly in-patient and in-patient) simplified.

1.2.3 Further important projects

1.2.4 Legislation concerning international trade

For a better control of original substances used for the production of illegal drugs the supervision of domestic and third country trade with raw material in the European Union has been laid down by law (Precursor Control Act of 1974, last amendment in 2002).

1.3 Laws implementation

1.3.1 Realization of legal targets and strategies

In its present issue the Narcotic Law offers extensive possibilities to terminate criminal proceedings already by the public prosecutor. In the past there were many reports about a different judicial practice in the individual Federal Laender. An earlier study (Aulinger 1997) showed that practice of criminal proceedings concerning possession of cannabis for personal use is carried out in a relatively uniform way. Against the background of considerable changes in the meantime, the practice of prosecution is currently being observed again on behalf of the Federal Ministry of Health and Social Security. They observe at the same time how the behaviour of taking drugs is effected by essential penalties.

An evaluation shall probably be carried out for two special legal requirements: §§35 ff of the BtmG offers since 1982 the possibility to start a therapy under suspension of punishment (“Therapy instead of Punishment”). This possibility is used very often. However, in many cases suspension is abolished, that is to say that the consumer of drugs changes from therapy to punishment again. The reasons for this are unknown.

Under certain conditions §31a of the BtmG allows to abstain from prosecution for the possession of drugs for personal requirements. As there are no standardised marginal values of the critical substance amounts in the Federal Laender, conformance of juridical practice is not clear.

Actually the German Federal Institute for Traffic is carrying out a research programme in order to examine the effects of the new legal basis enacted on January 1st, 1999, for the examination of applicants for a driving licence with regard to the possession of drugs and driving under the influence of drugs.

The Federal Government has basically reorganized substitution-supported treatment. For this reason special professional standards were determined for the treating physician and a comprehensive approach of therapy was pointed out. By request of the Federal Government the Federal Commission of Doctors and Health Insurances has adapted the guidelines about the evaluation of medical methods of examination and treatment ("BUB-Guidelines") with regard to the substitution-supported treatment of opiate addicts to the legislative amendment on 28th October 2002. These guidelines are valid for all treatments financed by the legal health insurance (GKV).

1.3.2 Politics of Prosecution

A change of priorities and targets concerning prosecution cannot be recognized on national level. Appropriate studies or statistics are not available right now. Generally the main emphasis in prosecution is put on drug trafficking and smuggling. There is a great number of consumption offences facing also a great number of terminations of proceedings.

1.4 Developments in public attitudes and debates

1.4.1 Public understanding of drug topics

Actual public opinion polls show clearly that the majority of the population is still against a further liberalization. According to a representative EMNID-survey carried out in August 2001 62% support the actual prohibition of cannabis. Regarding this result divided into age-groups, it becomes obvious that the number of supporters of this approach among young people is lower, approximately 40%, than among older people. But also amongst young people only about every fourth person supports a legal trade with cannabis for adults. Further details concerning this survey can be found in the REITOX report of last year.

1.4.2 Public discussions concerning subject drugs

Despite of the generally low interest in drug policy in the population, during the last years the subject „Legalization of cannabis consumption" revived again and again in public debates also in Germany. Individual groups of people have started campaigns for legalization trying to influence also opinion leaders via internet. In February 2002 political decision makers and scientists out of five European countries (including Germany) met in Brussels at an international conference in order to inform themselves about the actual state of research. In some central statements the final report corresponds amongst others to the results of a recent French study (INSERM 2001). A conference booklet of this meeting is available (Spruit 2002; Ministry for Health Belgium, 2002). At present this cooperation is continued on the basis of an action plan for the research on cannabis.

Activities towards legalization respectively depenalisation of cannabis are finding relatively little public attention outside the respective groups of interest. Nearly none of the political parties and no well known politician takes seriously care of this subject. The public discussion is ruled by questions concerning economy, unemployment and costs for health care.

1.4.3 Drugs in the Media

The discussion concerning the use of cannabis as medicine is still going on. The admission of new cannabis medicaments in the Netherlands met with a big response in the media.

1.5 Budgets and funding arrangements (2002)

1.5.1 Direct financing of drug-related subjects

Due to a change in the collection and summary of information by the Federal Laender for the reference year 2002 there are no actual financial data of the Laender available for 2002. Concerning federal budget and insurance there are data available for the year 2001.

For measures for the fight against the misuse of drugs and addictive substances the Federal Ministry for Health and Social Security had altogether a budget of 13.6 mio. Euro in the financial year 2002 (2001: 13.6; 2000: 13.9; 1999: 12.3) at its disposal. This field includes legal and illegal substances. Financial data concerning only illegal drugs are not available. The biggest share of the means, the amount of 6 mio. Euro, was provided for preventive measures. Model projects were promoted with 5 mio. Euro out of Federal means. Research and investigation in the field “drug and addiction” have been supported with roughly 1 mio. Euro out of means of the FederalMinistry for Health and Social Security. The work of the DBDD as well as investigations concerning basic indicators (surveys, treatment demand) were promoted with approximately half a million Euro altogether.

Expenses for (secondary) illnesses and physical detoxification are generally paid by the health insurances. In-patient and out-patient medical rehabilitation are paid by the pension insurances. In 2001 the legal pension insurances spent altogether approximately € 493 Mio for rehabilitation and other services for addictive illnesses (alcohol, pharmaceutics, drugs). Whereas the biggest part of the expenses is spent for in-patient treatment (77%) and financial help on a temporary basis (15%); help measures (3%), out-patient treatment (3%) or additional treatments (2%) have a subordinated role. Due to the statements of the legal pension insurances concerning the division of cases into alcoholic, pharmaceutical or drug-related problems it can be roughly estimated that drug addiction causes approximately 24 % of all expenses (Table 2).

Table 2: Budgets for drugs and addiction in Germany 2001/2002

Institution	Field of activities	(Mio. €)	
		Addictive Substances (no further specification)	Drug and multiple addiction[1]
Federal Ministry for Health[2]	Education in the field of misuse of drugs and addictive substances	6.1	
	Models in the field of misuse of drugs and addictive substances	5.0	
	Financial support for research and development projects in the field of misuse of drugs and addictive substances	1.0	
	Support of central facilities and associations	1.0	
	Support of national information focal points in the field of addiction	0.5	
Federation of German Pension Insurance Institutions (VDR)[3]	Inpatient services	379.2	100.5
	Outpatient services	14.5	1.5
	Bridging payment ("Übergangsgeld")	75.9	18.0
	Additional support	14.3	3.4
	Other services	9.3	2.2

In 2001 for altogether 9.767 treatments (especially for in-patient and partly for out-patient detoxification) were approved by the legal pension insurances (GVR) for psychological and behavioural disorders caused by pharmaceutics and drugs. The biggest number of treatments (7,041) are within the category "psychological and behavioural disorders caused by multiple substance use and the use of other psychotropic substances" which includes multiple use as well as other not specified substances. Moreover problems caused by opiates (1.906) are of importance (Table3).

[1] Factor is the proportion of finished rehabilitations because of drug and multiple addictions of all finished rehabilitations financed by public pension insurances in 1997 (VDR-Statistik Rehabilitation 1997 und 1999)

[2] Source: personal statement of the Federal Ministry for Health2002

[3] VDR-statistics rehabilitation 1999 (Federation of German Pension Institutions 2000)

Table 3: Payments by pension insurances

Payments for the treatment of psychological and behavioural disorders caused by…	Number of payments
Opiates	1,906
Cannabinoids	299
Sedatives and hypnotics	243
Cocaine	258
Hallucinogenics	13
volatile substances	7
multiple substance use and use of other psychotropic substances	7041

Source: VDR statistics rehabilitation 2001 (Federation of German Pension Institutions)

1.5.2 Direct financing of drug subjects in different areas

In addition to chapter 1.5.1 a further diversification of the used means is not possible for the reference period.

1.5.3 Results of national surveys of expenses

No surveys in relation to the recording of financial performances have been carried out in the reference period.

Part II EPIDEMIOLOGICAL SITUATION

2 Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

2.1.1 Overview of most important characteristics and developments of drug situation

The results see below allow a description of several types of drug users, even if the groups cannot always be clearly separated from each other.

- Persons who use drugs only few times before they stop the consumption again.
- Persons who have been using this drug for a certain period in life. They frequently live inconspicuously and without major problems and without further illegal drug use.
- Young groups of users with multiple drug use, which are less specific with regard to the choice of drug. Cannabis is in first place but ecstasy meanwhile is also used very frequently. This group is at least partly associated with the rave scene, where MDMA is particularly active (e.g. at techno and rave parties). Other drugs, however, have also made their way into this scene. In particular there is evidence of an increase in LSD and cocaine.
- The group facing the most difficult circumstances continues to be that of heroin addicts. Alongside heroin they have a considerable cannabis, cocaine and alcohol consume and alternative a misuse of medicaments.
- Users of cocaine who take no further drugs are statistically more common than heroin users. They are, however, clearly more inconspicuous as users of heroin - according to information from hospitals, counselling centres and other social institutions. In addition to results from general population surveys, it is chiefly the high volumes seized which point to a comparatively wide distribution of this drug.

2.1.2 New trends

While until a couple of years ago cocaine was almost exclusively used as secondary drug by heroin users there is a general increase in primary cocaine users in the meantime. Today the number of cocaine users seems considerably higher than the number of heroin users. Cocaine is much more frequent in urban or metropolitan areas but still rare in Eastern Germany.

Although Treatment statistics show, that persons with a mono cocaine use report fewer problematic somatic or social consequences than heroin users. An in-depth study in this field is running at the moment.

The clearest increase of drug use has been observed for cannabis. Recent police data indicates that the number of users has increased since the last survey in 2000. First results from a school survey (Health Behaviour of School-aged Children (HBSC)) show for about 15 years old male pupils in class 9 an increase of drug use prevalence from 17% to 22% for the last year, while the figures for girls remained stable. The distribution of Ecstasy has been stabilised, while amphetamines increased clearly.

2.1.3 Drug trends in wider social context

Most drugs are at least for drug experienced persons easily available in the entire Germany. Although there are indications, that in some regions pulverized cocaine was difficult to find on the market. This was a reason that the use of crack was reinforced.

2.2 Drug use in the population

2.2.1 Main results in the general population, school and youth population

Over the reporting period no new data and surveys have been received. Therefore only the most important sources are described and some basic data of the last population surveys were repeated. More details are available in the previous REITOX reports.

Data sources

Epidemiological sources on drug consumption and drug users in Germany are mainly based on regular representative population surveys and prevalence studies.

The Drug Affinity Study is a long-term examination of tobacco, alcohol and illegal drug use of young people and young adults and its underlying motives and preconditions. The next study will take place in 2004.

The Representative Survey on the Use of Psychoactive Substances is a questioning in written from on the use of psychotropic substances, its consequences and assessment as well as other framework data. The survey is carried out among a representative sample of 18 to 59 year old resident population every 3-4 years. The last survey took place in 2003. First results will be available at the beginning of 2004.

The Federal Laender Bavaria, Berlin, Brandenburg, Hesse, Mecklenburg-Western Pomerania and Thuringia are actually participating ESPAD, the international school survey for the use of psychoactive substances. Results will be available in the next national report (see 8.2.6).

In the study “Health Behaviour in School-aged Children” (HBSC) four Federal Laender (Berlin, Saxony, Hesse, North-Rhine-Westphalia) have been involved. The present survey provides also data on illegal drug use. The next REITOX report will refer to the results.

On behalf of the Federal Laender and city states regional or local prevalence studies were conducted from time to time. Those studies focus on specific substances, their extent, consequences and patterns of use or on features of a certain group of drug users. In Berlin,

North Rhine-Westphalia and Rhineland-Palatinate (2000) as well as in Hamburg (1997) local surveys have been carried out in the framework of the Representative Survey on the Use of Psychoactive Substances. Regional samples were additionally funded by the Federal Laender. In Saxony-Anhalt the Study on Modern Drug and Addiction Prevention (MODRUS II) was carried out for the second time, and a third collection is planned for autumn 2003. Subject were patterns of drug use, opinions etc. (Böttcher et al. 1999).

Due to the described situation of data in the following only the most important data will be shown. More detailed information is available in the last REITOX report 2001.

Lifetime-prevalence

The Representative Survey on the Use of Psychoactive Substances of Adults in Germany shows that 19.8% of all 18 to 59 year old adults questioned have used drugs at least once in their life (lifetime prevalence) 21.8% in the old Federal Laender and 11% in the new Federal Laender (Kraus and Augustin 2001). This corresponds to about 9.4 million adults with drug experience in the total population of Germany . 23.4% of men have made drug experience - obviously more often than women (16.0%). In the group of younger adults aged between 18 and 39, the proportion of people with drug experience is even 29.5%. In the new Laender the prevalence rate in this age-group is 19%. More than a quarter of all German teenagers and young adults (12 - 25 years) have made experiences with illegal drugs at least once in their lifetimes (table 4).

12-month-prevalence

In many cases, experience with drugs means a one-off or only infrequent use of drugs. After the drug was “tried” in most cases its use is completely discontinued in the course of the next few years. Lifetime drug use is therefore only a rough indicator of the extent of drug use at a given point in time. The figure includes people reporting experience with drugs going back 20 or 30 years. Drug use in the 12 months prior to the survey therefore is a better indication of current user numbers (12-month-prevalence).

In the meantime there are around 5.2% of adults between 18 and 59 years in the new Laender stating that they used illegal drugs within the past 12 months. 13% stated that they have already used illegal drugs (BZgA 2001) (table 4).

30-days-prevalence

3.6% of all adult men and women in the old Federal Laender and 2.6% in the new Laender stated in the Representative Survey that they have been using illegal drugs in the last 30 days prior to the questioning (Kraus and Augustin 2001). In the Drug Affinity Study (BZgA 2001b) no data on 30 days prevalence rates were collected (Table 4).

Table 4: Prevalence of illegal drugs in Germany

Source	Age-group	West	East	Total	Population per age-group	Projection total population
Lifetime-prevalence						
DAS ’01	12-18	n.a.	n.a.	17%	≈ 5 530 000	≈ 940 000
BUND ’00	18-39	29,5%	19,0%	27,6%	≈ 25 726 000	≈ 7 100 000
BUND ’00	18-59	21,8%	11,0%	19,8%	≈ 47 640 000	≈ 9 433 000
DAS ’01 BUND ’00	12-59	n.a.	n.a.	19,5%	≈ 53 170 000	≈ 10 373 000
12-month-prevalence						
DAS ’01	12-18	n.a.	n.a.	11%	≈ 5 530 000	≈ 608 000
BUND ’00	18-39	11,0%	9,5%	10,7%	≈ 25 726 000	≈ 2 753 000
BUND ’00	18-59	6,5%	5,2%	6,0%	≈ 47 640 000	≈ 2 858 000
DAS ’01 BUND ’00	12-59	n.a.	n.a.	6,5%	≈ 53 170 000	≈ 3 467 000
30-days-prevalence						
BUND ’00	18-39	7,9%	3,8%	5,9%	≈ 25 726 000	≈ 1 518 000
BUND ’00	18-59	3,6%	2,6%	3,3%	≈ 47 640 000	≈ 1 572 000
DAS ’01 BUND ’00	12-59	n.a.	n.a.	n.a.	≈ 53 170 000	n.a.

Source: Drug Affinity Study 2001 (BZgA 2001b); Representative Survey 2000 (Kraus and Augustin 2001)

1.) Statistisches Bundesamt 2001 (31.12.2000), (numbers were rounded off for a better over view)

2.) The conversion of the total population is to be seen as an approximation. Figures have been weighted and rounded off for a better overview.

Cannabis

Cannabis is the illegal drug most frequently used in Germany. 21.4% of all questioned Western Germans and 10.8% of all questioned Eastern Germans (18-59 years) have used cannabis at least once in their lifetime (Kraus and Augustin 2001). Cannabis is mostly used by 18-29 years old West German men (lifetime prevalence 40.4%; 12-moth-prevalence: 21.1%; 30-days-prevalence: 13%).

Amfetamin

About 3% of all persons aged 18 to 39 years have used amphetamines in their lifetime. With prevalence rates of 3.1% in the West and 2.9% in the East in this age-group amphetamines are as frequent in the West as in the East. Prevalence data of the last 12 Month are in 2000 1.1% (West) re. 0.8% (East). Amphetamine use is most frequent among 21 to 24 year olds (lifetime-prevalence: 5.6%; 12-moth-prevalence: 3.0%) (Kraus and Augustin 2001). The Drug Affinity Study 2001 shows that its use is less frequent among teenagers and younger adults (lifetime-prevalence and 12-moth-prevalence: 1.0%) (BZgA 2001).

Ecstasy

In 2000 Ecstasy is the only drug with higher lifetime and 12-months prevalence rates of 18 to 59 year olds in the East than in the West (Kraus and Augustin 2001). This is due to the drug use of younger interviewed persons. 6.5% of all those questioned in the new Federal Laender and 4.4% of those in the old Laender agreed that they have made experiences with ecstasy. During the last 12 months 1.9% of all 18 to 29 year old in the West and 2.8% in the East were using ecstasy. Among elder questioned Ecstasy is less prevalent, there are nearly no differences between East and West. In the Drug Affinity Study 4% of all 12 to 25 year olds have ever used ecstasy in their lives (BZgA 2001).

Cocaine

The lifetime prevalence of cocaine use within the age-group 18 to 39 years has been in 2000 3.8% (west) and 2.9 (east) (Kraus & Augustin 2001). 2% of all teenager and younger adults (12 to 25 years) have ever used cocaine before (BZgA 2001).

LSD

2% of all adults in the West and 1.1% in the East of Germany have ever used LSD in their lives, 0.2% in the last 12 months (in both parts of the country). Recent LSD use was most frequent among 18 to 20 year olds (West: 1.5%; East: 2.2%) (Kraus and Augustin 2001). The results of the Drug Affinity Study confirm that LSD plays only a minor part among younger drug users (BzgA 2001).

Heroin and other opiates

Heroin and other opiates are used only to a very small extent by the general population. The Representative Survey 2000 gives a corresponding image: 0.5% of all 18 to 39year olds in the West and 0.7% in the East have ever used heroin in their lives. In the last 12 months prior to the study these were 0.2% resp. 0.3% (Kraus and Augustin 2001). Heroin is not common among teenagers of younger adults as show the results of the Drug Affinity Study. Here the lifetime-prevalence is 0.2% in 2001 (BZgA 2001b).

In the Representative Survey lifetime-prevalence of other opiates (e.g. codeine, opium, morphine) are 1% among 18 to 39 year olds, the 12-month-prevalence is 0.2%. Methadone is not very important either (lifetime-prevalence 0.2%; 12-months-prevalence 0.1%) (Kraus & Augustin 2001). Prevalence and estimates for heroin use are subject to limited significance when based on population surveys, because it is not frequent and prosecuted (see 7.3). Therefore it may be underestimated considerably.

Mushrooms containing psylocibine

Since February 1st 1998, mushrooms containing psylocibine fall under the narcotic law. Among other natural drugs those psychotropic substances have been becoming more frequent in the last years. The largest lifetime prevalence of mushrooms containing

psylocibine and fly agarics is 7.2% among 18 to 29 year old East German men, among West German men in the same age-group the prevalence rate is 5%. Among women the highest prevalence rate is 3.3% (18 to 29 year old women in West Germany). Recent use in the last 12 months is only reported by persons under 30 years. Here too the respective percentage is highest among18 to 29 year old East German men (3.3%), followed by West German men (2.5%), West German women (1.2%) and East German women (0.5%). Use of mushrooms containing psylocibine was not subject of the Drug Affinity Study.

2.2.2 Specific groups

For specific groups there are no data available in 2002. For further information see chapter 12 and 16 of the REITOX-report 2001.

2.2.3 Trends and their causes

Concerning the increase of crack consumption in Hamburg and Frankfurt the better disposability of crack cocaine compared with pulverized cocaine might play a role. The strong growing of the use of cannabis has to be seen on the background of a reduced risk assessment in the general population.

2.3 Problem drug use

The term „problematic drug use“ is not standardized. Although for special subareas (e.g. prevalence estimate) working definitions according the EMCDDA exists. Basically drug use is assessed to be problematic, if it is

- connected with risks (risky use)
- harmful use or (F1x.1)
- dependency (F1x.2x) according to a clinical diagnosis (ICD or DSM)
- harm caused to other persons or
- connected with negative social consequences or delinquency

Independent of this factors drug use can also be problematic if the user in person has the feeling that he is a problem drug user (Kleiber, Soellner 1998).

The mentioned working definitions cover respectively different subsets of the described group. Only terms based on clinical classification systems are described definitely. Definition and understanding of the concept can vary widely with other terms like “risky drug use”.

To some extent there are considerable methodical difficulties in assessing the data from existing survey systems or studies in detail to establish whether they allow conclusions to be drawn as to the overall spread of problematic or harmful use. Police data can only provide information about the higher probability of seizures of intensive drug users as a pointer for problematic drug use, while studies can be useful for additional information (frequency of consumption, circumstances). Clinical Tests can be used for differentiations. Best

assignment is possible in the field of treatment, where staff members have got a special training or experience in diagnostics.

In addition to the inherent methodical difficulties in defining problematic use, there are a series of specific difficulties affecting statistical surveys in the area of illegal drugs. A series of investigations have shown that in surveys users of ‘hard drugs’ tend only to report correctly the use of "soft" drugs such as hashish or LSD, whilst denying the use of heroin, for example, or understating the frequency of use and the dosage.

Whereas representative surveys are able to provide valid statements on experimental drug use and lighter forms of multiple or permanent drug use the group of so-called “hard users” must be seen as underrepresented. Moreover, in their case the extent of the problem is “under-reported”. The more detailed the information on the pattern and details of use, such as quantity, frequency, method of administration etc., the more difficult it must be - considering the large amount of information needed - in the context of representative samples to portray adequately in particular that group of people already affected by harmful use, abuse or addiction. Methodological problems and some studies in the context of the representative survey are published by Kraus et al.(1998). For the reasons given, additional information is required, particularly in the area of "problematic use". This must above all take into account the groups of users that are under-represented in the representative studies. Here the most appropriate data takes the form of treatment statistics describing the use made of medical or welfare establishments dealing with substance addiction or abuse.

2.3.1 National and local prevalence estimates of drug use

The following data are based on a recalculation of the estimates, which were done by Kraus and Augustin 2002. The method was used analogue to the EMCDDA guidelines. Kraus et al. (2003) describe the proceeding exactly. An update of the estimates was not done due to the fact that no new data were available and the treatment figures of the reporting facilities show a weaker basis in 2001. For this reason the estimates refer to the year 2000 - a standardized reference year - and belong comparable. An update is intended for the REITOX report 2003. To give a complete overview, figures from last year were reported again in this chapter.

Figures from treatment facilities and drug related deaths lead to estimate the number of problematic drug users (opiates) for Germany between 153.000 and 198.000 persons. Due to limitations of data no separate estimate for drug injectors was possible.

The demographic method and the estimation on the basis of the HIV cases give lower estimates between 90.000 and 160.000. If the range is limited to those upper und lower boundaries, which are included at least by half of the methods, it is 150.000 to 160.000. The multivariate indicator, whose method includes several other indicators, is at the upper limit of this range already for the old Laender (West Germany). The new Laender still show much lower prevalence rates, but they cannot be ignored for a total estimation. Taking into consideration the estimates based on the broadest sets of data - police and treatment - a total number of 150.000-175.000 cases of problematic users of opiates is assumed for Germany (Table 5).

Table 5: Comparison of estimates for the year 2000 from different estimation methods

treatment	Police	Mortality	Demographic method	Extrapolation from HIV cases	Multivariate Indicator [1]
166.000-198.000	153.000-190.000	127.000-169.000	128.000-160.000	90.000-158.000	160.000

[1)] Old Laender only (West Germany)

If one considers only those three methods, which have produced estimates for 1995/97 and 2000, they indicate a clear increase in the prevalence of problematic opiate use between 1995 and 2000 (Augustin & Kraus in press). Part of this increase is caused by the multipliers. Through recent research results these have become more reliable, which has resulted also in an upwards adjustment. The real increase in cases therefore might be overestimated for treatment and mortality, while the estimation procedure for police data remained rather stable. Altogether an increase in cases of about one quarter can be assumed (table 6).

Table 6: Comparison of estimates from different years

Method	Estimate on the basis of data from the years 1995	Estimate on the basis of data from the year 2000
Treatment	78.000-124.000	166.300-198.000
Police	131.000-142.000	153.000-190.000
Mortality	78.000-104.000	127.000-169.000

The quality of estimates has improved considerably compared to former years. Several studies in the meanwhile allow to use empirically based figures instead of expert ratings for example for the access rate of drug addicts to treatment. Other factors also influence the results, e.g. the decreasing mortality of drug users as a consequence of the extension of substitution treatment. The factors have the tendency to underestimate the number of problematic drug users.

Problematic drug use at local level

Surveys on problematic drug use in German drug scenes are mostly conducted at irregular time intervals on an ad-hoc basis. As part of the Hamburg Project NOX - an inpatient counselling and treatment centre for homeless drug users of the open Hamburg drug scene - the clients (n = 166) were asked, among others, about their drug use (Prinzleve 2000). 75% of all persons interrogated stated that they had taken more than one substance on each of the previous 30 days before the survey. 82% regularly used heroin, 75% cocaine, 51% benzodiazepine, 38% cannabinoids, 32% methadone and 37% alcohol. Heroin and cocaine were intravenously applied by little less than 90%, benzodiazepines by slightly more than 40% of the clients.

A study currently conducted on crack use in Germany (Stöver 2001) confirms that crack is common use in specific scenes of the metropolises Frankfurt and Hamburg. However, the

results of the study do not suggest at present the existence of a nationwide ‘crack wave’. It remains to be analysed and observed whether crack is and remains a phenomenon of specific scenes in large cities (“open drug scenes”, availability of drugs due to closeness to seaports and airports).

There are two current studies analysing the group of crack-users in the local drug scenes of Frankfurt am Main and Hamburg. In Frankfurt Vogt, Schmid and Roth (2000) investigated three different sources of data: an interview of 59 crack users in cafés and drug consumption rooms (study 1), and interview of 312 users of beds provided by the AIDS-Aid for recovering during the day (study 2) as well as data from 2.160 clients registered in the “JJ basis monitoring system” (different institutions of treatment) in 1999 (study 3). In all three studies the mean age of women is slightly below 30 years, the mean age of men is slightly above 30 years. About two thirds of all persons were German citizens. One quarter (study 2) was registered in Frankfurt and only a small portion was living in an own apartment (study 1: 33% men; 27% women; Study 2: 9%men, 2% women; “JJ basis monitoring system”: 32% men; 61% women). In the first study all of the 59 interview persons were crack users, in study 2 (312 interviewed persons) 28% of men, 47% of women and in the “JJ basis monitoring system” 27% (men) resp. 26% (women) were crack users.

As data from the “JJ basis monitoring system” shows polyvalent patterns of consumption are predominant among crack users. For all substances mainly used there is a considerable use of additional drugs. Men and women with crack use more additional substances than those without crack use. Therefore crack users turn out to be a highly problematical group of drug users (Table 8).

Table 7: Polyvalent patterns of drug use of crack users

	Males		Females	
Drug use	Crack (n = 454)	No Crack (n = 1.176)	Crack (n = 137)	No Crack (n = 393)
Crack	100%		100%	
Cocaine	91%	80%	88%	80%
Heroin	87%	84%	90%	89%
Methadone	32%	26%	42%	28%
Codeine	38%	25%	44%	28%
Cannabis	84%	73%	73%	66%
Alcohol	67%	55%	62%	53%
Sleeping pills	49%	30%	56%	33%
LSD	47%	34%	39%	29%
Designer drugs	39%	26%	35%	24%
Tranquilizer	38%	27%	56%	35%

Source: Vogt, Schmid & Roth (2000)

In 1999 in the open drug scene of Hamburg 64 crack smokers were interviewed (Thane and Thel 2000). 63% were male (average age was 32 years), 37% were female (average age 29 years). This study also shows that smoking of crack is often accompanied by polyvalent drug

use. 83% additionally use cocaine, 75% heroin, 58% heroin and cocaine, 22% heroin, cocaine and other drugs. Only 8% use exclusively crack. 50% of the persons interviewed have a daily smoke of crack, 19 pipes on the average. The effects of the substance were reported to be 3 minutes on average.

2.3.2 Risk behaviour of drug users

To drug users a great risk is posed by the intravenous application of substances. Through the injection, the drugs directly get into the blood stream provoking a quicker and intense intoxicant effect. As quality and concentration of a substance may considerably vary, drug users are faced with an incalculable risk of infection and overdose. In this way, blended or filler substances also enter the blood circulation. Lower risk drug use such as smoking or sniffing of substances is often practiced by younger users.

In the German Drug Help Statistics (facility based information system for outpatient centres for the treatment of addicts) the drug application forms of patients treated on out-patient basis (2002: N = 95.468) have been also collected since 2000.

Table 8: Drug mode of application for clients in out-patient treatment

	Mode of application					
Substance	Injection	Smoking	Eating	Sniffing	Others	Total
Heroine	72,2%	16,8%	1,0%	9,0%	1,0%	6190
Methadone	3,2%	2,2%	93,9%	0,0%	0,6%	2838
Codeine	19,0%	5,7%	68,4%	5,7	1,3%	474
Other opiates	8,1%	9,3%	76,1%	0,3%	6,2%	356
Cannabis	0,3%	98,1%	1,4%	0,1%	0,1%	10281
Barbiturate	2,1%	1,3%	92,7%	0,2%	3,8%	478
Benzodiazepine	3,5%	1,8%	90,7%	0,8%	3,1%	1900
Other sedatives/ hypnotics	0,9%	3,3%	89,2%	0,5	6,1%	212
Cocaine	29,7%	21,9%	2,5%	40,4%	5,5%	3080
Crack	15,0%	51,2	2,4%	30,0%	1,4%	293
Amfetamine	3,0%	6,5%	52,8%	32,0%	5,7%	1757
MDMA	0,1%	1,6%	94,0%	1,5%	2,7%	2011
Other stimulants	1,5%	8,5%	53,7%	29,9%	6,5%	201
LSD	0,4%	5,6%	90,2%	0,9%	2,8%	673
Mescaline	1,5%	3,1%	92,3%	3,1%		65
Other halluzinogenic		10,4%	86,6%	0,7%	2,2%	268
Volatile substances		32,2%		67,8%		59
Other psychotropic substances	4,7%	13,2%	59,0%	5,7%	17,5%	212

source: Strobl et al.2003a, multiple response is possible

A difference is made between injecting, smoking, eating, sniffing and other forms of consumption. Heroin is the drug which is injected most frequently (72.2%) followed by cocaine (29.7%) (Strobl et al. 2003a). Cannabinoids (98.1%) and crack (51.2%) most frequently are smoked. All other substances are taken orally with the exception of volatile solvents (67.8%), cocaine (40.4%), amphetamines (32.0%), crack (30.0) and other stimulants (29.9%) which are snorted. German Drug Help Statistics do not survey drug use patterns in relation to combined drug use (e.g. heroin-cocaine-cocktails) (Table 9).

The danger of infection is particularly high with the shared use of utensils to prepare and inject the drugs (injection needles, spoons, water for dissolving the drug or cleaning the needle, cups, filters, stirrers). The following table, containing data about needle sharing, refers to some studies and their results.

Table 9: Studies with focus on needle sharing

Study	**Rotily, M., Weilandt, C., (1999). Multizentrische Studie „European Network on HIV/AIDS and Hepatitis Prevention in Prisons"**
Sample size and setting	N=437, criminal justice system Cologne
% Sharing	27%
Study	**Meyenberg, R., Stöver, H., Jacob, J., Popeschill, M. (1999). Infektionsprophylaxe im Niedersächsischen Justizvollzug**
Sample size and setting	N=142, prison Vechta and Lingen (Lower Saxony)
% Sharing	42%

3 Health consequences

3.1 Drug treatment demand

3.1.1 Number of people receiving treatment and trends

The annual German drug help statistics is based on data from a total of 95.468 people from 454 outpatient drug aid facilities. Out of this number 20.889 people received treatment due to drug problems. The remaining clients received treatment to a large extend due to alcohol problems. The current annual evaluation of 2002 covers with 454 facilities approximately 43% of all 1049[2] out-patient counselling and treatment facilities in Germany. Assuming that the remaining facilities see as much clients as the facilities covered by the German drug help statistics, there is a total of 46.600 clients receiving out-patient assistance to illegal drug problems in 2002. Measured by the number of withdrawal treatments financed by pension insurance institutions, the cover quota amounts to roughly 26% in inpatient treatment[3]. The evaluation of the treatment situation of drug users in Germany, made on the basis of the data on hand, can be qualified as sufficiently reliable.

In comparison with population surveys, treatment documentation statistics have the advantage of including the group of hard drugs users which apparently escapes from representative surveys leading to distorted results. On the other hand, particularly in the case of data from treatment monitoring systems, one has to acknowledge that there are limits on how representative they are, as their clients are not representative for all drug users.

[2] Länderkurzbericht 2001 (BMG 2002)

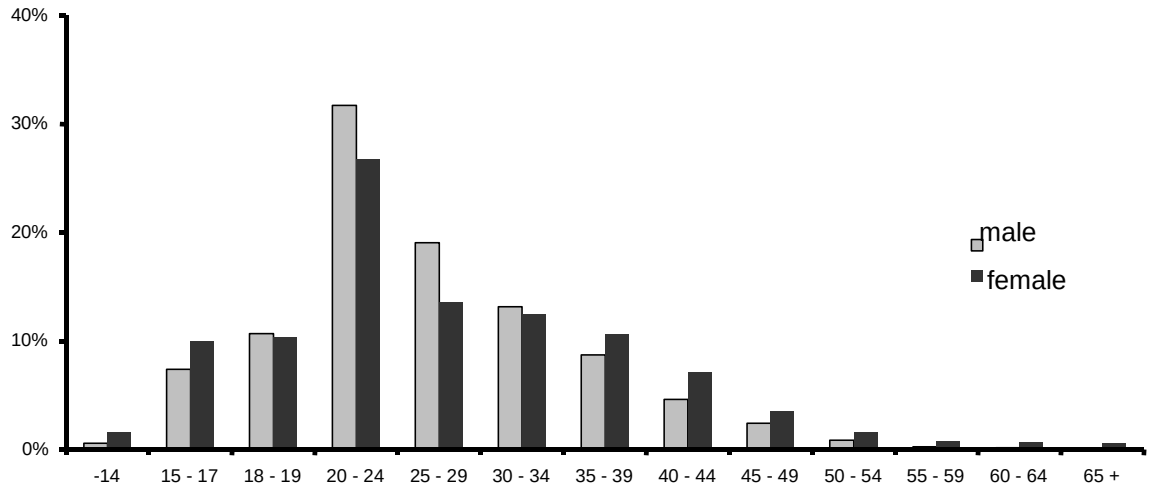
[3] VDR-Statistik Rehabilitation 2002, table 55M (VDR 2002)

3.1.2 Characteristics of drug users

Sociodemography

In the year 2002, almost 80% of all 20.889 clients in outpatient treatment were men. Over 80% of all male and 72% of all female clients were between 15 and 34 years old (figure 1).

Figure 1: Percentage of age patients in out-patient treatment (2002)



source: Strobl et al.2003a

83% of the clients treated in outpatient counselling and treatment facilities are Germans (Strobl et al. 2003). 1.6% come from European neighbour countries, 6.3% from non-EU member states like ex-Yugoslavia, Turkey or from the former Soviet Union. Drug-related problems differ between German and foreign clients. In both groups however, alcohol clearly represents the primarily used substance. It accounts for 72% with the German group and for a considerable lower percentage, i.e. 48%, with foreign clients (from EU- and non-EU-member states). In the foreign group, the portion of persons treated for opiates amounts to 32%, in the German group to 14%. Cannabis plays an important role in both groups; 10% of the foreign clients and 9% of the German clients named the substance as the main reason for treatment (Strobl et al.2003a).

Diagnostic data in the out-patient treatment sector

For the year 2002, data on main diagnoses of a total of 20.889 people (old Federal Laender: 16.109 new Federal Laender: 4.780) who started counselling or treatment in outpatient psychosocial drug counselling centres due to problems in connection with the use of illicit drugs were collected in the German Drug Help Statistics (facility based monitoring and reporting system). The main diagnoses are based on the diagnostic criteria of the international classification system of the WHO (ICD 10) (Table 11).

Table 10: Most frequent main diagnoses, out-patient centres (German Drug Help Statistics)

Main diagnoses harmful use/ dependency			Germany	East	West
(ICD10: F1x.1/F1x.2x)	Males	Females	Total	Total	Total
	16.692	4.197	20.889	4.780	16.109
Opiates	50,1%	54,1%	50,9%	25,1%	58,6%
Cannabis	32,6%	22,2%	30,5%	47,3%	25,5%
Cocaine	6,4%	3,8%	5,9%	5,9%	5,9%
Hypnotics and sedatives	1,7%	8,0%	3,0%	3,4%	2,9%
Halluzinogenic drugs	0,4%	0,4%	0,4%	1,5%	0,3%
Stimulants	6,9%	9,3%	7,4%	15,0%	5,1%
Volatile substances	0,1%	0,1%	0,1%	0,1%	0,1%
Other psychotropic substances	1,8%	2,1%	1,8%	2,6%	1,6%
Total	100%	100%	100%	100%	100%

Source: Strobl et al.2003a

In the year 2002, 51% of all clients started outpatient counselling or treatment due to the use of drugs or pharmaceutics containing opiates. In the old Federal Laender opiates accounted for a significantly larger portion in the problematic use of illicit drugs (59%) compared to the new Federal Laender (25%). In the new Federal Laender cannabis was found to be the most common reason for drug treatment (47%). Other main diagnosis such as cocaine or stimulants are in comparison not too prevalent. However, many clients do not only have problems with one substance. Often, several substances are taken simultaneously or one after another.

Diagnostic data from inpatient treatment

In the year 2002, a total of 2.166 persons (1.615 males and 551 females) were treated and finished the treatment in in-patient withdrawal clinics (registered by the German Drug Help Statistics) due to problems in connection with the use of illicit substances (including pharmaceutics) (Strobl et al. 2003b) Here as well, the main diagnoses – i.e. the substance for which the client is undergoing inpatient treatment – is based on the diagnostic criteria of the international classification system of the WHO (current version: ICD 10) for the classification of disturbances induced by psychotropic substances (harmful use and addiction) (Table 12).

Not only opiates with 44% of all main diagnoses, but also cannabis played an important role in inpatient drug treatment centres in 2002, even though the numerical distance to opiates is big. For about a third of the total cases there is no information concerning the main diagnosis.

Table 11: Diagnostic data from inpatient treatment (German Drug Help Statistics)

Main diagnoses harmful use/ dependency (ICD10: F1x.1/F1x.2x)	Male 1.615	Female 551	Total 2.166
Opiates (total)	47,3%	33,3%	43,7%
Cocaine	5,8%	3,1%	5,1%
Stimulants	3,5%	2,4%	3,2%
Sedatives / Hypnotics	3,4%	16,0%	6,6%
Hallucinogenic drugs	0,2%	0,0%	0,2%
Cannabis	8,3%	2,4%	6,8%
And. psychotropic substances	31,4%	42,6%	34,3%
Volatile substances	0,1%	0,2%	0,1%
Total	100%	100%	100%

Source: Strobl et al. 2003b

3.1.3 Client profiles in different types of treatment

There is no information available for clients under medical treatment in prison or in a doctor's practice. Therefore mainly out-patient and in-patient treatment centres will be compared. Concerning illegal drugs, problems with heroin are dominating in in-patient centres, problems with cannabis in out-patient centres. Costs, organisation and time exposure affect furthermore the admission for in-patient centres. In tendency in-patient clients are compared with out-patient clients more often male, employed and a bit elder.

3.1.4 Treatment demand for different drugs

Treatment demand for different drugs is shown under 3.1.2. The relative great and strong growing number of persons with a primary cannabis problem reflects different effects. About one third of male clients coming to treatment centres were involved in road traffic problems (driving under the influence of drugs, issuing a driving licence). Normally these persons were referred to treatment centres by court or by official authorities. For women these proportions are far lower. Another group of people have problems caused by intensive cannabis use and related problems. The need of treatment and the motivation of both groups might differ strongly. Detailed results were expected at the beginning of next year. A study regarding this matter will be completed by then The study is carried out by the IFT - Institute of Therapy Research and supported by the Federal Ministry of Health and Social Security.

3.2 Drug-related mortality

3.2.1 Drug-related deaths

3.2.2 Deaths related to opiates and to other drugs

Method

In Germany, drug-related deaths are registered by two countrywide documentation systems: the “Case File” of the Federal Office of Criminal Investigation (BKA) and the general “Death File” of the Federal Statistical Office (StBA).

Police register

Drug-related deaths are registered by the State Criminal Investigation Departments of the individual Laender or respectively the State Statistical Offices and then passed on to the federal authorities for aggregation and evaluation purposes.

In doing so, there are differences in the collection modalities and evaluation bases for drug-related deaths used by the individual Laender. Toxicological expert reports play an important role for the definition of the cause of death providing sufficient information on drug use at the time of death. However, in the last year, the portion of autopsies on deceased drug users varied remarkably in the Laender. Berlin, Mecklenburg-Western Pomerania, Saxony, Saxony-Anhalt and Saarland had a autopsy rate of 100%. The average autopsy rate was 72% (2001 and 2000: 70%). Autopsies did not always include a toxic examination.

In order to simplify the registration of drug-related deaths and to reduce mistakes the BKA specified the following categories for drug-related deaths in a leaflet (Bundeskriminalamt 1999) :

- deaths following unintentional overdose,
- deaths following health defects (physical decline, HIV or Hepatitis C, weakness of an organ) caused by long-term drug abuse,
- suicide resulting from despair about the personal circumstances of life or the effects of withdrawal symptoms (e.g. delusions, heavy physical pain, depression),
- fatal accidents under the influence of drugs.

General mortality register

In Germany for each dead person a death certificate has to be completed. This paper includes personal informations as well as informations about the cause of death and pass from the local health authority to the State Statistical Office. Aggregation and evaluation on federal level is done by the Federal Statistical Office.

From the general mortality register specific causes of dead will be taken into account. The selection is based on requirements of the EBDD (selection B). In comparison data from the Federal Criminal Office follow a wider definition of drug related death. For classifying cases the suggested disorder (ICD10-Codes, F11-F19) and the suggested cause of death (ICD10-Codes X,T and Y) respectively is taken as basic principle.

As in Germany, data from the general mortality register were collected to a large extend according common standards, comparisons with the foreign countries of Europe should be carried out with this register. Data from the police register in comparison lead due to the wider definition of drug related deaths to higher estimates. Police data are important for monitoring national trends. They are less useful for Europe-wide comparisons due to the differences to the EMCDDA standard for drug related deaths.

Both methods don't cover all drug related deaths. In each case a certain number of relevant cases is not recognized, not registered or classified wrongly. Compared over a long period there are similar trends between both registers. This monitoring allows to speak from a kind of cross-validation.

Number and characteristics of drug-related deaths

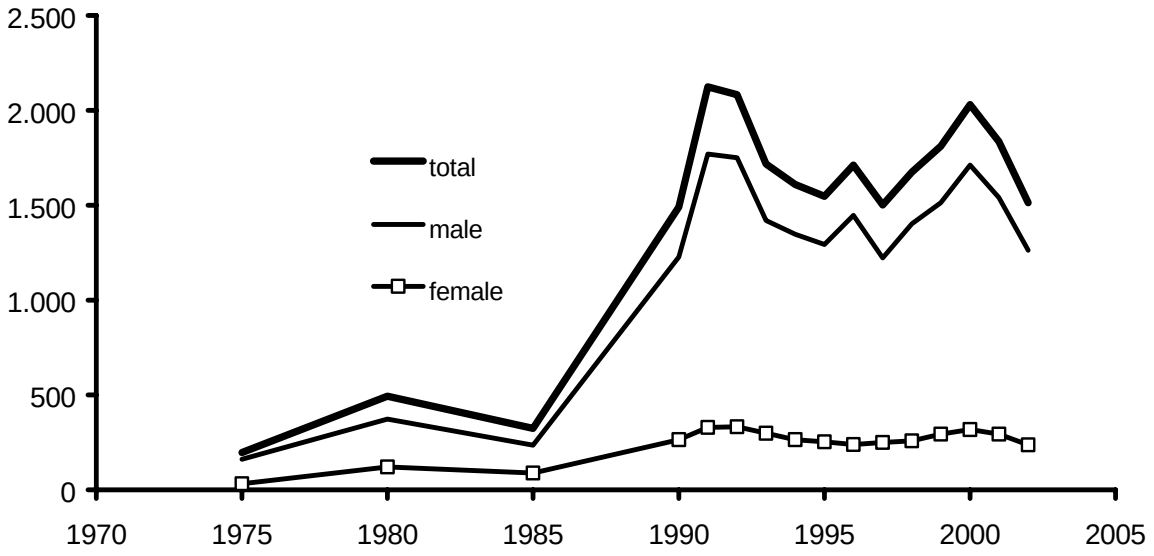
Data from police register

The number of drug related deaths in the "Case file" of the Federal Office of Criminal Investigation (BKA) drastically increased from the middle of the eighties till the beginning of the nineties and reached a maximum of 2.125 drug related deaths in 1991. In the following years the number decreased again reaching the lowest point since 1990 with 1.501 drug related deaths in 1997. After a further increase between 1998 and 2000 the figures decreased again since 2001. In 2002 altogether 1.513 drug related death were registered. Compared with last year these are 322 cases less (17,5%).

In all Laender, except of Saxony (+73% from 11 to 19 cases) the figures for drug-related deaths are decreasing. The number of drug victims decreased in Thuringia (-43%), Bavariy (-24%), Hamburg (-24%) and Baden-Württemberg (23%) above average. The number of drug-related death in the new Laender, altogether 43 registered (previous year 44) is still not very high.

For the cities with more than 100.000 inhabitants, Bremen currently has the highest quota countrywide with 8.5 deaths per 100.000 inhabitants followed by the cities Essen (6.0) Cologne (5.6), Mannheim (5.5), Berlin (5.0), Munich (4.9), Hamburg and Frankfurt/Main each with a quota of 4.5%. The proportion of men under drug-related death shows since years little fluctuation (84%).

Figure 2: Drug-related deaths by gender

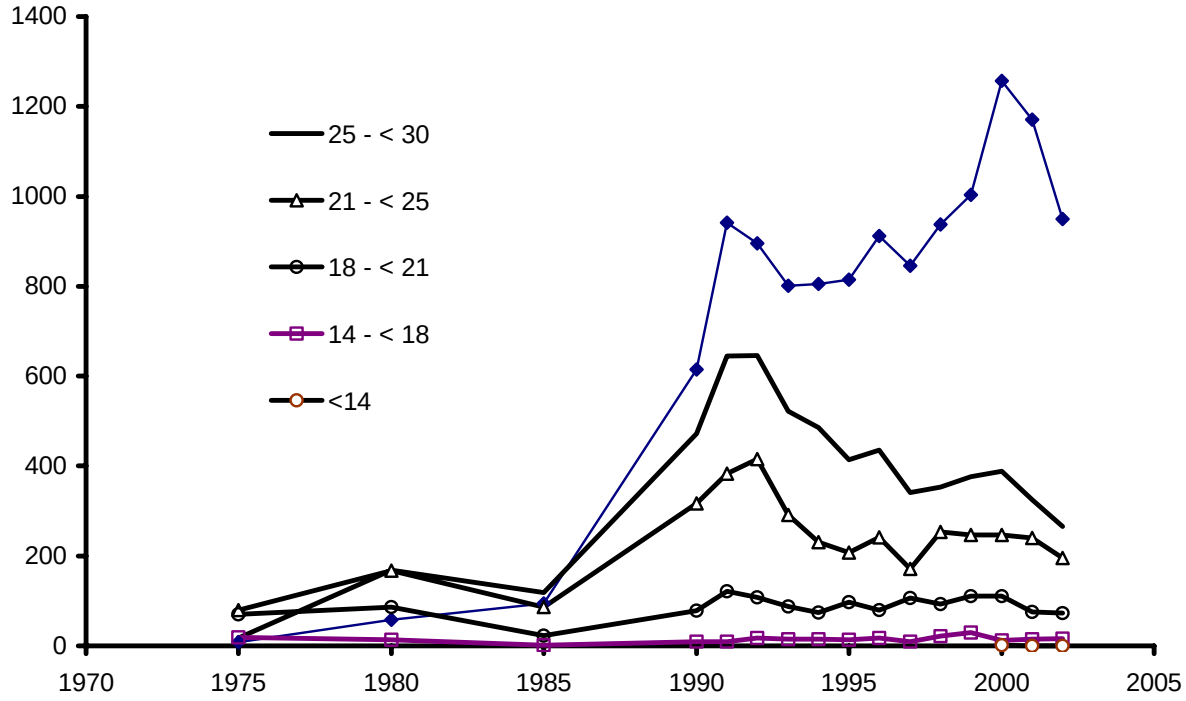


Deaths	1975	1980	1985	1990	1991	1996	1997	1998	1999	2000	2001	***2002***
Male	162	373	235	1.227	1.770	1.447	1.223	1.401	1.513	1.712	1541	***1.263***
Female	33	121	89	264	329	238	250	258	294	318	294	***237***
N.a.	1	0	0	0	26	27	28	15	5	-	-	**-**
Total	196	494	324	1.491	2.125	1.712	1.501	1.674	1.812	2.030	1835	***1513***

Source: Rauschgiftjahresbericht 2002 (BKA 2003a)

The age distribution remained almost constant compared with the previous year (Figure 3). Most drug-related deaths were registered for the age group 35-40 (19%), followed by the age group 30-35 and 25-30 (18% each). About 20% of the drug related deaths were under 25 years old. The strongest group is the age group over 30 years (see 3.2.3).

Figure 3: Drug-related deaths by age groups



Age*	1975	1980	1985	1990	1991	1995	1996	1997	1998	1999	2000	2001	***2002***
Up to 14 years	2	0	0	0	0	0	0	0	0	0	1	0	***0***
14 - < 18	19	14	2	9	9	13	18	9	21	29	12	15	***16***
18 - < 21	70	86	23	78	121	97	79	106	93	110	111	75	***73***
21 - < 25	79	167	86	317	383	208	241	171	253	247	247	240	***195***
25 - < 30	17	169	119	472	645	414	435	341	354	376	388	325	***266***
> 30 years	8	58	94	615	941	815	912	846	938	1.004	1.257	1.171	***950***

Source: Rauschgiftjahresbericht 2002 (BKA 2003a)

The most common cause of death was the overdose of heroin (41°%, 2001: 48°%). This category includes death cases in which only heroin was proved and cases in which heroin and additionally other drugs were proven. For the year 2002 the fraction of people who died because of substitution substances / pharmaceutics / narcotics and alcohol is 30°%. According to the Federal Office of Criminal Investigation, 19 people died in 2002 caused through the use of ecstasy alone or in combination with other drugs (Table 13).

Table 12: Drug-related deaths 2002

Cause of death	Percentage	Number of Cases
1. Overdose from		
Heroin	27%	551
Heroin in combination with other drugs	14%	285
Cocaine	2%	47
Cocaine in combination with other drugs	4%	84
Amphetamine	1%	10
Amphetamine in combination with other drugs	1%	27
Ecstasy	0%	8
Ecstasy in Combination with other drugs	1%	11
Pharmaceutics/ Substituion substances[1]	7%	145
Narcotics i.c[2]. with alcohol / substitution substances	23%	453
Other narcotics / unknown	3%	54
2. Suicide	7%	133
3. Long term harm	8%	165
4. Accicent / Others	2%	33
Total*	100%	2006

Source : Statement of BKA (2003)

* Due to multiple choices all causes for death given sum up to more than the number of drug-related death, which is 1.513

[1] Due to different ways of counting within the individual Federal Laender considerable differentiations particularly in these categories appeared compared to the previous year.

[2] In conjunction with

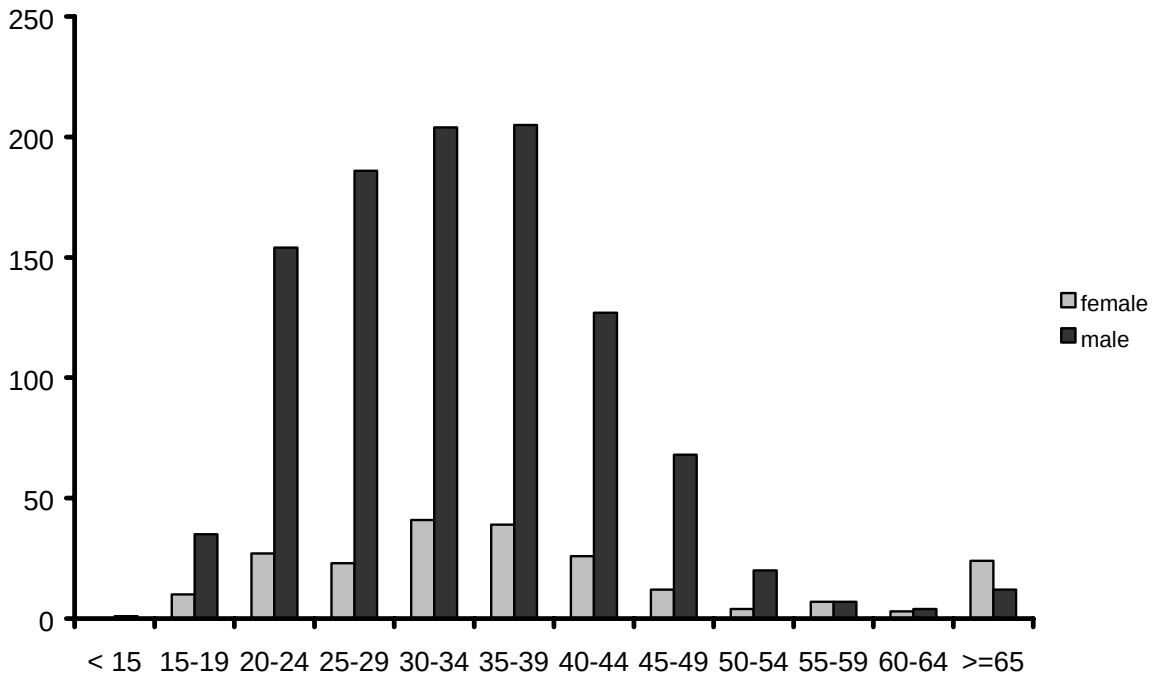
The proportion of Russians with a German background on the whole number of drug related deaths (1.513) was with 9% relatively high. Compared with the previous year (8%) there is no significant change.

Local studies concerning the development of figures and characteristics of drug related deaths are available for Bavaria (von Meyer 2002), Baden-Württemberg (Kraus 2001) and Hamburg (Raschke, Püschel & Heinemann 2002). The studies show remarkable fluctuations, which cannot be always traced back to a simple cause. Rather a complex co-action of a bundle of different influencing variables is seen as cause (Kraus & Püschel 2002).

Data from the general mortality register

The most current figures on drug-related deaths available from the general death register are from the year 2001. Here, in total, 216 females and 1.023 males have been registered as deceased in connection with drug use. Thus, the total figure of 1.239 drug-related deaths is lower than the figure given by the Federal Office of Criminal Investigation (2000: 1.835). Most people died in the age groups from 25 to 39. Most of them were men (Figure 4).

Figure 4: Drug-related deaths 2001



Source: Federal Statistical Office

A study from Elstner (2002) points out a group of drug related deaths which is little noticed. Through inquiries he found out that from 1996 to 2001 at least 9 Persons aged between 12 and 16 died from butane gas inhalation (sniffle) in Germany. The study includes a discussion about the exact cause of death. In Southern Germany one event of death was traced back to the inhalation of gas used for antiperspirant sprays.

3.2.3 Trends on drug-related deaths

In 2002 the average age of drug-related deaths decreased from 33.2 (2001) years to 32.2 years, whereas for the first time no sex-related differences were registered. Despite a slight decrease, most drug-related deaths were registered for the age group 35-40 (19%), followed by the age group 30-35 and 25-30 (each with 18%). About 20% of the drug related death were under 25 years old. The most serious changes happened within the age group 30-35, where the proportion decreased around 6% Ffigure 3). In 2002 police registered a total of 1.513 drug-related deaths, compared with the previous year these are 322 cases (17,5%) less (Figure 3).

3.2.4 Overall mortality and causes of death in drug users

There is no mortality-overview of the whole drug consumer population. Therefore some data from drug addicted people in treatment are reported. According to the German Drug Help Statistics 2002 (Strobl et al. 2003) the treatment of drug clients ended in 0.7% with the death. Due to the varying duration of treatments an exact mortality rate cannot be calculated. A cohort study in Hamburg (N=4.504; 72% male) referring to treatment beginners reports from

414 deaths over the whole period of 11 years (1990-2000). As data were only available from the general mortality register of Hamburg, the real number of deaths might be higher. In most cases (231) an overdose was registered as cause of death.

3.3 Drug-related infectious diseases

In its function as a federal authority, the Robert-Koch-Institute (RKI) collects nationwide data on infectious diseases, among others also on HIV and hepatitis. The AIDS-Centre of the Robert-Koch-Institute regularly publishes data on confirmed HIV-antibody tests of iv- (opiate) users. According to the German regulations on laboratory reports, all laboratories in the Federal Republic of Germany are obliged since 1987 to anonymously report to the AIDS Centre of the Robert-Koch-Institute any confirmed HIV-antibody tests. These laboratory reports contain information on age, gender, place of residence and the way of transmission of the infection. In addition, epidemiological data on diagnosed AIDS infections are collected in the AIDS-case file in an anonymous form and based on voluntary reporting of the attending physicians. The regularly updated epidemiological data can be viewed on the internet (http://www.rki.de/INFEKT/ AIDS_STD/AZ.HTM).

Since the new law on protection against infectious diseases (IfSG) was introduced on the 1st July 2001 information about the ways of transmission for hepatitis B and C must be reported to the Robert-Koch-Institute by the laboratories as well as by approved physicians. Due to changes within the collection of new HIV it was achieved to exclude multiple reporting – which remained unrecognised before – more effectively.

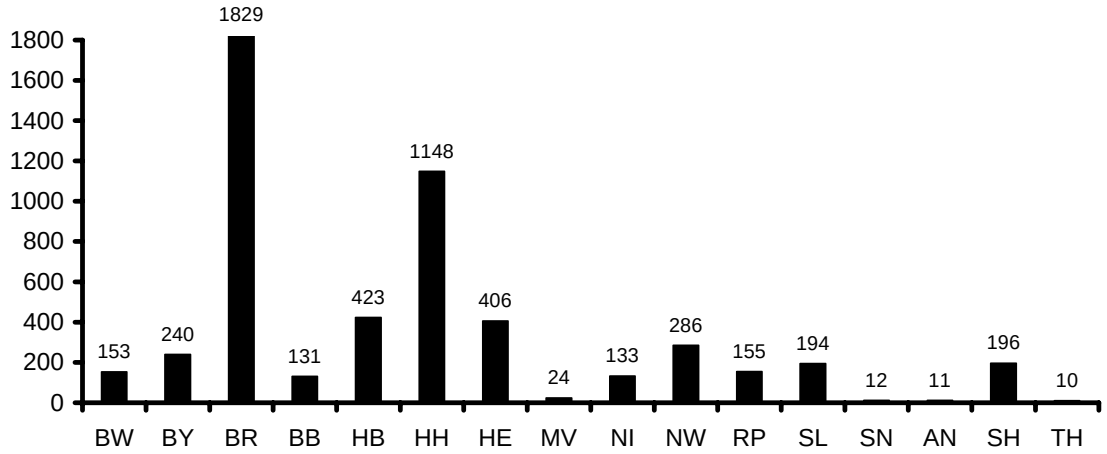
Because data which refer to persons must be deleted by health authorities after three years for data protection reasons and because the Robert-Koch-Institute only has information in anonymous form at its disposal, multiple reporting cannot completely be excluded. Due to this kind of notifications trend analyses on case level are not possible. However, this is not relevant for HIV infected, because only fresh injections (incidence) are reported.

Since the situation of data in the field of infectious diseases is altogether bad, some study results are cited again which have been already reported in earlier annual reports.

3.3.1 HIV and AIDS

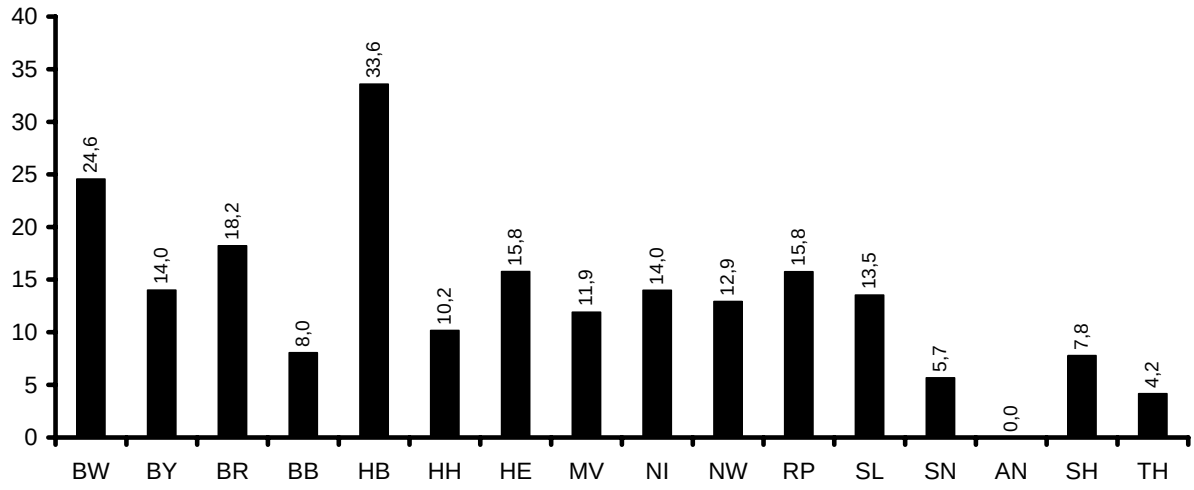
After the group of homosexuals, the group of drug users is the second largest risk group for HIV-infections and AIDS. The number of AIDS cases vary considerably in the Federal Laender. Whereas in the new Laender still few people suffer from AIDS most infected are in the city states Berlin (1.829 per 1 million inhabitants) and Hamburg (1.148 million inhabitants). According to the AIDS centre of the Robert Koch Institute (http://hiv.rki.de) 15% among the new AIDS cases in 2002 were i.v. drug addicts. Regarding all reported AIDS cases (n=21.906) up to now the percentage of the i.v. drug users is 15.4% In Germany the highest values are in Bremen (33.6%) and Baden-Württemberg (24.6%) (Figures 5 and 6).

Figure 5: AIDS cases within the Laender (per million inahabitants)



Source: Robert Koch Institute (2003).

Figure 6: Percentage of AIDS cases by iv addicts (IVDA)



Source: Robert Koch Institute (2003).

BW	Baden-Wuerttemberg	HE	Hesse	SN	Saxony
BY	Bavaria	MV	Mecklenburg Western Pomerania	AN	Saxony Anhalt
BR	Berlin	NI	Lower Saxony	SH	Schleswig Holstein
BB	Brandenburg	NW	North Rhine Westphalia	TH	Thuringia
HB	Bremen	RP	Rhineland-Palatinate		
HH	Hamburg	SL	Saarland		

In Germany it has been possible to slow down substantially the spread of the HI-virus among drug users in the last years. Prevention measures, campaigns to discourage needle-sharing and innovations such as substitution and syringe-exchange programmes have clearly had an effect here. Through the introduction of new antiretroviral substances and the quantitative measurement of HIV-RNA a more effective treatment of HIV is possible. Drug users can make use of this therapy at specialist general practitioners or in clinics. The health insurance covers the costs.

Via the German Drug Help Statistics data has also been collected on HIV infections of drug dependent clients in outpatient counselling and treatment. For the year 2002, information is available on the HIV-status and testing of a total of 741 clients for the whole of Germany. 25.4% of the clients have not yet made an HIV-test. For 60.5% the test result was negative, for 11.3% positive. 2.8% of the clients have been tested, the result however is unknown. Since the data on infections may be entered optionally into the German Drug Help Statistics only 14 out of 454 participating facilities reported it in 2002. Therefore these figures has to be valuated carefully.

The in-patient treatment sector of the clinic Nord in Hamburg provides prevalence rates for HIV of 420 iv drug addicts who took part in a withdrawal treatment in 1999/2000. The HIV infection rate of men was 4.1%. The value for women was with 3.4% a bit lower (Heinemann, personal communication)

A study which was carried out in two prisons in Berlin showed each prevalence rates of 18% shortly after imprisonment (Stark et al. 2001).
Data on infectious diseases of drug users are also provided by forensic institutes carrying out post-mortem examinations. In several regions, like for example in Hamburg, Frankfurt and Munich, autopsies include HIV-tests on a routine basis; hepatitis B however, is only tested in Hamburg. Due to the Federal Office of Criminal Investigation 43 out of 1.513 drug-related death (2.8%) were HIV infected in 2002 (BKA 2003a). However in North Rhine Westphalia and in Berlin no data on HIV infections is collected. Except of the death cases in those two Laender there is a HIV rate of 4.5% among drug-related deaths. The rate of autopsies varies in some Laender remarkably and is in most Laender under 100°%. Thus the significance of the causes of death and infections is limited.

The HIV quota of the mentioned drug consumption groups – depending on the examined population – lies between 4.6°% - 18°%.

3.3.2 Estimates on subgroups

Prevalence estimates for different subgroups in Germany are - apart from the information in 3.3.1 - not available.

3.3.3 Hepatitis B und C

Countrywide studies providing information on the propagation of hepatitis B and C among drug users are presently not available. However, since the beginning of 2001 due to the new law on the protection against infectious diseases information on the transmission of hepatitis B and C has to be passed on to health authorities by general practitioner and laboratories. The following aggregation and evaluation of the information is to be done exclusively by the Robert-Koch-Institute. Local studies (qualified withdrawal treatment, penal institution, substitution) show a very high prevalence of hepatitis B and C among opiate users in different settings. The quota for hepatitis B differ between 33°% and 64°%, for hepatitis C

between 60 and 90°%. Studies shown in table 13 refer to the investigation period between 1990 and 2001. Publication were presented partially not until 2002.

Table 13: Hepatitis B and C: seroprevalence (%) on drug use

Main researcher/ author	Population/ Period of investigation	n	HBc-AK	HBs-Ak	HCV-AK
Backmund	IVDA /1991-1997	1049	--	--	61.3
Brack	Drug addicted / 1993-1997	1791	41.4	1.2	59.9
	subgroup IVDU		44.2		83.9
Heinemann	IVDA	420	64.1 (f)		89.3 (f)
	1999/2000		63.3 (m)		80.4 (m)
Stark	IVDA	575	62.0	7.0	84.0
Wehner*	Drug related deaths / 1998-2001	36	33.0		81.0

* Institute of forensic medicine, University of Tübingen

Estimates from heads of drug consumtion rooms are to a large extend similar to the prevalence data for hepatitis C shown in table 13 (80-90%) (ZEUS 2002).

From 1997 to 1999, Backmund et al. (2001) carried out blood tests in Munich on 492 opiate users or patients who were dependent on multiple substances and undergoing inpatient treatment. There was a continuous increase of the portion of patients with hepatitis from 1997 to 1999 (Table 14).

Table 14: Prevalence data on hepatitis B and C

	1997 N = 181	1998 N = 171	1999 N = 140
%Anti-HBc	36%	45%	52%
%HBs-Antigen	2%	2%	2%
%Anti-HBs postiv	35%	42%	63%
%Anti-HCV positiv	62%	67%	66%
% HCV-RNA positiv	39%	45%	45%

Source: Backmund, Meyer & Zielonka (2001)

For Germany there are no data available about other infectious diseases related with drug consumption. On the basis of reports on individual cases it is suspected that TB plays an important role.

3.3.4 Genotype distribution

Concerning the distribution of genotypes there are only few data available. A systematic monitoring does not exist in this filed.

3.4 Other drug-related morbidity

The physical condition of drug users, in particular of heroin users, is often very poor due to malnutrition, lifestyle and insufficient health care. In addition to skin or venereal diseases, other health impairments like diseases of the teeth, mouth and jaws, internal and psychiatric disturbances occur. On this, data were represented in the REITOX report 2001. For the reporting period new results area not available.

4 Social and legal correlates and consequences

4.1 Social problems

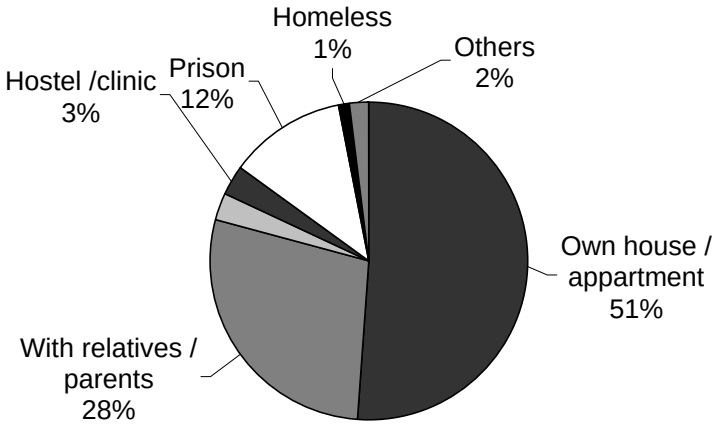
4.1.1 Social exclusion

Social problems like poor education, unemployment or debts are considered as risk factors in the aetiology of substance related disturbances. But often they are also the consequences of addiction itself. The results of the treatment documentation system German Drug Help Statistics (Strobl et al. 2003) suggest that a considerable percentage of the clients treated last year are socially relatively well integrated, however, there still remains quite a high percentage for which this is not the case.

More than half of clients being in treatment in 2002 are single (53°%), 32°% live in lasting partnerships, 10°% in temporary partnerships. Males live apparently more often without a partner than women. Since a partnership is considered to be an important element for social integration which is supporting a successful treatment these figures are to be viewed critically.

The predominant majority of clients undergoing inpatient or outpatient treatment in 2002 either lived independently in an apartment or with their parents or other relatives (79°%). 12°% are in prison, 3°% in a home or clinic, further 3°% in an assisted living community. 3°% of the clients are homeless or have unclear housing conditions (Figure 7).

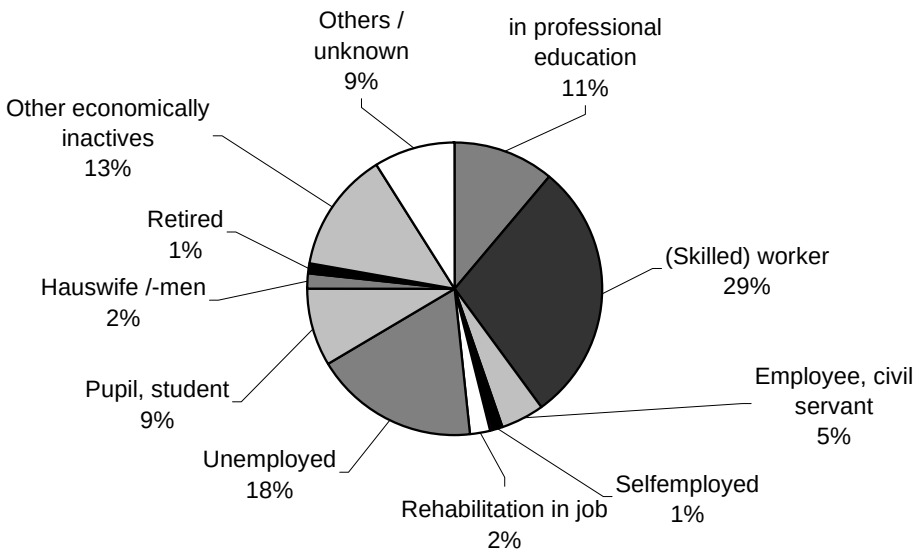
Figure 7: Housing conditions of clients with substance-induced disorders



Source: Strobl et al. 2003a

With regard to occupation, a striking third of the clients are out of work (31°%), 35°% are employed and 20°% do school or vocational training (German Drug Help Statistics) (Figure 8).

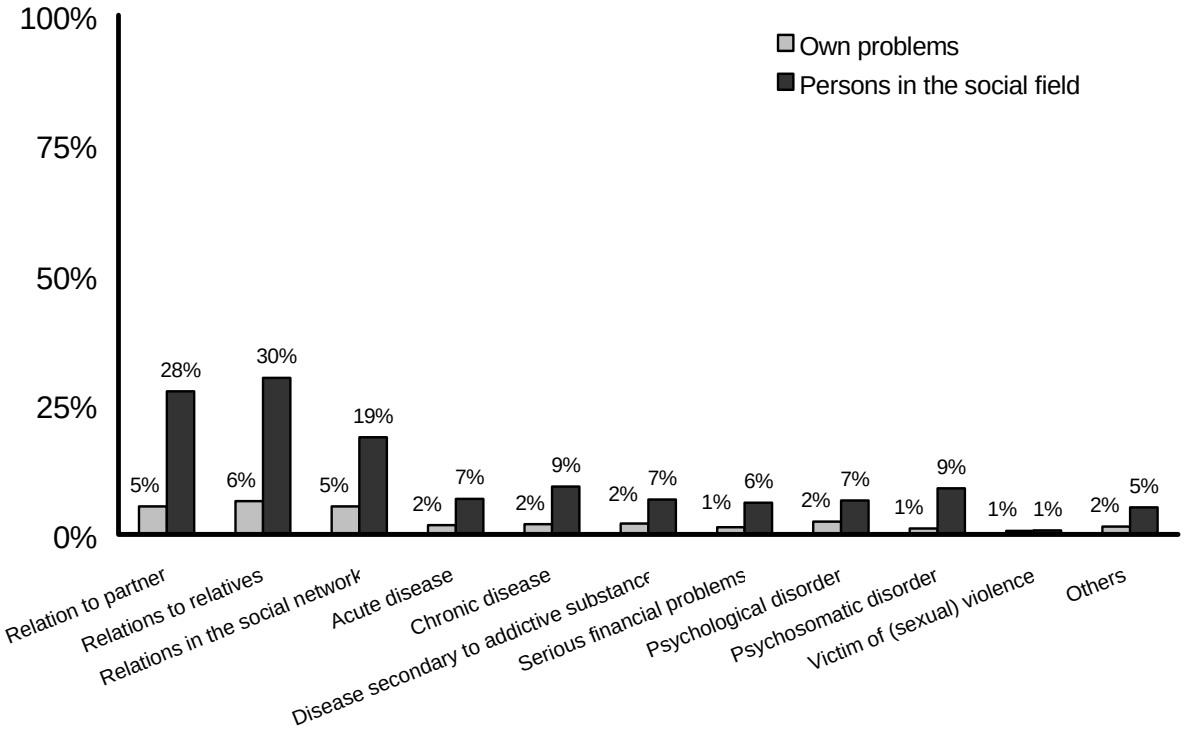
Figure 8: Occupation of clients in outpatient treatment



Source: Strobl et al. 2003a

The dimension of further problems in the field of drug consumption is shown in figure 9.

Figure 9: Further problem fields of clients in outpatient treatment



Source: Strobl et al. 2003a

Drug councelling centres report lately from an increase of Germans with a Russian background searching for help. The fact that this group of people is not integrated well, is seen to be one reason for this development. The absence of language skills, particularly in the younger generation makes the process of integration more difficult (***www.bundesregierung.de***).

4.1.2 Public nuisance and community problems

There is an accumulation of drug addicts in the surroundings of drug user rooms which are placed in central areas. Residents complain about this matter. Similar problems occur frequently with the setup of low threshold offers. The evaluation of drug user rooms describes this fact also as an unsolved problem, especially when the user rooms are established in residential quarters (see 8.2.4).

4.2 Drug offences and drug-related crime

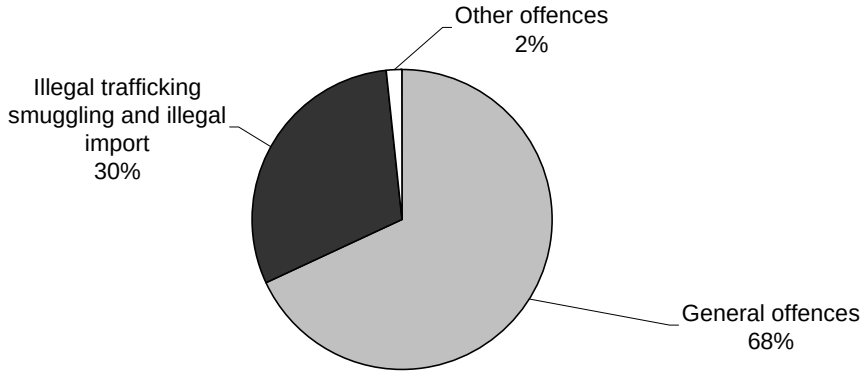
4.2.1 Offences

In terms of drug offences, the Federal Criminal Police Office (BKA) makes a distinction between crimes involving offences against the Narcotics Law and cases of direct supply-related crimes in its statistics. Offences against the Narcotic Law are described by four different kinds of offences (Figure 10):

- General offences in accordance to §29 of the Narcotic Law (offences related to drug use: mainly possession and purchase),
- illegal traffic and smuggling of drugs in accordance to §29 of the Narcotic Law,
- illegal import of a considerable amount of drugs in accordance to § 30 of the Narcotic Law (described by using the term of “more than a negligible amount”)
- other offences against the Narcotic Law.

In 2002 altogether 250.969 drug-related offences were registered. As figure 10 shows, 170.629 general offences (mainly offences related to drug use) are with 68°% the largest portion of all offences. In 76.038 cases (30°%) offences were related to illegal trafficking and smuggling. and illegal import of narcotics of more than negligible amounts). In 4.302 cases other offences against the Narcotic Law have been registered (2°%).

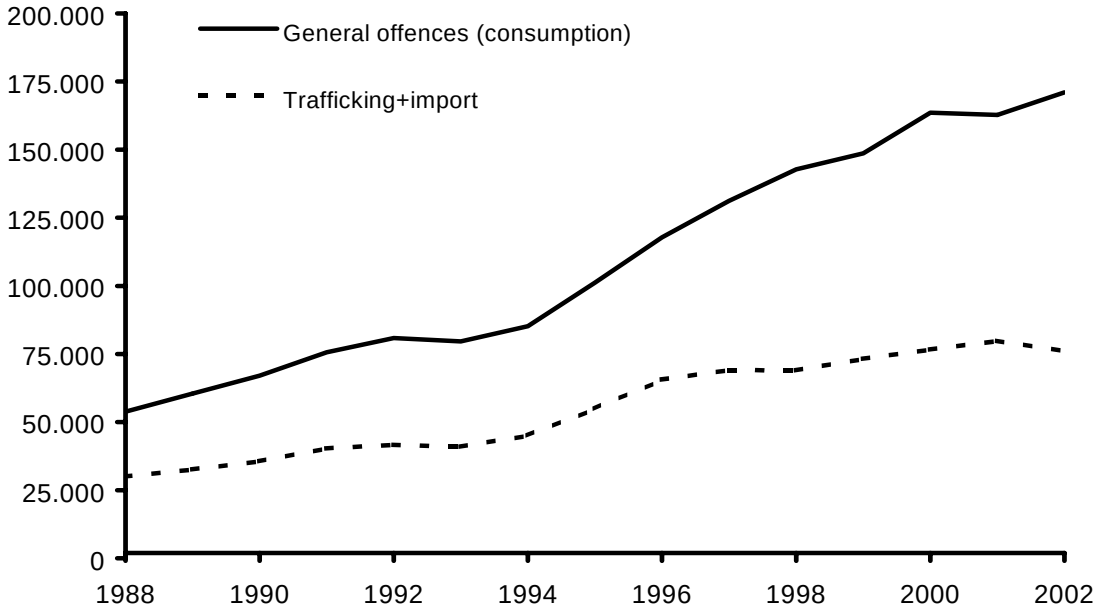
Figure 10: Drug-related offences, distribution according to offences



Source: Rauschgiftjahresbericht 2002 (BKA 2003a)

Compared to the year before the number of offences in relation to drug use has somewhat increased, the number of illegal trafficking has declined slightly (Figure 11)

Figure 11: Offences against the narcotic law – trends in offences since 1988

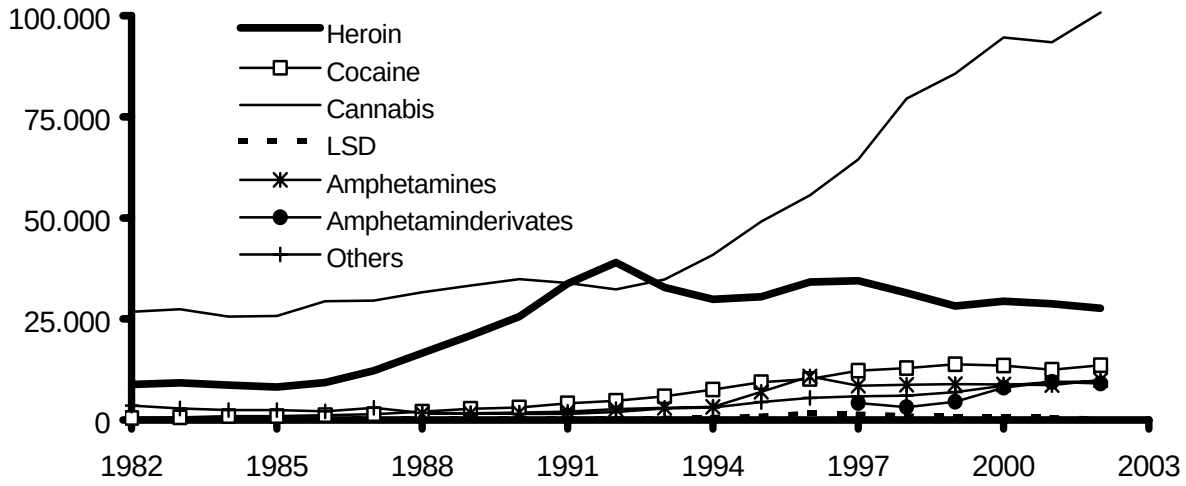


	1988	1991	1994	1995	1997	1999	2000	2001	2002
consumption related offences	53.854	75.631	85.234	101230	131.208	148.650	163.541	162.740	170969
trafficking, smuggling, illegal import	30.035	40.286	45.088	54889	69.093	73.271	76.594	79.787	76038

Source: Rauschgiftjahresbericht 2002 (BKA 2003a)

Crimes related to “direct supply” include all crimes committed to get in possession of drugs, substitution substances or alternative drugs. 2.807 cases have been registered during the reporting year, more than half of them were related to forgery of prescriptions (58%). Cannabis and heroine play a pre-eminent role with offences in relation to drug use. Since in some cases of multiple consumption cannabis as a drug with less risks will be not listed, the significance of cannabis in these statistics is often systematically understated. Figure 17 shows that offences related to cannabis use have increased to a considerable extent in the last few years and in 2002 the highest rate was reached since the data have been collected (2002: 100.779; 2001: 93,449; 2000: 94.633; 1999: 85,668). Offences related to cocaine oscillate since 1999 between 12.500 and 14.000 (2002: 13.541; 2001: 12,436; 2000: 13.488; 1999: 13,810). The number of drug-use-offences in connection with amphetamine derivatives almost doubled in the years 1999 and 2001. In the reporting year a slight decrease could be noticed (2002: 9.020; 2001: 9,451; 2000: 8.010; 1999: 4.497). The number of drug offences in connection with amphetamines increased in 2002 after a slight decrease in 2001. In 2002 18.895 drug-use offences in connection with amphetamines and amphetamine derivatives were registered. Similar figures were registered for offences in connection with the use of cocaine (Figure 12).

Figure 12: Offences against the narcotic law – trends in drug-use related offences since 1982



Source: Rauschgiftjahresbericht 2002 (BKA 2003a)

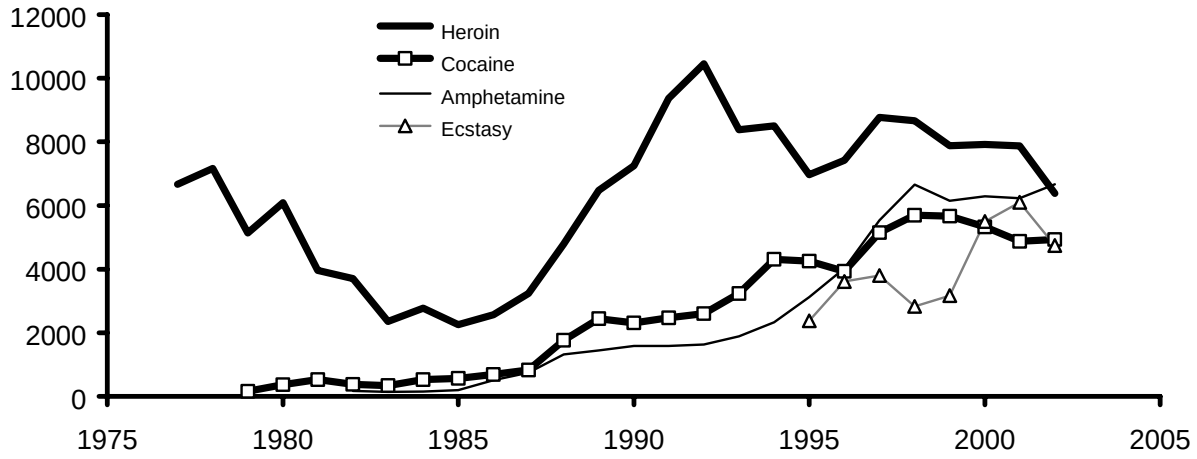
In addition to the total group of offences, the Federal Criminal Police Office also publishes statistics on those persons who were noticed because of drugs for the first time. Since spring 1997 persons having a usable amount of drugs with them and who are not exclusively seen as drug traders, were also noticed. This figure has also increased remarkably since the middle of the eighties. In the year 2002 less persons were registered than in the previous year. (-10.3%).

People who consumed heroin for the first time represented till 2001 the highest number of people using hard drugs for the fist time. After a clear decrease of this group (2002: 6.378; 2001: 7.868; 2000: 7.914 people who consumed for the first time) a change in the hierarchy

of illegal drugs emerge. The number of people, using amphetamine the first time, increased (2002: 6.666; 2001: 6.229; 2000: 6.288;). As effect this group ranks the first time (figure 13).

For cocaine (2001: 4.872; 2000: 5.327; 1999: 5.662 people who consumed for the first time) numbers slightly increased in 2002 (4.933) after a decrease in 2001. Whereas a clear decrease was obvious for LSD (2002: 229; 2001: 549; 2000: 770) for some years, the number of people using Ecstasy for the first time decreased after a longer and fast increase (2002: 4.737; 2001: 6.097; 2000: 5.495). The file which register people, consuming for the first time don't obey cannabis offences. Therefore one can not make a statement for this group of people (Figure 13).

Figure 13: First offenders using hard drugs



Users	1980	1985	1990	1994	1995	1997	1999	2000	2001	2002
Heroin	6.091	2.254	7.252	8.501	6.970	8.771	7.877	7.914	7.868	6.378
Cocaine	364	567	2.308	4.307	4.251	5.144	5.662	5.327	4.872	4.933
Amfetamine		194	1.586	2.333	3.119	5.535	6.143	6.288	6.229	6.666
Ecstasy					2.371	3.799	3.170	5.495	6.097	4.737
LSD			200	321	772	1.356	738	770	549	229

Source: Rauschgiftjahresbericht 2002 (BKA 2003a)

4.2.2 Sentences for drug offences

In this area there are no actual statistics available.

4.2.3 Imprisonment for drug law offences

Altogether 14°% (8.574) of all persons incarcerated at the fixed date 31.03.2002 have been imprisoned because of offences against the Narcotics Law (BtMG) (Statistisches Bundesamt 2002b). Moreover, it is assumed that a number of further drug users has been arrested due to burglary and other offences. Valid total numbers are not available, for specific offences see 4.2.4.

4.2.4 Other drug-related crime

In 2002 1.635 cases of prescription falsifications were registered in order to receive narcotics (see 4.2). 34% out of these cases happened in large cities with more than 500.000 inhabitants (Bundeskriminalamt 2003a).

The criminal prosecution statistics shows altogether 362.054 accidents with personal injuries. Among them 1.262 accidents happened under the influence of intoxicating substances. The estimated number of unknown cases of these data supposed to be high. Within the frame of these accidents 68 persons died and 595 people got hurt seriously (Federal Statistical Office /team VC traffic, personal communication).

Within a study the results of blood and urine tests carried out in 2001 in institutions of forensic medicine in Munich, Frankfurt and Berlin were gathered. The analyses refered in 5.420 cases to driving offences, in 1.798 cases to other criminal offences and in 657 cases to events of death. The results are not representative for the common road traffic since the analyses were done only in cases with a running court proceeding or in cases were the procedure was regulated by law. The substances found by far most frequently were cannabis with 61.6% and opiates / strong analgesics with 37.4% (Institute of forensic medicine without year).

Data related to drug induced violence are not available in combination with illegal drugs. 185.394 cases were registered which happened under the influence of alcohol.

For an overview of drug-related activities of the police see:
www.bka.de/pub/veroeff/band/band02/drogen_sucht.pdf **.**

4.3 Social and economic costs of drug consumption

Until now there are no comprehensive studies available which give the social and economic costs of drugs for the entire Germany. A current synopsis looking into financial aspects of substitution treatment (Ahrends et al. 2003) underlines the relevance and the value of adequate studies.

5 Drug Markets

5.1 Availability and supply

In 2002, like in previous years, large quantities of drugs were seized in Germany, in particular at the borders to neighbouring countries, at seaports and airports. More than 50% of the seizures affected the border to the Netherlands. For some of the seized substances police and customs have started investigations to identify countries of departure, countries of origin or transit countries. (Bundeskriminalamt 2003a). Southeast Asia (in particular Afghanistan) remains the most important source of origin for heroin with Turkey and the Balkan route being import access routes. In addition, the route over the Central Asian countries (Uzbekistan, Turkmenistan, Tajikistan, Kirgizistan and Kazakhstan) towards Europe is gaining more and more importance. Small quantities come from the Netherlands. Cocaine is smuggled mainly from Columbia, Peru and Bolivia or from the Netherlands. In many cases, Germany was not only the destination but was also supposed to serve as a transit state. In 2002 a prominent quantity of cocaine (1.250 kg) was seized. The quantity was not meant to remain in Germany, but intended for further distribution on the European market. The Netherlands were the main country of origin for synthetic drugs (amphetamines, amphetamine derivatives and LSD) and cannabis products. Increasing quantities of amphetamine and methamphetamine („Crystal“) arrive from the Czech Republic for mainly Bavaria and Saxony.

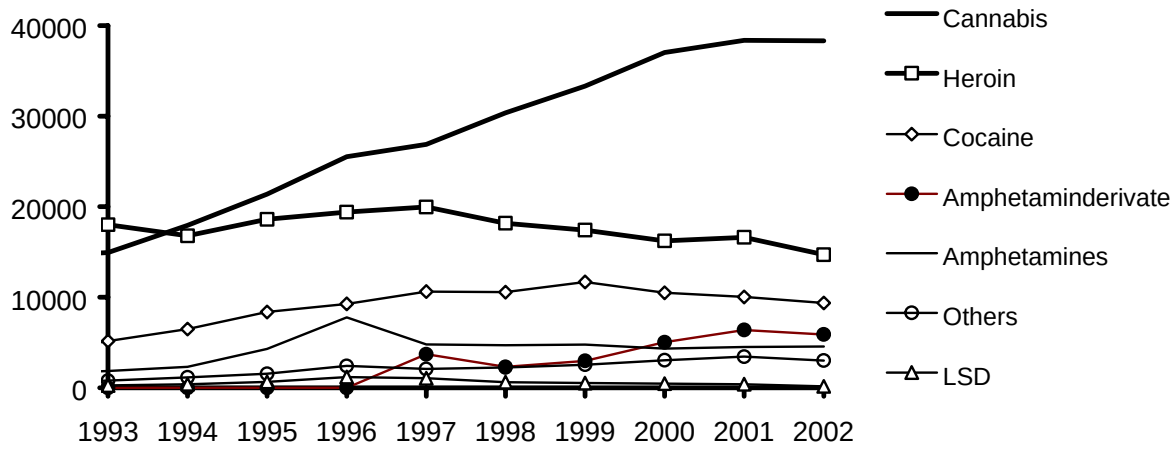
The supply situation of illicit drugs is reflected in the trends on the availability of drugs. The representative survey investigates whether the interviewees consider it possible to procure certain drugs within 24 hours without any difficulties. For persons without drug experience particularly cannabis is achievable (East: 9%, West: 16%). The availability of extasy is seen to be more difficult (East: 3%, West 5%). However persons with drug experience report particularly for cannabis from a very high availability (East: 75%, West: 63%) (Kraus & Augustin 2001.

5.2 Seizures

In the year 2002, about 76.038 offences in connection with illicit trafficking and smuggling as well as the import of considerable quantities of illicit narcotics were registered. For seizures there is only a common statistic available, therefore it is not possible to distinguish between seizures from police and from customs.

Most of the offences registered occurred again in connection with cannabis (2002: 38.303**,** 2001: 38,387; 2000: 37,030; 1999: 33,305). heroin (2002: 14.690**,** 2001: 16,632; 2000:16,216 ;1999: 17,421), cocaine (2002: 9.372, 2001: 10,038; 2000:10,488; 1999: 11,689), amphetamines or amphetamine derivatives (2002: 10.482, 2001: 10,869; 2000: 9,352; 1999: 7,770), LSD (2002: 180; 2001: 391; 2000: 479; 1999: 526) and other substances (2002: 3.011, 2001: 3,442; 2000: 3,030; 1999: 2,560) account for the rest of the drug-related offences (Figure 14).

Figure 14: Trafficking, smuggling and illegal import of significant amounts (case figures)



Source: Rauschgiftjahresbericht 2002 (BKA 2003a)

From the middle of the eighties until 1992, the number of offences more than tripled for heroin, since 1998 there is a slight downside trend noticed. As for cannabis-related offences, a continuous upward trend in particular since 1994 is observed – also for the reporting year. The corresponding figures for cocaine have increased six fold since the eighties. However, it decreased by more than 20% since 1999. Offences related to trafficking, smuggling or the import of not insubstantial quantities of amphetamine have decreased slightly in the reporting year. Like in the previous year offences committed in connection with LSD have decreased in the reporting year.

The seized amounts of heroin, cocaine amphetamine and LSD increased compared with 2001. For LSD an increase of more than 160% can be noticed. This increase goes together with falling numbers of offences. The increase of seized cocaine is primarily caused by a great seizure of 1.250 kg cocaine (see 5.1) which was according the police not meant for the German market. The quantities of seized ecstasy decreased about 30% compared with the previous year. The quantities of cannabis seized considerably vary from year to year. Whereas in comparison to 2001, marijuana seizures strongly increased from 2.079 kg to 6.863 the seized quantity of cannabis decreased from 6.863 kg in the previous year to 5.003 kg in 2002. The number of seizures of other drugs varies to a similar extent (Table 15).

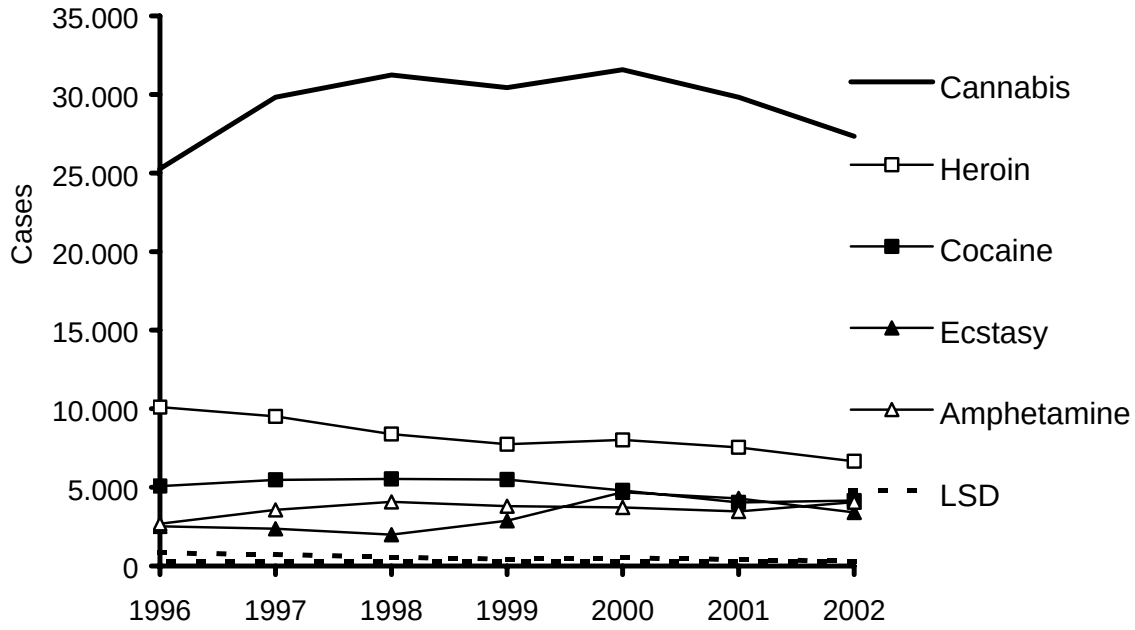
Table 15: Seizures (quantity) 1991 - 2002

Year	Heroin (kg)	Cocaine (kg)	Cannabis(raisin +marijuana) (kg)	LSD (Trips)	Amphetamine (kg)	Ecstasy (Units of 0,3g)
1991	1.595	964	12.344	13.887	88	
1992	1.438	1.332	12.166	29.571	105	
1993	1.095	1.051	11.353	23.442	117	77.922
1994	1.590	767	25.693	29.627	120	239.051
1995	933	1.846	14.245	71.069	138	380.858
1996	898	1.373	9.355	67.082	160	692.397
1997	722	1.721	11.495	78.430	234	694.281
1998	686	1.133	21.007	32.250	310	419.329
1999	796	1.979	19.907	22.965	360	1.470.507
2000	796	913	14.396	43.924	271	1.634.683
2001	836	1.288	8.942	11.441	263	4.576.504
2002	520	2.136	11.133	30.144	362	3.207.099

Source: Bundeskriminalamt (2003a).

Since the quantity of seizures can vary strongly over the years due to capacious single seizures, below also the number of drug seizures is reported. The total number of seizures has decreased slightly compared with the previous year. About 58% of all drugs seized were cannabis products or plants respectively. The case figures given for cannabis products have been relatively stable but decreased slightly in the previous two reporting year (2002: 27.333 2001: 29.824; 2000: 31.564; 1999: 30.433). Figure 15 shows – though with certain fluctuations – a similar situation for heroin (2002: 6.658; 2001: 7,538; 2000: 8,014;), . The number of amphetamine seizures (2002: 4.048; 2001: 3.459; 2000: 3.726) increased in the reporting year. The number of cocaine seizures remained rather constant (2002: 4.163, 2001: 4.044; 2000: 4.814) and the number of LSD seizures has decreased to a great extent from 2000 on (2002: 158; 2001: 289; 2000: 510). After the number of seized ecstasy increased in 2000 a decrease in seizures can be noticed (2002: 3.417, 2001: 4,290; 2000: 4,681; 1999: 2,883) (Figure 15).

Figure 15: Number of drug seizures in the Federal Republic of Germany



Source: Bundeskriminalamt 2003a

5.3 Price and purity

A further indicator of the illegal drug market is provided by changes in drug prices and in the purity of the drugs. Since 1975, the Federal Criminal Police Office has established an average price for different drugs on the basis of seizures. A distinction is drawn between small quantities of several grams and quantities of 1 kilogram and over. The price for small quantities shows the price paid by the user, while the price for large quantities reflects the costs which are relevant for drug dealers. The drug prices thus ascertained can only be interpreted as approximate values, particularly since the sometimes very great differences in purity between the drugs are not taken into account when the price is ascertained. There is the further difficulty that the individual seizures on which the price is based are not genuine "random samples" of drug purchases, so that random effects may alter the figures substantially. The latest information available is from 2002.

For some time, the Federal Criminal Police Office has ascertained not only the prices but the purity of the various drugs on the market. In 2002 analyses of the purity and content of active substances are based on about 17.906 samples resulting from seizures. All the values should be interpreted only as rough guidelines, as marked random effects may arise, chiefly from the very great differences in purity between the various drug seizures. The following description is based on the Annual Drug Report 2001 of the Federal Office of Criminal Investigation (BKA 2002) and reports of the customs administration. The potency of heroin, cocaine and amphetamine is broken down for the first time in the three dimensions: street level (< 1g), medial level (1g to < 100 g) and wholesale trade level (>= 100g).

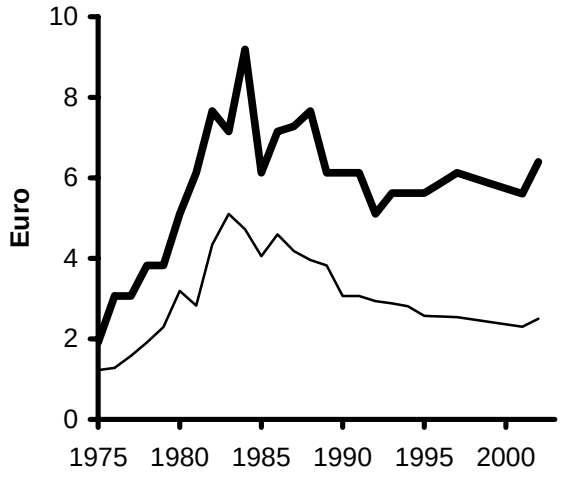
Cannabis

The price for cannabis which reached its peak with 9,20 € per gram in 1984, was on average 6.40€ (2001: 5.60 €) in street trafficking of the individual Federal Laender in 2002 (Figure 16).

Out of 3.752 quantified samples of cannabis resin, 72 % showed a tetrahydrocannabinol (THC) level of 3 to 12 %. 9 % of the tested samples had a lower potency. 19 % of tested samples showed a higher potency. There were samples with a THC content of more than 20 %. The highest level found was 39 %. The proportion of samples with a potency extremely high does not differ much compared with the previous year (Figure 17).

Nearly 50% of the 3.705 reported marihuana samples showed a THC-level of up to 8%. For 15 % of the samples the level was over 14 %. The highest concentration for marihuana was 40 %.

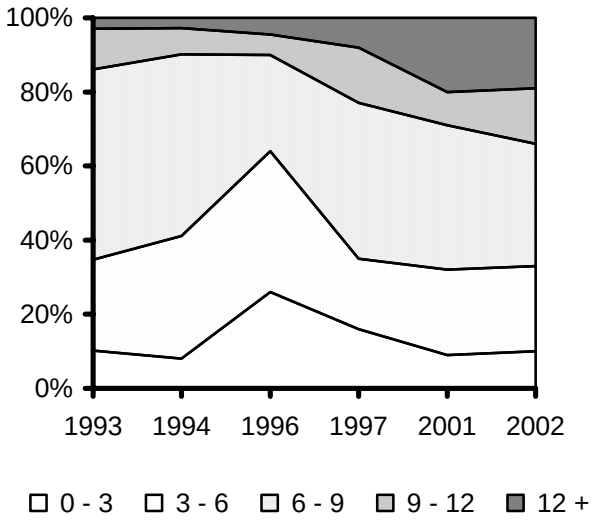
Figure 16: Prices per gram hashish for small and large quantities



€	1975	1985	1995	2000	2001	2002
Small	1,90	6,10	5,60	5,60	5,60	6,40
Large	1,20	4,10	2,60	2,30	2,30	2,50

Source: BKA 2003, department in charge OA 21

Figure 17: THC-level of hashish



% of speci-men	<3%	3-6%	6-9%	9-12%	>12%
1997	16%	19%	42%	15%	8%
1998	9%	17%	47%	13%	14%
1999	8%	13%	43%	20%	16%
2000	10%	16%	46%	11%	17%
2001	9%	23%	39%	9%	20%
2002	9%	23%	37%	12%	19%

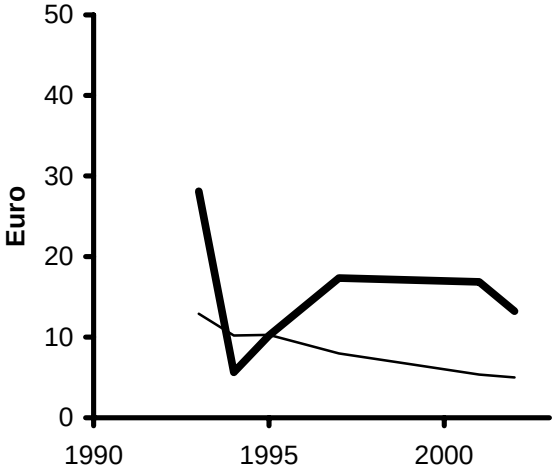
Source: Zerell et al. 2003

Amphetamines

The price for amphetamines which reached its peak in 1993, remained relatively stable and was on average 13.20 € in street trafficking of the individual Federal Laender in 2002 (Figure 18).

Out of 1.530 examined preparations 68 % (2001: 71%) had an amphetamine content of less than 10 %. 17 % were in the quality range of 10-20 %. For the rest of the samples, the quality levels were evenly distributed between 30 % and 80 %. On the lowest level, the street level there is with 75 % an increase in the lower content levels up to 10 %. 13 % of the samples on this level showed a potency between 10 and 20 % and 6 % a potency between 20 and 30 % (Figure 19).

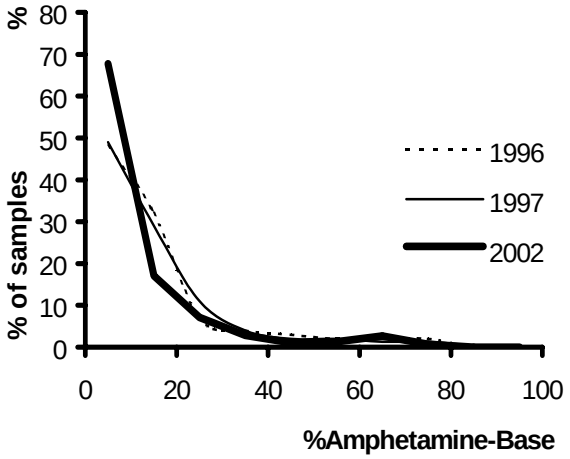
Figure 18: Prices per gram amphetamine of small- and large quantities



€	1993	1994	1996	2001	2002
Small	28,10	5,60	13,80	16,80	13,20
Large	12,90	10,20	9,10	5,40	5,00

Source: BKA 2003, department in charge OA 21

Figure 19: Purity of amphetamines



% of speci-men	<10%	10-20%	20-30%	30-40%	>40%
1996	48%	32%	7%	4%	9%
1997	49%	29%	11%	4%	7%
2001	71%	17%	6%	2%	4%
2002	68%	17%	7%	3%	5%

Source: Zerell et al. 2003

The preparations contained most frequently caffeine (65 %), metamphetamin (9 %) and ephedrine (2 %) as additive. Mainly lactose (78 %) and glucose (14 %) were blended into the analysed samples.

Amphetamine derivates

For a total of 2.335.062 tablets and capsules (2001: 2.836.101) – in the following named consumption units - purity was proofed. 99.6 % contained one psychotropic agent (mono-preparations), the rest two and three additive drugs. 98.4 % of the mono preparations contained MDMA, and the remaining contained 1,6 % amphetamine, methamphetamine, MDE and MDA. Regarding ecstasy the amount of active substance fluctuates between 3 and 362 mg per consumption unit. The average is around 63 mg.

The following table 16 lists the concentration of active ingredients in the individual substances.

Table 16: Active ingredients in seized amphetamines

Active substance	*Range (mg per consumption unit)**	*Average contents (mg per consumption unit)**
MDMA	***3 - 362***	***63***
Amfetamin	***< 0,1 - 36***	***10***
MDE	***14 - 62***	***42***
MDA	***21 - 69***	***46***

Source: Zerell et al. 2003

* calculated as base

Mono preparations and combined preparations contained most frequently lactose as an additive.

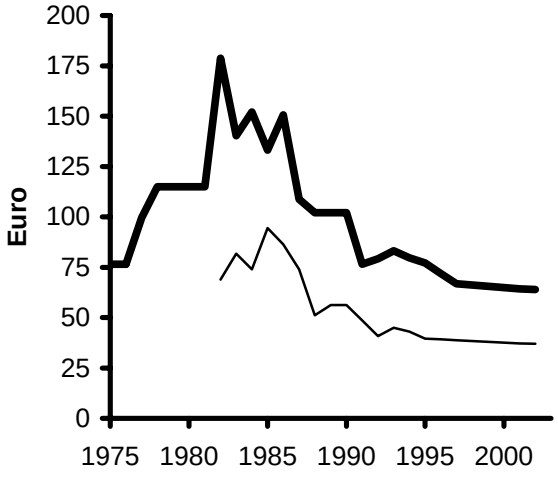
The problem of impurity and unclarity of the chemical substances in tablets sold as ecstasy seems to be rare. The wide fluctuation is problematic for consumers in terms of a dosage with little risks. Pill-testing supposed to undertake especially chemical analyses with quantitative methods in order to reduce the risks of consumption.

Cocaine

The prices for cocaine also decreased considerably from 1985 to 1995. Since then they have remained stable. In 2000, approximately 62 € were paid for one gram of cocaine, in 2002 the price paid in street trafficking was 64 € on an average. Quantities above one kilogram, as seized from drug dealers, cost about half the price, i.e. 37 € (Figure 20). The purity of 2.780 samples was analysed. 14°% of the samples showed a cocaine content less than 20°%, 44°% a content ranging between 20 and 60%. 34°% showed a content ranging between 60 and 80°%. On the lowest trade level (street level) there is an increase in lower content domain. 31°% of these samples showed a cocaine purity under 20°%, 35°% a content ranging between 20 and 60°% and 28°% a content between 60 and 80°% (Figure 21).

Blended into the 1.996 analysed samples were mainly lactose (64°%) and mannit (20°%). The additives lidocaine (30 %), caffeine (8 %), and phenacetin (5 %) were mostly found among the active substances.

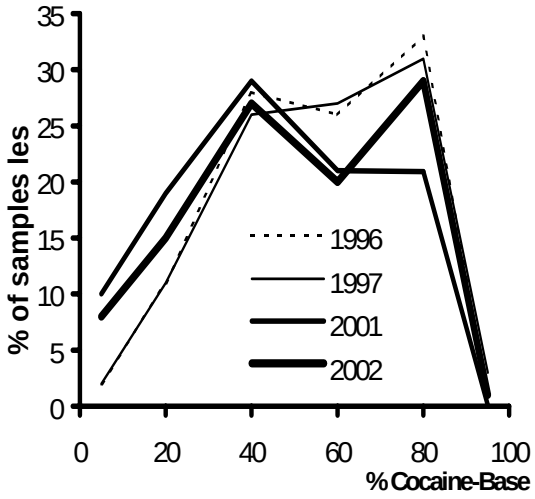
Figure 20: Prices per gram cocaine for small and large quantities



€	1985	1995	2000	2001	2002
Small	133	77	62	64	64
Large	95	40	37	37	37

Source: BKA 2003, department in charge OA 21

Figure 21: Cocaine base content of cocaine



% of specimen	<20%	20-40%	40-60%	60-80%	>80%
1997	5%	20%	28%	31%	16%
1998	12%	25%	29%	29%	5%
1999	5,8%	18%	24%	46%	6,2%
2000	19%	32%	20%	24%	5%
2001	19%	25%	25%	27%	4%
2002	14%	24%	20%	34%	8%

Source: Zerell et al. 2003

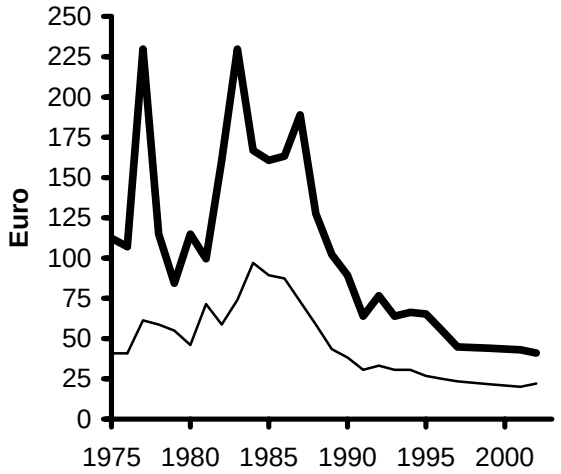
Heroin

Since 1975, the price of heroin had been subject to relatively sharp fluctuations. In the year 2002 the street price was on average 41 € per gram (Figure 22). The interrelation between price, purity and consumers or numbers of drug-related deaths is complex and cannot be represented by simple models (Kraus & Püschel 2002). Besides global circumstances (extent of opium harvest) also the local situation of drug dealers, huge seizures, etc. take effect.

The average level of diacethylmorphin reflects the purity of heroin samples and the level of active ingredients in the substance being offered on market. Out of 4.213 analysed samples 77 % showed a diacetylmorphine-level of less than 20 %. 20 % of the heroin formulations had a purity degree ranging between 20 % and 40 % (figure 23). Within the samples with a quantity less than 1 gram (street level) there is a decrease on the lower content level of less than 20 %.

Among the additives of the 4.147 samples caffeine (98 %) and paracetamol (99 %) and among the diluents glycerine (3 %) and lactose (5 %) were most frequently found.

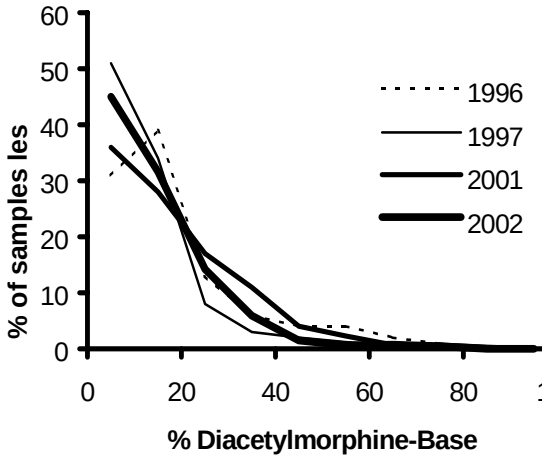
Figure 22: Prices per gram heroin for small and large quantities



€	1975	1985	1995	1999	2001	2002
Small	112	161	65	44	43	41
Large	41	89	27	22	20	22

Source: BKA (2003), department in charge OA 21

Figure 23: Frequency distribution of the diacetylmorphine-level in heroin samples



% of specimen	>10%	10-20%	20-30%	30-40%	>40 %
1997	51%	34%	8%	3%	4%
1999	49%	27%	11%	7%	6%
2000	37%	26%	16%	12%	9%
2001	36%	28%	17%	11%	8%
2002	45%	32%	14%	6%	3%

Source: Zerell et al.2003

6 Trends per Drug

6.1 Cannabis

Currently, cannabis is the most commonly used illicit drug of adults and adolescents. After alcohol and opiates cannabis is also the most common cause for outpatient councelling or treatment. In the year 2002 use of cannabis was the most important reason for counselling or treatment of 30.5% of the outpatient clients (Strobl et al. 2003a.). In inpatient treatment the portion of clients treated mainly for problems with cannabis was clearly lower with 6.8% (Strobl et al. 2003b). Cannabis also assumes big importance in criminal prosecution: More than half of the drug-related offences are carried out in connection with cannabis (2002: 59%, 2001: 57%). A look on the prevalent type of offences reveals that drug-use-offences account for two thirds of all drug offences in this context (BKA 2003a).

6.2 Synthetic drugs

3.1% of the people between 18 and 39 years in the old Federal Laender and 2.9% in the new Federal Laender have used amphetamines at least once in their life, 1.1% and 0.8% respectively in the last 12 months (Kraus and Augustin 2001). The number of amphetamine and amphetamine derivatives seizures decreased again in 2002 after it had increased significantly in 2000 (2002: 7.465; 2001: 8.038; 2000: 9.352; 1999: 7.770;) (Bundeskriminalamt 2003a). There was an increase of amphetamine users who became conspicuous to the police for the first time (2002: 6.666; 2001: 6.229; 2000: 6.288; 1999: 6.143). Also of the quantity of seized amphetamines/methamphetamines increased (2002: 362 kg; 2001: 262.5 kg; 2000: 271.2 kg; 1999: 360 kg) (Bundeskriminalamt 2003a). For the first time, consumers of amphetamines represent in 2002 the largest number of first offenders using hard drugs (32.9%) (see 4.2).

Ecstasy made its appearance on the German drug market at the beginning of the 90s. Despite relative small prevalences in current population surveys, ecstasy can be called the most popular illicit drug after cannabis used by adolescents (BZgA 2001b; Kraus and Augustin 2001). In the adult general population, ecstasy is most commonly used by the 21-to 24-year-old (Kraus and Augustin 2001). The number of cases found by police indicate an sharp increase for the year 2000. However, the number of seizures decreased slightly the last two years (2002: 3.417, 2001: 4.290; 2000: 4.681; 1999: 2.883; 1998: 1.986). The number of ecstasy users who were registered by the police for the first time because of drug use decreased after a continuous increase again in 2002 (2002: 4.737; 2001: 6,097; 2000: 5,495; 1999: 3,710; 1998: 2,830) (Bundeskriminalamt 2003a). 7,4% of all clients undergoing outpatient counselling or treatment in 2002 did so mainly because of ecstasy and other similar substances (Strobl et al. 2003a).

Mushrooms containing psilocybin and LSD are the most commonly used hallucinogenid drugs in Germany (Kraus and Augustin 2001). Other substances like for example mescaline, hardly count anymore. While LSD was a „cult drug“ in the 70s, it does not play an important role anymore these days in terms of figures. However, the number of LSD-seizures increased shortly at the end of the 90s, but decreased considerably afterwards (2002: 158, 2001: 289; 2000: 510; 1999: 434; 1998: 561; 1997: 727; 1996: 822) (Bundeskriminalamt 2002).

6.3 Heroin/Opiates

Heroin and other opiates like methadone, codeine, opium and morphine are only used to a small extent by the general population. Despite the fact that opiates use is not widely distributed among the total population it still is the main reason for treatment demand. 50.9°% of all main diagnoses were falling into this substance group in 2002. Risky application forms are widespread among opiate users. More than 70 % of the treated heroin users inject the drug (Strobl et al. 2003a). About 27°% of drug-related deaths registered by the police in 2002 were caused by a heroin overdose. In another 14 % heroin was the cause of death in association with other drugs (2002: 34% caused by a heroine overdose, 14 % caused by heroin in connection with other drugs). The number of heroin seizures registered by the police in Germany had decreases in the last few years with the exception of the year 2000 (cases in 2002: 6.658, 2001: 7.538; 2000: 8.014; 1999: 7.748; 1998: 8.387). With the total number of 6.378 individuals heroin users represent no more the highest percentage among hard drug users registered by the police or custom authorities for the first time (31.5%) (Bundeskriminalamt 2003a) (see 4.2).

6.4 Cocaine/Crack

Cocaine use significantly increased in the 90s. This applies both for the use during a certain period of life and current use (Kraus and Augustin 2001). Contrary to ecstasy or hallucinogenic drugs, whose consumption shot up only at the beginning of the nineties, the group of cocaine users in Germany has shown a steady yearly increase for more than a decade. Cocaine abuse or dependence as main diagnosis accounts for approximately 6% in out-patient treatment (Strobl et al. 2003a) and 5.1% in in-patient treatment (Strobl et al. 2003b). Cocaine is often used as an additional drug and taken together with opiates, but, to an increasing extent, also in combination with other substances (Vogt et al. 2000; Thane and Thel 2000). There was a downward tendency of cocaine seizures during the last few years, however there is a slight increase in 2002 (2002: 4.163, 2001: 4.044; 2000: 4.814; 1999: 5.491; 1998: 5.532). Also the number of cocaine users who became conspicuous to the police for the first time show after a decrease during the last years a slight increase in 2002 (2002: 4.933, 2001: 4.872; 2000: 5.327; 1999: 5.491; 1998: 5.691).

The use of crack which is a derivative of cocaine and is sold in the open drug scene under the term “stones” or “rocks” plays a special role. Frankfurt/Main and Hamburg are still focal points of this development (Kemesis 2001). Compared with the previous year the number of

crack seizures (2002: 1.628; 2001: 1.372) increased as well as the quantity of the seized crack (2002: 7.2 kg; 2001: 2.1 kg). Experts report about a high disposability of crack on local markets. At the same time a shortage of pulverized cocaine is reported. A higher level of aggression is noticed in crack users compared with heroin users.

6.5 Multiple use

Patterns of multiple use of drugs can be very different depending on the psychosocial context and motives of drug use of the user groups as well as the setting where the drugs are taken.

Table 17: Polyvalent consumption patterns of drug addicted men

	Main diagnosis						
Individual diagnosis	Alcohol	Opioide	Cannabis	Sedatives hypnotics	Cocaine	Other stimulants	Halluzi-nogenes
Alcohol	-	5%	3%	0%	1%	1%	0%
Heroin	5%	-	3%	0%	3%	1%	0%
Methadone	2%	-	1%	1%	1%	0%	0%
Codeine	10%	-	4%	2%	2%	1%	0%
Other pharmaceutics containing opiates	12%	-	5%	1%	3%	1%	
Cannabinoide	13%	29%	-	0%	5%	6%	0%
Barbiturate	18%	53%	5%	-	2%	2%	0%
Benzodiazepines	14%	61%	4%	-	3%	2%	0%
Other sedatives/ hypnotics	24%	35%	7%	-	3%	4%	1%
Cocaine	9%	47%	12%	1%	-	6%	0%
Crack	8%	47%	10%	1%	-	3%	-
Amphetamines	10%	25%	25%	1%	7%	-	1%
MDMA	8%	24%	32%	1%	7%	-	1%
Other stimulants	10%	17%	28%	1%	5%	-	1%
LSD	10%	36%	24%	1%	8%	12%	-
Mescaline	10%	33%	28%	1%	6%	14%	-
Other Halluzinogenes	12%	21%	41%	1%	6%	11%	-

Source: Strobl et al. 2003

The results of the German treatment documentation system (Strobl et al. 2003a) for the clients treated on an out-patient basis in 2001 and 2002 reveal that in particular patients with an opiate diagnosis (harming use or addiction syndrome according to the definition of ICD10) show to great extent polyvalent consumption patterns (table 17 and 18). Thus clients starting treatment primarily because of opiate use have frequently diagnosis concerning benzodiazepine (2002: women 51%, men 61%; 2001: women 46%,men 61%), cocaine (2002: women 56%, men 47%, 2001: women 55%, men 48%) or crack (2002: women 59%,

men 47°%, 2001: women und men 43°%). too. These figures have to be taken into consideration critically, especially with regard to the practice of substitution treatment in Germany. There are considerable risks in substitution treatment induced by the use of different drugs (Table 17 and 18).

Table 18: Polyvalent consumption patterns of drug addicted men

	Main diagnosis						
Individual diagnosis	Alcohol	Opioide	Cannabis	Sedatives hypnotics	Cocaine	Other stimulants	Halluzi-nogenes
Alcohol	-	5%	1%	1%	0%	1%	0%
Heroin	5%	-	2%	1%	1%	1%	0%
Methadone	2%	-	1%	1%	0%	0%	0%
Codeine	7%	-	3%	3%	0%	2%	-
Other pharmaceutics containing opiates	9%	-	2%	3%	3%	2%	-
Cannabinoide	10%	33%	-	1%	2%	9%	0%
Barbiturate	22%	33%	1%	-	0%	1%	0%
Benzodiazepines	17%	51%	2%	-	1%	1%	0%
Other sedatives/ hypnotics	25%	17%	3%	-	2%	2%	-
Cocaine	9%	56%	8%	1%	-	6%	0%
Crack	7%	59%	8%	1%	-	2%	-
Amphetamines	6%	28%	15%	1%	4%	-	0%
MDMA	6%	26%	22%	1%	5%	-	1%
Other stimulants	11%	21%	11%	2%	2%	-	-
LSD	11%	45%	16%	2%	3%	13%	-
Mescaline	-	37%	33%	-	4%	11%	-
Other halluzinogenes	5%	32%	25%	-	3%	21%	-

Source: Strobl et al. 2003

7 Discussion

7.1 Consistency between indicators

Most indicators show a close correlation since several years. In particular persons who are registered by the police for drug issues for the first time and treatment data reflect very similar trends. Compared with police data the higher increase of opiate users in the treatment sector during the last years may reflect that persons could be reached better by treatment offers. The considerable increase in methadone treatments might be the reason for it. Other indicators, partly based on very limited samples, seem to be influenced by many factors beside overall prevalence of drug use: The decrease of heroin prices since the middle of the 80ies goes in line with an increase in the number of heroin users noticed by the police for the first time until 1992. Availability and prevalence of heroin use were decreasing afterwards.

7.2 Methodological limitations and data quality

Whereas figures describing the consumption of “soft” drugs among the general population and their partial groups are relatively valid and statistical reliable, data describing the hard core of heroin users are limited due to numbers and quality. The police, having access to this group, is only able to provide an absolute minimum of data (age, gender, drug, location of arrest). Informations coming from treatment centres are also limited in their meaningfulness, due to the fact that not all persons affected use these offers. However, a satisfying quality of overall statements is enabled by cross-validating data coming from different sources.

Several indicators describing the epidemiological situation are not yet fully conform with the standard of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). For example the drug related death indicator: The age groups of drug related death cases delivered by the Federal Bureau of Criminal Investigation don’t fulfil the EMCDDA standard. In consequence the Europe-wide comparability of these data is reduced. The staff of the German focal point try together with experts to adapt the data. In order to harmonize especially the key indicators these experts take part in different working groups.

However national requirements referring to financial and technical limitations have to be taken into consideration. For this reasons the implementation of all demands might be delayed. Data from treatment centres still cover less than 50% of all existing out-patient centres.

For the year 2002 a poor representation of drug help centres has been registered from the National Drug Help Statistics (Simon et al. 2003). Not all Federal Laender are in bond to collect data according to the German core data set. The data transfer for national analyses is not standardized too. Basic statistics from individuals being by general practitioners under medical treatment specially for substitution, are not available. The national register for substitution treatment in it’s present form is able to deliver in future only the number of clients, their age and sex. In surveys information from individuals under 18 years is recorded

insufficiently. Six Federal Laender co-operate with ESPAD in 2003, which will improve the situation concerning data significantly.

The bulk of data used for the so called key indicators is primary intended for different purpose. The quality of the investigation, aggregation and the completeness of data can be controlled or influenced by the national focal point only in a restricted manner.

7.3 Conclusions

This chapter has been added to the structure of the REITOX-report 2002 in order to discuss general questions raised by the guidelines of the REITOX annual reports.

In particular the increase of ecstasy consumption activated public discussions and sorrows considerably at the end of the last decade. Specific prevention projects for rave party visitors and for techno music fans have been started. At least police data show a stabilisation of the situation and a shifting towards amphetamines respectively. Preventive measures and harm reduction measures supposed to keep this development in mind.

At the moment the indicators of drug market, treatment centres and police offences refer to a stabilisation and decrease of the heroin problem respectively.

Crack is getting more and more common and dominates in few large cities already the cocaine market. Up till now this applies only for Hamburg and Frankfurt. The spread of crack should be monitored intensively due to a strong pauperization and an increasing disposition of violence going together with the misuse of this substance. Maybe thereby a further geographic distribution can be avoided.

Even as primary drug cocaine is widely spread. Nevertheless most of the users remain without attracting attention. The extend of cocaine related problems, problem drug use patterns and effects are subject of a ongoing survey financed by the Ministry of Heath and Social Security. The results of that study are supposed to assess the problems of this group better than before in order to clear the question whether this people really don’t need help or whether help has to be offered in a different way.

The clear increase of seizures as well as the increase of consumer- and client numbers with regard to cannabis has induced the BMGS to finance a study to this. Results supposed to be available in 2004. Further activities are in discussion. The main question is whether the available help offers can manage this challenge concerning qualitative and quantitative aspects and what consequences this development might have for the discussion about the legalization of cannabis which is consistently flaming up. The clear increase of cannabis consumption within the population and the increase of treatment demand are important factors.

Prevention treatment, research and development are short of funds. Considering this situation the emphasis of different drugs in drug policy has to be proofed on the background of the demonstrated epidemiological development. Especially the strong concentration on heroin as a leading drug comes up for discussion.

Part III DEMAND REDUCTION INTERVENTION

8 Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

Prevention and treatment represent two thrusts of the national strategy for addressing the drug problem. They are the central strategic features (see 1.1). The division of tasks between the national and regional governments corresponds to the constitution, in which the responsibility for health affairs is given primarily to the federal states. The national level determines the legal and political framework, especially through the Narcotics Act (Dangerous Drugs Law) and the national action plans. Basically the same strategies are followed in the federal states as on the national level in dealing with addiction and drug problems. There are, however, differences in emphasis, depending on the drugs policy orientations of the individual regional governments and on the dimensions and manifestations of local drug problems.

Responsibilities at national level

The issue of “demand reduction” falls within the competences of various political and administrative bodies on the national level. Those primarily concerned are the Federal Ministry for Health and Social Security (BMGS) and the Federal Centre for Health Education (BZgA) which operates within the ministry remit. They undertake initiatives in this field and coordinate prevention-related activities. The BMGS, the Federal Ministry of the Interior (BMI) and the Federal Ministry of Justice (BMJ), in agreement with the federal states, determine the legal framework, which is of considerable relevance in **Measures for Reducing Demand**. Apart from its crime-focused measures with regard to drugs, the Federal Criminal Investigation Office (BKA), which is subordinate to the Ministry of the Interior, also undertakes information campaigns and preventive projects. The overall strategy, in which prevention is an integral component, is presented in the new “Drugs and Addiction Action Plan”, described in detail in Chapter 1.1.

Principles of prevention and treatment

Drug dependence in Germany is regarded from an insurance angle as a disease linked with psychological, social and somatic disorders. This corresponds to the concept of a disease as described in the WHO international classification scheme (ICD 10). In Germany, apart from prevention provisions, support is given for counselling and treatment with a wide-ranging addiction relief system tailored to the individual needs of people suffering from addiction. This consists of low-threshold social and health-related provision in the outpatient sphere, with special emphasis on survival aids and damage-limitation measures to reduce morbidity and the death rate among drug addicts and motivate more of those affected to accept further aid measures.

The “outpatient before inpatient” principle in medical treatment, also valid for drug problems, is not a new one, but up to now was applied to addiction treatment of opiate addicts almost exclusively in the context of substitute drugs. Rising figures and quotas in outpatient therapy financed by pension insurance schemes for drug addicts indicate that a gradual change is taking place, at least with regard to such treatment measures. The proportion of those insured who were granted for outpatient rehabilitation on account of drug addiction more than doubled from 1997 (4%) to 2002 (9%).

Up to now, a third (Strobl et al 2003) of all outpatient addiction treatment offered has been financed through local government funds, whereas all the other parties involved - regional authorities, the federal government and the insurance companies - provided obvious less. In view of the financial situation, particularly of many local government bodies (Süddeutsche Zeitung 10.07.2003), drastic reductions in voluntary contributions by regional and local authorities make a far-reaching restructuring process necessary. In the sphere of integration, close cooperation between social welfare organs at the local level and the branches of the Federal Employment Office has become more urgent in the face of the high numbers of unemployed.

8.2 Approaches and new developments

8.2.1 New and innovative approaches

At federal level

The 2003 “Drugs and Addiction Action Plan” drawn up by the federal drug commissioners sets out an overall strategy for the coming years. It foresees the intermeshing and mutual supplementation of the various complementary measures undertaken by the federal, regional and local governments and the social insurance bodies. Priority is attached to decentralised and local concepts (see 9)

- Measures to increase life skills are to be addressed above all to children and young people. Furthermore, preventive activities should include polyvalent and risky consumption patterns of young people to a greater extent,be more gender-specific and longer term.
- Public and private websites on illegal drugs are widely available from addiction prevention units, the youth services, schools, the medical sphere, the universities and committed private individuals. With the cooperation of the federal states, it is now planned to create a coordinating national Internet portal on the subject of “Addiction”, in order to network the available resources more efficiently. It is intended to establish links with other European networks on addiction prevention and be oriented to the requirements of users.
- Increasingly drug treatment centres offer counselling also online. This concept shall be further developed.

www.drugcom.de is an internet platform of the BZgA, which is addressed to young people and wants to inform about drugs. The consulting offers were used by more than 2,500 persons in the year 2002. 1.881 visited the general chat room, in which group discussions take place, moderated by specialists. In addition 374 single consultation in the chat room and 299 email consultations were carried out. Cannabis was the main topic in nearly half of the cases (personal report by Susanne Jordan, BZgA)

Drug relief services are increasingly offering online counselling. This approach is to be further developed.

The consumption of illegal drugs is particularly problematical in certain groups of young people. Efforts are being undertaken nationwide at various levels to reach young people with dangerous consumption patterns early and organise the appropriate support. The prerequisite for this is above all the sensitisation of local youth support bodies to the risks and consequences of drug consumption. It also requires addiction relief agencies to adjust their support structures to encompass the needs of young people. There are currently few structural points of contact between the youth support and addiction relief agencies, so cooperation between the two systems entails extensive specialist discussions.

At Laender level

To find out about initiatives and provision in the federal states, the DBDD interviewed the states' drug commissioners. A number of activities are presented here as examples from the information provided by the ministries. Since this report is principally concerned with changes and new developments, the depiction of the states in particular given here is not representative of the totality of their activities. In prevention work and to some extent in counselling and treatment it is difficult to distinguish between legal and illegal substances. The assignment of budgets to the subject of drugs is also not always possible according to the federal states.

Prevention

The Federal pilot programme "Early intervention for newly recognised drug consumers" (FreD) selected 15 pilot locations in 8 federal states to examine the extent to which youngsters and young adults coming into conflict with the law for the first time for the consumption of illegal drugs could be helped to change their behaviour through cooperation between public prosecutors, the police and drug relief agencies. The positive results presented in June 2003 in the monitoring report suggest the advisability of further intensifying cooperation between prosecuting authorities and relief provision.

The regional "Peer project in driving schools" initiative incorporates a special "teaching unit" in standard driving school training, in which peers address the issue of alcohol/drugs and driving. Input coming from those of the same age group is perceived as more authentic by young people. The exchange between peers makes them think about the issue and leads to behaviour modification. Initiated in Saxony-Anhalt, the concept has now been adopted by four other federal states and implemented in the state-owned driving schools.

Baden-Württemberg is planning two cross-border projects with France and Switzerland concerned with cannabis consumption. In the case of Switzerland, which shares a border with Baden-Württemberg, the planned further decriminalisation of cannabis is the subject of joint discussions and studies.

In the field of primary addiction prevention the state of Brandenburg is conducting various anti-smoking campaigns such as “Smoke-free school”, “Helping young smokers quit” and “Be smart – don’t start”. The state is also participating in the OPUS (Open participation network and school health) pilot project on health promotion and substance-specific addiction prevention in schools. This currently involves twenty schools. Pupils are trained as mentors who use health promotion information to point other pupils and young people towards healthy lifestyles.

Counselling and treatment

Bavaria is conducting a pilot study on motivating “therapy-resistant” drug addicts to undergo treatment. The question being examined is how chronic recidivist addicts, who have evaded established therapy provision or who have repeatedly broken off therapy and have no social foothold, can be offered low-threshold support. A therapy handbook has now been produced for this target group. The initial results are expected in 2004.

On the basis of a demand analysis conducted by the FOGS institute, Berlin is restructuring its outpatient drug treatment system. Six regional addiction services are being set up for the field of illegal drugs which guarantee provision of basic supply and integrate related fields (e.g. youth help system, medical care system). In future an integrated offer of help and care for addicts of legal and illegal substances will be developed. In Bremen, too, FOGS is currently helping to prepare a concept for restructuring the outpatient drug relief system. One aim of the restructuring measures is the development of a local coordination office. The city of Hamburg has commissioned an evaluation of its addiction relief system, the results of which will be available at the beginning of 2004. Special attention is being devoted to the issue of “orientation for quitting”.

In Mecklenburg-Western Pomerania the “Addiction Focus Practices” project for the long-term treatment of addicts is being financed by the health insurance system as part of a modern disease management initiative. The findings of the project evaluation report indicate that patients of medical practices with a focus on addiction tend to call on professional help more and so are more firmly integrated in the regional addiction relief system. The special position of the doctors in such practices offers the possibility of longer-term care of patients (Riedel et al. 2003).

A specific support provision for consumers of synthetic drugs and cocaine has been developed by the Youth Counselling and Youth Support Association in Frankfurt. This is directed in addition towards all Internet users wanting information on the subject of drugs and comprises a chat room and email advice. In 2002, 740 people visited the chat café; 562 people, hardly any of whom had ever sought contact with a drug counselling or addiction advice service before, used the possibility of asking questions by email (information from the

Department for Synthetic Drugs, Frankfurt). The Internet advice centre is thus reaching a group of drug-endangered or drug-taking youngsters and young adults, who have not so far felt themselves addressed by the established drug relief counselling provision.

Reintegration

In Pforzheim (Baden-Württemberg) the original Q-Train pilot project, since expanded to become Q-Train 2000, has been investigating the extent to which former illegal drug addicts, who have a fixed residence and can claim unemployment benefit or social security support, can be integrated into the working market. The results of the project have shown the importance of successful integration of the client into working life for the success of addiction therapy (see 11.3).

8.2.2 Socio-cultural developments relevant to demand reduction

With regard to cannabis especially, changes in public attitudes and a reduced estimation of risk are making it particularly difficult to deal with this substance. The discrepancy between the attitude on the support side and the demand for help and support on the consumer side is considerable. On the one hand there are cases, in which clients can't accept the abstinence oriented approach of the counsellors, on the other hand some counsellors do not always take the call for help of consumers and their parents serious enough.

8.2.3 Developments in public opinion

If drug consumption rooms are located at the focus of full public attention – such as in main squares – they often give rise to complaints from residents and not infrequently lead to campaigns aimed in particular at preventing people in the drug scene from gathering in the proximity of the premises involved. Rooms for taking drugs which are not in the public gaze or are in entertainment districts appear to have fewer acceptance problems (ZEUS 2002).

Similar problems are also familiar when it comes to setting up new drug institutions. In one town taking part in the heroin study, for example, a new institution had to be relocated several times during the planning stage, because each of the locations chosen caused massive protests from local residents.

8.2.4 New research findings

Pill testing

In Lower Saxony an evaluation study funded by the EU Commission was conducted in 2002 into the effects of pill testing programmes on the consumption behaviour and risk awareness of consumers of synthetic drugs (Benschop, Rabes, Korf 2002). The study was carried out simultaneously in Hanover, Amsterdam and Vienna. The joint analyses assessed data from 702 participants in the study. The adjusted sample from Hanover encompassed a subgroup of 235 participants.

The empirical findings of the study – which came in for some methodological criticism – showed among other things that:

- pill testing programmes can establish contacts with people who previously had not been reached,
- the programmes raise the level of knowledge about Ecstasy and lead to a less risky consumption behaviour,
- the programmes do not increase the consumption of Ecstasy and delay or prevent the onset of Ecstasy consumption among those still undecided.

Drug consumption rooms

The Federal Ministry of Health and Social Security (BMGS) conducted a survey of all 19 drug consumption rooms operating in January 2002 in order to evaluate their work.

The survey was conducted by the Centre for Applied Psychology,

Environmental and Social Research (ZEUS) and produced the following results:

- In the period from 1995 to 2001 over 400,000 drug consumption instances were recorded annually.
- In the period from 1995 to 2001 there were 5,426 emergencies and one death.
- Affects on the number of drug deaths are assumed. In a time series analysis for a set of cities statistically sinking death numbers were brought into connection with the establishment of drug consumption rooms.
- Drug consumption rooms improve the links between users and the health services.
- The target group foreseen by the legislation is reached; other people are effectively excluded: 96% of those taking part in the survey had been opiate addicted for several years.
- The problem of people in the drug scene gathering near the premises, which in some cases prompts regular complaints from local residents, remains unsolved.

8.2.5 Specific events during the reporting year

The Federal Women's Congress on Addiction

In September 2002 the "Federal Women's Congress on Addiction" took place. It was initiated by the Drug Commissioner of the Federal Government and accomplished in cooperation with the "quality circle women" of the professional association drugs (FDR). In this meeting the principle "Gender Mainstreaming" was stressed in the expert discussion.

Substance consumption in combination with cultural patterns of manliness and womanliness, as well as male and female development, leads to differing preferences for psychoactive substances. Gender-specific prevention and drug relief provision should therefore be increased. The experience of violence in childhood and early adulthood, the often heavily

concealed use of drugs and gender-specific risks in the consumption of psychotropic substances were important aspects. The special therapy needs of drug-dependent women in charge of children have also been insufficiently taken into account to date.

The year of young people suffering from drug-dependence

The German Centre for Addiction Issues (Deutsche Hauptstelle für Suchtfragen) declared 2003 the "Year of young people suffering from drug addiction" and launched an information campaign with comprehensive material for specialists, drug addiction relief organisations, youth support services and the media. This included an extensive "Young people and addiction" package of materials, a handbook for dealing with drugs in youth support inpatient facilities and a dedicated supplement for the magazine "Der Journalist".

The "Exemplary strategies in local addiction prevention" competition

On the initiative of the federal government's drug commissioners a competition to identify exemplary local strategies in addiction prevention was organised by the BZgA in cooperation with leading associations operating at local level. A total of 193 towns, rural districts and local authorities took part. Thirteen of the 220 competition entries won awards. Important addiction prevention target groups at local level were reached in their own environment. The local authority response to the competition was so lively that it will be repeated at two-yearly intervals in future.

Addiction prevention in the party scene

Following on from the "Drug abuse in the party scene" conference in 2001, the BZgA marked the International Day against Drug Abuse by holding an expert discussion on the subject of improving cooperation among the various bodies involved in the party scene. This discussion was the curtain-raiser for measures aimed at concentrating the resources available in the leisure sector for addiction prevention work.

9 Prevention

9.1 Summary

9.1.1 National Strategy

Since the early 1980s, a gradual shift in addiction prevention has been taking place; from purely providing information, the emphasis initially moved on to deterrence and later to promoting life skills. On the basis of broad specialist consensus, the development of resources and protective factors has become the main thrust of addiction prevention.

The new “Strategy on Drugs and Addiction” of the Federal Government, setting out the national principles for addiction and drugs policy for the coming years, places great emphasis on the field of prevention. The overall strategy is described in 1.1.

In view of the increase in consumption and abuse of “party drugs” in the 1990s, initiatives from secondary and tertiary prevention are now playing a greater role in current addiction prevention thinking. Based on the experience and concepts of secondary prevention, safety rules and pragmatic consumer counselling have been developed (Laging-Glaser2001), combined with provision for counselling and support.

The scientific principles for primary prevention were compiled in an expert study (Künzel-Böhmer, Bühringer, Janik-Konecny 1993) which is currently being updated with the support of the BZgA.

9.1.2 Organisation and co-ordination within national structures

Implementation of all laws connected with addiction prevention lies within the competence of the federal states [Laender]. Legislative measures, so far as initiatives in the fields of youth, education, social affairs and health are concerned, are subject to the competing legislation of national and state [Land] authorities.

Responsibility for financing, promotion of events and provisions for addiction prevention is shared by the states (see 8.1), social insurance agencies and local government authorities.

On the local government level, where most preventive measures take place, prevention in the sense of prophylactic health care is one of the obligatory tasks of the public child and youth services (SGB VIII). Within the framework of general youth work, youth social services and the protection of children and young people, addiction prevention should be aimed at fostering the development of children and young people and promoting self-determination. The nature, extent and quality of such measures are left to the local authorities.

Apart from special units for addiction prevention, which generally fall within the health sector, addiction prevention is also addressed in measures undertaken by the youth services, particularly the youth protection organisations. Youth service measures tend to focus on secondary preventive goals. With regard to addiction prevention in schools there are no

unified and binding standards of implementation; educational policy is the responsibility of the individual federal states and each school is responsible for conducting its own measures.

9.1.3 Expenditures on prevention

Funds for addiction prevention are provided by the federal states and also by social insurance organs and local government authorities. Within the framework of existing legislation, they are independent of federal government directives.

Each authority and funding agency is free to organise the financing and promotion of its addiction prevention activities as it thinks best. This also applies to the nature, extent and targeting of such measures. The distinct responsibilities of the federal, state and local authorities are defined by the constitution. The social insurance organs are independent of the state but are governed by special laws (esp. SGB).

The Federal Centre for Health Education (BZgA) is a body of the Federal Ministry for Health and Social Security (BMGS). It has a current annual budget of approximately € 6 million for addiction prevention, provided for from within the total budget of the BMGS (see 1.5). From this amount, roughly equal funds are allotted on the one hand to mass communication activities within Germany (production and dissemination of basic materials, advertisements, posters and audiovisual media) and, on the other hand, to direct communication measures within Germany (exhibitions, campaigns, training courses, Internet presentations and chat rooms etc.) as well as quality assurance and evaluation activities.

As the umbrella organisation of many associations involved in addiction care, the DHS receives annual project funding of around € 300,000 from the Federal Centre for Health Education for prevention projects.

Figures provided by the sixteen federal states indicate that they devote a total annual amount of some € 15 - 20 million to addiction prevention measures (state 2001; more current data is not available). There are no reliable figures for the extent of additional funding for addiction prevention activities provided by local government authorities.

9.2 School programmes

9.2.1 Specificities of policies

Due to federal state autonomy in education, in-school addiction prevention is organised separately by each federal state. Measures to promote life skills in kindergartens and schools have generally proved successful. Such strategies, which are mainly integrated in school curricula, consist of components with substance-specific issues (e.g. dealing with conflicts) and substance-specific content (e.g. tobacco consumption). Further to these are schools beginning to introduce measures targeted at endangered young people (e.g. older school pupils or pupils from higher-risk social areas).

9.2.2 Models of school interventions

There are models on three different levels for school prevention measures in Germany:

- Strengthening protection factors for children and young people
  - Life skills model / alternative experiences to drug consumption, by means of experience learning and cultural teaching elements
  - Peer education
- Early intervention and intervention in drug incidents
  - Crisis intervention and swift interventions providing motivation towards drug consuming pupils
  - Targeted contracts between teachers and pupils
  - Involvement of local prevention and counselling specialists
- Structural measures towards a “healthy school”
  - Creating a healthy learning atmosphere
  - Training counsellors for addiction prevention
  - School organisation
  - Addiction prevention as an interdisciplinary teaching principle / integration in the school curriculum

9.2.3 Available prevention programmes

There is a large number of school prevention programmes in Germany but these have not been systematically collected. In order to stay within the bounds of this report, here are just a few examples of widely used programmes. A broader survey of diverse programmes can be found in the EDDRA data bank at:

http://www.emcdda.eu.int/responses/methods tools/eddra.shtml

Examples of nationwide programmes for life skills promotion, already reported on (REITOX reports 2000 and 2001), are Klasse 2000 (*Super class 2000*), ALF and “Erwachsen werden” (*LIONS QUEST*).

In Germany, peer education is increasingly being used in preventive work and, given the right conditions, can be an effective method of reaching young people.

Example

Project title	**Buddy**
Institution	Koordinationsstelle für Suchtfragen/Landkreis Heilbronn und Landratsamt Heilbronn (*Coordination Centre for Addiction / Issues/Heilbronn District and Local Authorities*)
Target group	Two level 7 classes in Heilbronn and Weinsberg (pilot)
Aims	Developing alternative attitudes to addiction and violence among young people
Activities	Young people are provided with a “buddy” - a comrade and tutor - who builds up trust over the course of their relationship and acts as a confidant when problems arise

Further examples are “GLOS” (Gemeinsam leben ohne Sucht - *Living together without addiction*), the peer education programme in Saxony-Anhalt; “Nico”, the peer education programme in the Saarland; “Kids for Kids” and “Echter Rausch kommt von innen” (*A genuine high comes from inside*), multiplicator courses for school pupils in Thuringia.

Early intervention and intervention in drug incidents are aimed at the early recognition of abuse and the beginning of dependence, targeted at limiting the danger of chronic abuse. These measures are also effective in preventing consumption of illegal substances.

In the educational sector, provisions for health promotion and in this context for addiction prevention are now frequently components of school curricula. Prevention events in the form of project weeks are often organised for levels 8 to 10. In many schools there are “liaison teachers” or “counselling teachers for addiction prevention”, whose tasks include procuring and disseminating information relevant to addiction, informing and advising pupils, teachers and parents on matters of addiction and, if necessary, setting up contacts with local counselling units.

Example

Project title	**I lost my lung, Bob**
Institution	NLS - Niedersächsische Landesstelle gegen die Suchtgefahren (Lower Saxony Regional Office against the Dangers of Addiction)
Target group	Schools, from secondary grade 1
Aims	Healthy schools. Long-term aim: smoke-free schools
Activities	Concept for supporting schools aiming to be smoke-free

Example

Project title	**Initiated abstinence**
Institution	KOSS - Koordinationsstelle Schulische Suchtvorbeugung Kiel(Kiel Coordination Office for Addiction Prevention in Schools
Target group	Young people aged 15 to 18 (school levels 9 to 12)
Aims	“Initiated abstinence” provides an opportunity to become aware of and question one’s own behaviour and perhaps to change it.
Activities	11 steps from the establishment of the framework and schedule, making the contract and fulfilling it, to talking it over afterwards at various intervals

Example

Project title	**On the way to a smoke-free school - a guide for educators on how to deal with smoking**
Institution	Bundeszentrale für gesundheitliche Aufklärung (BZgA) (Federal Centre for Health Education)
Target group	Teachers, counselling teachers or educational social workers, pupils who smoke
Aims	Preparing and carrying out school or class-based contracts on dealing with smoking and implementing abstinence aids in school for pupils who smoke
Activities	Concept of the guide: 1. School measures for dealing with smoking 2. Class-based measures for dealing with smoking 3. Abstinence aids for pupils who smoke

9.2.4 Evaluation studies and results

The evaluation results of school programmes are presented in table 19. Evaluation results from projects reported on earlier can be found at:

http://www.emcdda.eu.int/responses/methods tools/eddra.shtml

Table 19: Evaluation and results of prevention programmes in schools

Projekt	Statistische Daten	Evaluationsergebnisse
Initiated abstinence	25,000 pupils from 90 schools 1994-2002 in the preliminary "Transparent School" model No data available from current stud	At the end of the first evaluation phase, the results show that immediately after the school prevention component 63%, and up to 12 weeks after the class unit 65%, displayed significant changes in attitude and behaviour. In the period 2003 -2006, the programme is to be evaluated for its long-term addiction prevention effects. Expansion to other EU countries is planned (Raschke & Kalke 2002)
Be smart-don't start	In the 2002/2003 school year, 8,402 classes = 218,000 pupils are involved.	The results of the process evaluation show that there was great acceptance of this project among pupils and teachers. The majority of pupils (72%) and teachers (78.5%) assessed the competition and the rules as "very good" or "good". In the follow-up one year after the start of the measures, 5% fewer pupils in the experimental group admitted to having smoked than in the control group (measured on the "four-week prevalence" basis). Furthermore, 70% of teachers questioned regarded the competition as "not very time-consuming" and as "easy to integrate into the teaching plan". (Hanewinkel & Wilborg 2003)

9.2.5 Research projects

In a continuation of the EU project "Addiction prevention in schools; scientific testing and conceptual further development of the 'Transparent School' school programme" (Raschke & Kalke 2002), the "Initiated abstinence" measure is currently being carried out among young people aged 15 to 18 (class levels 9 to 12) and evaluated external. This is aimed at testing

whether the “Transparent School” programme leads to positive effects among this age-group, with its specific consumption behaviour - a strong increase in prevalence rates and experimental behaviour, as well as the start of using illegal drugs.

A new expert study on primary prevention is currently being prepared by the IFT, the results of which will be available in early 2004. The study is receiving financial support from the BZgA.

9.3 Youth programmes outside school

9.3.1 Definitions

This section reports on programmes that are aimed at a young target group but are not part of in-school work or linked to them. Youth programmes outside school on addiction prevention are oriented to leisure activities or the workplace. In the first case, they range from simple leisure activities, discussion events, sports activities and party projects to elaborated experience-based learning concepts in the sphere of both organised and non-organised youth leisure activities. Work-oriented programmes for trainees take place in the context of in-house vocational training.

9.3.2 Types and characteristics of interventions

Organised leisure sphere

In many federal states there are federations of member associations for the promotion of legislative, educational and structural youth protection with the emphasis on addiction prevention. Addiction prevention measures in the public youth services are primarily aimed at providing leisure activities to meet the needs and problems of young people and at training the staff of youth institutions in dealing with young people with conspicuous behaviour patterns. The planning and execution of project work as a special form of carrying out addiction prevention measures in the youth sphere has therefore gained in importance over recent years (BZgA, 2003).

Example

Project title	**MOVE - Motivierende Kurzintervention bei Konsumierende Jugendlichen (*Motivational swift interventions for young consumers)***
Institution	Ginko-Landeskoordinierungsstelle Suchtvorbeugung NRW (*Ginko - NRW Regional Coordination Office for Addiction Prevention*)
Target group	Young consumers
Aims	Improving communication between reference adults and young people on their specific consumption behaviour and developing a professional approach to discussion. Promoting motivation towards changing possibly problematic consumption behaviour and agreement with the young people on concrete steps to be taken.
Activities	Training courses and handbook. Existing everyday contacts to young are made use of for systematic interventions (Move 2000).

Example

Project-title	**Addiction skills training**
Institution	Sozialpädiatrisches Zentrum (SPZ) Hamburg (*Hamburg Social Paediatric Centre*)
Target group	Teams of public educators
Aims	Training public educational staff to support children and young people in avoiding and overcoming problems with consumption and addiction.
Activities	A new ten-component training programme developed by the SPZ is being tried out this year with two of Hamburg's public education institutions to enhance the skills of the teams in the promotion of addiction prevention, in he early recognition of addiction-risk behaviour among the children and young people in their charge, and in appropriate intervention.

For sports clubs as elements of the organised leisure sphere, there are now well-proven methods; their effectiveness has been substantiated in evaluation studies (BZgA 2003), even though there are clearly limits to what is possible (Brettschneider & Kleine 2002). Further training of youth workers and trainers is an important component, for example, of the BZgA's "Make children strong" campaign. In the seminars, staff of sports clubs concerned with child and youth work are intensively schooled in comprehensive addiction prevention. Since 1995, 10,000 trainers and coaches from sports clubs throughout the country have been reached in 400 seminars.

Addiction prevention in vocational training

A large number of firms, businesses and administrative bodies carry out in-house addiction prevention and counselling measures, aimed especially at alcohol-related problems. The target groups of these measures are trainers and trainees. No statistics in this field are as yet available.

9.3.3 Evaluation studies and results

In the sphere of organised leisure activities for young people, Germany has tried and tested measures for addiction prevention, at local, regional and national levels. For other settings, such as youth leisure facilities, there are as yet no measures that have been established as effective (BZgA). Table 20 presents a survey of results from recent evaluation studies in this sphere.

The police, too, undertake preventive measures, which vary in their extent from region to region. Police research activities relating to drugs can be found at:

www.bka.de/pub/veroeff/band/band02/praevention.pdf

Table 20: Evaluation studies and results in the organised youth leisure sphere

Project	Statistics	Evaluation results
MOVE- Motivational swift intervention for young consumers	54 specialists from prevention and youth services as multiplicators	Evaluation of intervention from the point of view of contact persons and multiplicators: - the contact persons were able to use motivational discussion successfully in their everyday professional life - after their own further training, the multiplicators see themselves capable of conducting the training for others and schooling contact persons in motivational swift intervention.
Make children strong - further training for youth workers and coaches	Approx. 60 seminars = approx. 1.500 multiplicators in 2002	- the majority of participants report not only a clear increase in knowledge but also an enhanced degree of awareness of addiction-related issues - changes were less evident on the action level. In some areas, reactions were altered (listening more carefully, even to subjects unrelated to sports, a strengthening of community-oriented activities), but discussion of addiction prevention did not figure large in the context of work in the clubs.

9.3.4 Specific training for professionals and peers

In fast allen Bundesländern werden Schulungen für Multiplikatoren der offenen Kinder- und Jugendarbeit sowie für Ausbilder in Betrieben angeboten. Wegen der Vielzahl unterschiedlicher Anbieter fehlt es an einer Gesamtstatistik dieser Angebote.

9.4 Family and childhood

9.4.1 Definitions

Courses are provided in nearly all the federal states for multiplicators in the field of child and youth services and for trainers in the workplace. Comprehensive statistics are lacking, due to the wide range of different providers.

9.4.2 Types and characteristics of interventions

A range of skills-promoting and risk-reducing measures have proved their worth in kindergartens and schools. Measures that have proved especially effective are those that are ongoing and interactive, measures that can be refreshed by means of follow-up and reinforcing units and that influence knowledge, attitudes and behaviour on the cognitive and affective as well as on the behavioural level. Apart from behaviour-oriented measures, structural measures for organising the kindergarten and school environment are being put into practice.

Institutions that wish to acquire a health-promoting and drug-discouraging environment can receive support from their regional coordination offices for addiction prevention.

Parents' evenings in kindergartens and schools reach a large number of mothers, fathers and other reference adults with preventive messages (BZgA, 2003). www.starke-eltern.de is an Internet forum for education and addiction prevention set up by the Hesse Regional Office against the Dangers of Addiction.

There are now some projects in Germany that make special provision for the children of parents suffering from addiction, e.g. the Prevention Centre in Bremen, which with the help of experts is developing projects and materials for working with the children of addiction-affected families at the elementary and primary level.

Example

Project title	**LOS – Leben ohne Sucht und Gewalt** (*Life without addiction and violence*)
Institution	Bayerisches Staatsministerium für Gesundheit, Ernährung und Verbraucherschutz, Rotary Club (*Bavarian Ministry of Health, Nutrition and Consumer Protection*), Rotary Club
Target group	Target group Educators, heads of kindergartens, parents
Aims	Widespread implementation of educational methods and measures in kindergartens for preventing addiction and violence
Activities	- Further training of teachers in methods of preventing addiction and violence - Organising and carrying out circle meetings for kindergarten heads and staff - Parents' evenings

Example

Project title	**Experiencing and creating healthy kindergartens**
Institution	Landesvereinigung für Gesundheitsförderung Thüringen (*Regional Health Promotion Association, Thuringia*)
Target group	Children, teachers, parents
Aims	Creating healthy kindergartens
Activities	Events for promoting health, addiction prevention being one of six components - Further training - Work with parents

Example

Project title	Network for promoting non-smoking around birth
Institution	Büro für Suchtprävention Hamburg (*Hamburg Office for Addiction Prevention*)
Target group	All agencies, institutions and sectors concerned with expectant and young families and children, especially relevant medical institutes, health professions, anti-smoking promotion units in general and family education agencies.
Aim	Highlighting the importance of non-smoking in the context of a particularly motivated target group and a sphere with especially far-reaching effects (the family as an institution establishing life prospects and its children as future potential (non-) smokers).
Activities	Strengthening awareness of the importance of anti-smoking promotion, motivating and enhancing skills in each professional group and sector. - Creating opportunities for discussion of the issue and eventually eliminating - taboos on the subject - Further training provision for relevant professional groups

Example

Project title	"Make parents strong" - organising parents' evenings
Institution	Aktion Jugendschutz, Sozialministerium Baden-Württemberg (*Youth Protection Action, Baden-Württemberg Ministry of Social Affairs*) and Gewerkschaft Erziehung und Wissenschaft (GEW) Nordbaden (*GEW Teachers' Union, North Baden*)
Target group	Teachers and educators, parents
Aims	Strengthening awareness of addiction prevention among parents
Activities	Workshop for multiplicators in child and youth work and in schools on organising parents' evenings

9.4.3 Research projects and evaluation results

Further comprehensively evaluated experience of addiction prevention measures for families is not available, at least for the German-language area. Although the international literature indicates the usefulness of community-based provision oriented to families as a whole, in Germany there are only a very few exceptional concepts on which to draw in practice. One good example is the evaluated model on addiction prevention in family education centres (Suckfüll / Stillger, 2000).

9.5 Prevention in recreational settings

9.5.1 Strategies in recreational settings

In the non-organised and commercial leisure field, addiction prevention is currently just beginning. In the sphere of parties, in particular, many measures have been developed that pursue the aim of aiding young people towards as critical and risk-reduced substance use as possible. However, it is not just in the techno and party scene but also among risk-experienced young people and young adults who are difficult to reach that addiction prevention is faced with a new challenge: in future, preventive interventions should increasingly contribute to transforming short-term risk-experimentation or dangerous patterns of drug-use into stable and long-term "risk-competence". (Franzkowiak, 2002)

Party settings are the main focus in preventing abuse of recreational or party drugs. Here, a large number of potential consumers can be addressed at the same time. And personal communication methods meet with a large degree of acceptance. The question of the "right" way to communicate on the subject of drugs has yet to be solved and is still the subject of intense discussion among scientists, academics, politicians and practitioners. Whereas on the one hand the aim of abstinence continues to be propagated, other concepts are oriented towards achieving "competence" in the use of substances (e.g. measures on circumstance-related abstinence in the context of alcohol, and advice on damage limitation in the consumption of party drugs).

9.5.2 Legal situation of work in recreational settings

Drug checking - though controversial among both specialists and health policy experts - is a further element of secondary prevention and is aimed at providing information to reduce the consumption risks connected with the illegal drug market. In Germany, apart from a few exceptions, drug tests are not available. One such exception is the provision made by the DROBS drug-counselling unit in Hanover. With the help of an on-the-spot test (the Marquis Test) and examination of their external characteristics, pills at techno parties are identified on the basis of comparison lists. No detailed chemical analysis of the substances is undertaken. With the support of the Hanover public prosecutor's office, a way was found of carrying out tests without violating the Narcotics Act (Dangerous Drugs Law) (see 8.2.4).

The central legal problem involves the handling of the substance by the tester, since it is only within very narrowly defined limits that this is not regarded as 'dealing'. The fact that only in this one case was an appropriate arrangement with the prosecutor's office arrived at underlines the difficult legal conditions associated with this initiative in Germany.

9.5.3 Basic standards for regulating nightlife settings

All in all, party events have so far been permitted without restrictions but are often accompanied by police security measures. In order to improve communication between addiction prevention personnel, the organisers of events, the police and government authorities, the BZgA - on the International Day against Drug Abuse, June 6th 2003 - organised a forum of experts entitled "Cooperation to Optimise Addiction Prevention in the Leisure Sector". The potential for cooperation between the various parties was discussed, using the example of a summer festival in Cologne.

9.5.4 Guidelines for recreational settings

In September 2001 the BZgA held a conference on the development of addiction prevention in the context of the party scene and on the state of research with regard to Ecstasy. A reassessment of the guidelines in use since 1997 on the prevention of Ecstasy consumption was made. It was agreed between the participants and the representatives of the federal states that guidelines should now be based on the current action recommendations: "Prevention of Drug Abuse in the Party Scene - Tasks and Strategies" (BZgA 2002).

10 Reduction of drug related harm

10.1 Overview

10.1.1 The role of harm reduction within national drug policies

Harm reduction is one of the four pillars of the national drug strategy (see 1.1.1.) The major aim of harm reduction is to reduce mortality and morbidity. Social, psychic and somatic damage is to be reduced and the access to additional measures is to be simplified. Individual Laender refused explicitly individual measures of harm reduction, for example, supervised distribution of heroin to addicts or the offer of drug consumption rooms.

10.1.2 Harm reduction practice

During the last few decades a system of low threshold measures has been built up which has an important function in particular in the drug scenes of cities. Apart from supporting addicts to stop taking drugs the objective of contact centres and drug consumption rooms is to reduce the mortality rate among drug users.

10.1.3 Range of services

Outreach work is one method of supporting harm reduction in Germany. It addresses people who stay – in some cases because they are homeless – in streets and at public places and take only little or no advantage of help offered in the institutional framework. A second possibility are drug help centres which serve as a contact address for addicts and give support in emergency cases by offering psycho-social and medical help. In drug consumption rooms the risk of intravenous injection should be minimized.

10.1.4 Co-operation

Linking the offers of harm reduction and additional offers is to guarantee that the target group of the surviving help services can enlist the help of further measures without great problems. This political decision in favour of further development is the result of the development in this field during the last few years.

10.1.5 Co-ordination of national policies and local practice

According to the data available currently there are about 400 institutions offering services of harm reduction in Germany. These services are primarily financed by the municipalities. Consequently, there are problems concerning the financing.

10.2 Description of interventions

10.2.1 Outreach work recreational settings (definitions and delivery of services)

Outreach work is a part of social work and thus an essential basis for the actions of the help system for drug addicts. By taking up streetwork they try to increase the acceptance of help

offers. The aim is to increase or enhance the contact to addicts or people with harmful drug use, to support them and to initiate processes of change. The major objective of outreach work is to establish contact. Subsequently, sustainable relations are established and accompanying social support, for example, emergency help, crisis intervention and social counselling, is offered. Since streetwork requires a great amount of personnel and is thus an expensive way of addressing the target group using it as an approach seems to have decreased. On federal level it is not documented in how many projects and to what extent streetwork has been offered.

10.2.2 Prevention of infectious diseases

Preventing infectious diseases - like HIV, hepatitis B and C - offered by low threshold centres for contact and crisis interventions is the major measure of harm reduction. This idea of prevention plays also an important role for the self-help of drug addicts.

Distributing condoms for free and exchanging syringes are the major prophylactic measures. Syringes can be obtained in help centres for drug addicts, by means of syringe machines or against a small fee in pharmacies. In the field of self-help for drug users „safer-use-training“ is also offered. In many German health centres free HIV testing including additional counselling is possible. Since 1999 HIV tests have been part of a medical benefits catalogue of the public health insurance. The health insurance scheme pays for the tests if there are symptoms for a HIV-infection. If the test is made without any of these symptoms the tested person has to pay for it.

10.2.3 Prevention of drug related overdoses

In most cases drug related deaths can be prevented in drug consumption rooms since experts supervise the injection of narcotics and medical help is available in emergency cases (see 10.2.4.)

In addition to various media and help measures the organisation „Fixpunkt“ in Berlin has developed a video film - addressing drug addicts having life-threatening crises caused by their drug use – which was financially supported by the BMGS (Federal Ministry for Health and Social Security. In combination with first-aid courses the video is used to convey knowledge about drug emergency cases. It shows how an overdose is recognized and teaches how appropriate help measures are carried out, for example, the application of an opiate antagonist (Naloxon) in a drug emergency case. The organisation is the responsible body of the model project “Mobilix” which concerns the prevention of drug emergency cases and drug related deaths.

The results of the experts conference “Prevention of Drug Related Deaths” which took place at the beginning of 2001 were published in 2002 (Kraus & Püschel 2002). The major demands are to improve the quality of substitution measures (Kraus, Müller-Kalthoff & Shaw 2002), to enhance the access to substitution measures (Raschke, Püschel & Heinemann 2002) as well as to use Naloxon in acute emergency cases (Korporal & Dangel-Vogelsang 2002).

10.2.4 Users rooms / safe injection rooms

Although the injection of narcotics is monitored in drug consumption rooms by medical experts they can only appeal to drug addicts to prevent infections because the drug itself and frequently also the necessary utensils are taken to the drug consumption rooms by the drug users.

In drug consumption rooms the injection of narcotics is monitored by experts. The objective is to give surviving help, to stabilise health and to offer help to stop taking drugs, in particular to addicts who cannot be contacted elsewhere. The governments of the Federal Laender can pass regulations concerning the setting up of drug consumption rooms. 8 out of 16 Laender have passed respective regulations. In June 2002 there were 21 drug consumption rooms in 10 cities in Germany (ZEUS 2002). The framework regulation of the Federal government includes basic regulations for securing the quality of the programme, for example, emergency help must be available at any given time, subsequent help measures and qualified personnel must be provided, the co-operation with law enforcement authorities and the prevention of criminal acts inside and in the immediate surroundings of drug consumption rooms must be given (Table 21).

All 19 drug consumption rooms which were set up until January 2002 were examined on behalf of the Federal Ministry of Health and Social Security (BMGS) to evaluate the work of drug consumption rooms. The examination was carried out by the Centre for applied psychology, environmental and social research (ZEUS) and showed a number of positive results (see 8.2.4.).

Table 21: Overview of consumption rooms in Germany

City/Town	Consumption places for iv. consumption	Smoking places
Hamburg	55	17
Frankfurt	35	0
Saarbrücken	20	0
Hannover	11	0
Essen	8	4
Münster	6	1
Wuppertal	5	3
Cologne	2	1
Aachen	2	2
Dortmund	16	?

(dated: 02.01. 2002)

10.3 Standards and evaluations

10.3.1 Existence of professional standards on harm reduction interventions

Only experts with a qualified further education are allowed to work in the framework of treatment of addicts. A training for therapists specialised on addiction lasting 3 years in addition to an university degree or a degree of a technical college of higher education (for example in social work or psychology) is required. In some fields further qualifications are required. Physicians who are responsible for substitution need further education in medical rehabilitation of addicts. However, for work in the the field of harm reduction there are no special regulations or standards.

10.3.2 Evaluation studies harm reduction measures

Apart from the evaluation of the effects of drug consumption rooms (see 10.2.4) no additional studies were available when this report was written.

10.3.3 Training of staff

Workshops and trainings take place for the field of harm reduction and other special fields in the framework of further education concerning institutions and further education programmes on regional level. Charitable institutions, responsible groups, universities and training locations offer a wide range of programmes.

10.3.4 Research projects

There were no large-scale research projects in this field when this report was written. The new action plan drugs and addiction includes early recognition of new drug phenomena and early intervention as topics for the support of research. However, the budget has not been determined so far.

11 Treatment

11.1 „Drug-free“ treatment

11.1.1 Objectives and definitions of drug-free treatment

The concrete therapy objective of drug-free treatment is abstinence. Substitution is limited to the medication during the detoxification phases.

For addicts who want to cope with their addiction with professional help there is much help to get out of drug use, and there is a wide range of therapeutic services available. According to the recent state of knowledge treatment is split into four fundamental stages which actually merge in practice.

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

For further details please refer to the report of 2002.

11.1.2 Criteria of admission to substitution treatment

Out-patient treatment is available for everybody. To participate in measures of in-patient rehabilitation financed by the bodies of pension insurances requires the approval of the respective application. The objective is to re-establish the ability to work. The application can be refused because of doubts concerning the success of the treatment when the addict has already received several treatments. If the addict has no pension insurance or the pension insurance is not willing to pay it is also possible that the in-patient treatment is paid by the addict himself or by the body responsible for income support. In general the patient will not get an admission to substitution treatment before it is clear how the treatment is financed.

11.1.3 Availability, financing, organisation and delivery of drug-free treatment services

The available treatment offers cover the current demand essentially. Various forms of treatment’s organisation were developed in the structured system of national insurance in Germany. Out-patient counselling departments offer contact, motivation and a out-patient treating whereas withdrawal is generally carried out in so-called “regular hospitals” or in a few specialised institutions, too. Various kinds of institutions for the phase of rehabilitation have been established, for example, specialised units of hospitals, specialised clinics of therapeutic communities. In the phase of further treatment and after care a complex offer of help is made depending on the addict’s need which concerns jobs, housing projects or life in communities.

The objective of all those offers is to stabilise drug abstinence. However, in the field of substitution – a non-drug-free treatment - remarkably more drug addicts have been reached. So far the linking of the regular system of health providing in Germany and the special system of the drug help to a efficient union has not been completely satisfying. However, in some cases co-operation and co-ordination at regional level have developed well.

The transition between substitution and drug-free treatment has been simplified by the fact that meanwhile some in-patient institutions admit patients to the phase of rehabilitation even when they still substitute.

For many years the responsible bodies as well as many experts have been of the opinion that “first out-patient then in-patient treatment” is the basic principle for all kinds of medical treatment. Nevertheless the number of intensive out-patient drug treatment paid by bodies of the pension insurances has been relatively small. Current figures show a positive development. The amount of out-patient measures and financed rehabilitation treatments rose from 4% to 9% from 1997 to 2001 (VDR 2003) (Table 22).

Table 22: Approved treatments of rehabilitation

	1997	1998	1999	2000	2001	***2002***
in-patient	7.128	7.581	7.164	6.487	8.256	***8.152***
out-patient	304	571	564	570	***623***	***848***
total	7.432	8.152	7.728	7.057	***8.879***	***9.346***

Source: VDR 2003

The majority of the help institutions is financed by voluntary payment of the Laender and communities. In particular in-patient treatment is financed by public law bodies and commercial bodies.

Since the agreement „drug addiction diseases” was put into force on 1st July 2001 the process of treatment is clearly regulated between the bodies health and pension insurances. This agreement makes the tight connection between a qualified withdrawal and rehabilitation treatment possible. Furthermore, it simplifies the change between out-patient, partly in-patient and in-patient treatment. This agreement creates a good basis for a well-functioning rehabilitation of drug addicts. The structured system of financing in the Federal Republic of Germany includes benefits from social help, the legal health insurance, the pension insurance and the unemployment insurance for different aspects of treatment. Due to this fact problems appear often at the intersections. Up to now it is therefore hardly possible to finance measures of social rehabilitation, for example, work and activity projects, housing offers or measures to improve social integration by local welfare bodies. The result might be that in each case after finishing rehabilitation the re-integration into work and other social fields will not be supported sufficiently.

11.1.4 Evaluation results, statistics, research and training

One of the major standards in drug addiction treatment is the co-operation of different professional groups in the fields of medicine, social work/education and psychology. Holders of institutions, the Federal Laender or communities are responsible for quality management and professional monitoring of out-patient services, whereas in the field of detoxification and rehabilitation the respective funding authorities are responsible. Measures of out-patient rehabilitation financed by the pension insurances are controlled by experts of the pension insurances.

Experts who have generally qualified in specific further education work in all these fields. In the field of medical rehabilitation a therapeutic further education concerning addiction is obligatory and is examined and approved by the Union of German Pension Insurance Bodies (VDR) (see 10.2.1).

There are 300 specialised drug counselling centres and approximately another 800 addiction counselling centres which are in charge of drugs apart from other psychotropic substances. More than 1,500 withdrawal places and approximately 5,000 rehabilitation places are offered for drug addicts. Furthermore, there are additional addiction counselling centres for drug problems and other difficult situations.

In 2002 the bodies responsible for financing medical rehabilitation approved of 11,304 in-patient rehabilitation treatments and 1241 out-patient rehabilitation treatments for drug addiction and multiple drug addiction (Union of German pension insurance bodies, personal statement 2003).

A project concerning alcohol addiction developed and scientifically accompanied by the University of Oldenburg proved that a close co-operation of experts for addiction improves the treatment of addicts. The EVS project (Entwöhnung im Verbundsystem – rehabilitation in a networking system) supported financially by the LVA (Landesversicherungsanstalt – public law insurance corporation on Laender level) Oldenburg-Bremen was tested over a period of three years (2000-2003) and is now being introduced in the entire region (www.uni-oldenburg.de/devianz).

The project focussed on the difficulties of interacting out-patient and in-patient treatment (see 11.1.2) and the extension and networking of out-patient and in-patient treatment offers in this region. The basis of the project is a new application process concerning the financing by the pension insurance body LVA based on a concretely defined framework of payments within the public law regulations (among others SGB VI, Vereinbarung “Abhängigkeitserkrankungen - agreement on “addiction diseases” – dated 4th May 2001). It includes a general payment approval for out-patient and in-patient treatment measures within a treatment period of 52 weeks. The result was that the addicts were reached more efficiently by help services located close to the surroundings of them. Moreover, there was a considerable increase in out-patient rehabilitation treatments which cost compared to in-patient treatments substantially less. Accompanying the patients during the change between the out-patient

department and the clinic was in particular important for the successful conclusion of the treatment (Tielking and Kuß 2003).

11.2 Substitution and maintenance programmes

11.2.1 Objectives for substitution treatments

Substitution serves primarily for safeguarding lives, preventing secondary damage (in particular the infection with HIV) as well as for stabilising health and the social background of the patient. Moreover, the aim of substitution is to give patients the opportunity to participate in further treatments successfully and to make the accessibility to such treatments easier. The long-term perspective is the freedom of drugs.

11.2.2 Criteria of admission to substitution treatment

The Federal Chamber of Doctors included in its "Guidelines concerning substitute treatment for opiate addicts" that treatment is indicated if

- a manifest opiate addiction exists since longer and attempts of abstinence have not been successful
- a drug-free therapy cannot be carried out at the moment
- substitution treatment seems to be more successful than other therapy options

These guidelines which meet the requirements of the Prescription of Narcotics allow in contrast to their former version a greater range of clients to participate because no further diagnosis or follow-up diseases are required. Substitution can only be a part of an extensive therapy concept which requires apart from an extensive medical case history psycho-social care as well as the checking of the treatment and its results.

11.2.3 Availability, financing, organisation and delivery of substitution treatment services

The legal framework of substitution is essentially the Narcotic Law (BtmG) and the Prescription of Narcotics (BtMVV) (see 1.2). The BUB guidelines (guidelines about the assessment of examination and treatment methods of physicians according to $ 135 Abs. 1 SGB X) regulate the financing of treatment for members of the legal health insurances, and the guidelines of welfare bodies on municipal level according to the Federal Law on Social Help regulate the financing of treatment for people who are not a member of any legal health insurance. Generally, physicians are paid according to the EBM (Einheitlicher Bewertungsmaßstab = Uniform evaluation criterion). Since the BUB guidelines have also determined the regulations concerning psycho-social care – as long as counselling centres did not confirm it as not indicated – the discussions about funding of psycho-social care have intensified recently. This treatment is not financed by the health insurances, but mainly communities or integration help according to the BSHG. Laender and associations of drug experts are currently working on guidelines concerning psycho-social care.

In 2002 carrying out substitution treatment became remarkably easier. Instead of an approval process now it is sufficient when the start of a substitution treatment is indicated. In addition quality requirements were increased by the fact that physicians who carry out substitution treatment must have a qualification which must be obtained by special further education.

11.2.4 Substitution drugs and mode of application

Table 23 gives an overview of currently used substances and their mode of application in substitution treatment in Germany.

Table 23: Substitution drugs

Substance	Name of drug	Mode of application
Methadone	Methaddict	oral
Levomethadon	L-Polamidon	oral
Buprenorphin	Subutex	sublingual
Codein/Dihydrocodein		*oral*

Source: Möller, Lander 2001

The substitution drug can distributed in hospitals, doctor's consulting rooms and in pharmacies. Moreover, the distribution is also possible in appropriate facilities of addiction help which are recognised by the responsible Laender authority. For clients who are in need of nursing service- which must be confimed by a physician - it is allowed to apply the substitution drug during the visit at the client's home.

Distributing the substitution drug is only allowed for immediate oral use under visual contact. For codeine and dihydrocodeine it is possible to distribute single doses in packets for the rest of the day when the client has already taken one dose being monitored. Physicians are allowed to prescribe the substitution drug for seven days at most (take home prescription). This kind of prescription requires certain preconditions (minimum duration of treatment, no or at least only little consumption of other risky substances, monitoring on a regular basis).

In contrast to methadone, levomethadone and buprenorphin codeine/dihydrocodeine is not approved for substitution, but it can be used in well-founded exceptional cases. Physicians carrying out substitution are obliged to inform their clients about effects and risks of substitution drugs, the danger of accumulation and the danger of additional drug use which is not monitored and counsel them.

11.2.5 Psycho-social counselling (requirements and practice)

Psycho-social counselling is carried out by appropriate institutions of the addiction help. The transitions between counselling and treatment are fluid. The objective is

- to stabilise and improve health
- to regulate material situation
- social integration
- integration in jobs
- freedom of opiates/drugs

It offers appropriate help measures within and outside the drug help system in an objective orientated way and addresses each individual case. This requires a differentiated knowledge of the different offers of the psycho-social help system and the co-operation with the various institutions. Support measures of the psycho-social care institutions offered by interdisciplinary teams consisting of social worker, educationalist and psychologists can be, for example,

- support management
- social help in individual cases
- individual counselling
- group therapy
- offers for free-time/workshops/therapeutic group travels
- psychotherapy

The institutions offering counselling are financed in the framework of voluntary payment of the Laender and communities or in the form of integration help according to § 39 BSHG. However, permanent and stable financing of these forms of treatment is not guaranteed. Regulations are required urgently.

11.2.6 Distribution of substitution drugs

Reliable data is not available. According to police and therapists it is likely that the access to methadone on the black market is relatively easy. So far illegitimate production or import of methadone are not indicated. Consequently the methadone available on the black market is above all probably part of the stock of substitution drugs. However, its amount cannot be estimated.

11.2.7 Evaluation results, statistics, research and training

In 2002 approximately 35, 000 addicts were substituted with methadone, 11, 000 with levomethadone, 3,800 with buprenorphin and 2,300 with dihydrocodeine. These figures are based on an estimation of the DBDD which included the following aspects: the daily average dose of the used substance, the purchase of the mentioned substances (amount) by pharmacies in 2002, duration of the substitution. Since 1st July 2002 every physician who prescribes substitution drugs for opiate addicts is according to the Prescription of Narcotics (BtmVV) obliged to report the prescription, the substitution drug and client (code) to the

substitution register of the Federal Centre for Drugs and Medical Devices (BfArM). As soon as the initial difficulties with this register will be worked out more exact figures concerning the group of substituted are expected. Substitution on private prescription, which is likely to be the most common form today, will then be recorded as well. So far this field has mainly been excluded from monitoring because it is not subject to the regulations of legal health insurances.

In a meta analysis submitted by Reuter and Küfner (2002) altogether 14 studies concerning the results of methadone substitution in Germany in which more than 7,000 clients participated between 1992 and 1999 were evaluated. The authors noted that a high percentage of the clients stayed in contact and showed (one year after the start of treatment/care 85% of the clients had still contact with the institution) and constant improvements in the fields of health condition, job and delinquency. Additional use of other drugs has decreased slightly, however certain substances were still used by at least 30% of the clients. The clients consumed rather more alcohol. After one year 7% of the clients showed abstinence from opiates and the figure increased during further course. Comparing the results with drug-free treatment is regarded as difficult because of the different modes of selecting clients.

On 1st March 2002 the model “heroin supported treatment” started as a new offer of the surviving help. It has been carried out in 7 German cities and has been financed by several Laender and the respective communities. The model has been carried out as a clinical trial and accompanied scientifically. A limited number of heroin addicts who had not been successful in therapies so far, who could not be treated satisfyingly using methadone substitution or heroin addicts who had not been treated before have obtained heroin for injection as a medicine on trial basis. Parallel a control group obtains methadone. Both groups are regularly in medical care and are accompanied by a psycho-social therapy. You can find detailed information about the research design on the website of the project (www.heroinstudie.de).

Bonn, Frankfurt/Main, Hannover, Hamburg, Karlsruhe, Cologne and Munich have participated in the project. Altogether the participation of 1,120 addicts in the study is planned, half of them have been treated with methadone as the control group. The model project has been financed by the Federal government, the Laender and the cities. The scientific accompanying as well as half of the costs for the Case management personnel are paid by the Federal government whereas the costs on side and partly the Case management and physicians who are in charge of the study are financed by the cities. At the end of 2002 approximately half of the participants were selected and integrated in treatment. Even today the psycho-social care has already got a positive resonance (4th Interdisciplinary Congress of Addiction Medicine, Munich 2003). The substitution drug study co-ordinated by the Centre for interdisciplinary addiction research of the University of Hamburg (ZIS) and accompanied by the Federal Doctors Chamber is to be submitted in 2005 and might be the basis for applying for the approval of diamorphine as a substitution drug.

Since 1st July 2002 - according to the Prescription of Narcotics (§ 5 Abs. 2 Nr 6 BtMVV) - generally every physician prescribing substitution drugs must have a basis qualification of addiction therapy which is determined by the doctors chambers according to the general knowledge of medical science. Thus further education trainings are given by means of which the respective qualification can be obtained.

11.3 After-care and reintegration

11.3.1 Links with national strategy and legislation (new developments)

Reintegrating the drug users in jobs, housing and other fields of social life is a major aspect of the lasting success of the therapeutic efforts.

However, after-care and reintegration are financed only to a small extent by Laender, communities or holders of social security. Funding is not based on the Social Law.

11.3.2 Objectives, definitions and concepts of reintegration (such as education and training, employment, housing)

The objective of professional integration is to find a job including the payments for the social and pension insurances again - if possible on the first labour market. Social integration is primarily given by finding one's own flat.

11.3.3 Accessibility for different target groups (after treatment, after prison, for long-term substitution clients)

For clients participating in rehabilitation measures there is a relatively high chance that in particular measures of professional integration are supported financially. However, many drug users have no pension insurance. Thus reintegration measures are financed by special fonds of the job centres or communities. Due to the currently difficult budget situation it is very difficult to have access to such measures.

11.3.4 Organisation, financing, managing, availability and delivery of services

Apart from the holders of in-patient institutions approximately 150 holders of mainly common facilities offer a variety of different measures concerning after-care and integration which depend on regional necessities and conditions and address drug users in different phases.

In view of approximately 50,000 substituted annually in Germany the existing supports in the field of job/qualification for around 1,500 people, in the field of education for around 300 people and in the field of housing for around 2,000 people are not sufficient at all.

Accompanied housing is the major intervention of social reintegration. Accompanied housing is a generic term for different form of help in the field of housing. Its objective is to stabilise, to give aid to orientation, crisis intervention as well as in-patient treatment. Accompanied housing can be offered for substituted as well as for people who already live drug-free or people who need support. More than 2,100 places are available in approximately 80

institutions. Accompanied housing addresses people who need the care of experts on a regular but not permanent basis.

In Germany there are about 75 job projects and qualification measures with around 1,000 places for drug users. In view of the instable regulations concerning employment promotion of the Social Law a fall in places must be expected.

11.3.5 Statistics, research, and evaluation results

No new results or reports have been available when this report was written. Older projects are included in the REITOX report 2001.

11.3.6 Training

In this field there are no specific offers.

12 Interventions in the Criminal Justice System

12.1.1 Overview

The execution of sentences is under the responsiblity of the Federal Laender. The organisation of imprisonment, collaboration in law-making, financial and staff ressources, the fields of safety and building, employment of prisoners are under the responsibility of the respective departments of the Ministries of Justice.

To get drugs within prison is more difficult than to get them outside the prison. That is why drug addicts more often use risky ways of consuming (needle-sharing etc.).

12.2 Assistance to drug users in prisons

12.2.1 Availability, financing, organisation and delivery of interventions

Repression is the primary strategy of drug policy in prison to handle misuse of and addiction from substances. Through security measures (e.g. video monitoring, guards) and controls (e.g. urine samples, prison rooms) followed by consequences (e.g. withdrawal of relieves) drug use should be reduced. An additional external addiction counselling in prisons exists since the mid 80s and seems to become more and more established. Drug use in prisons is no longer generally denied but the aim within prison still is to be drug-free. Also within the execution of sentences more and more the paradigm of „addiction as a disease“ is followed.

Financing of supplies results from prisons and from employer centres. Counselling takes partly place with social workers serving in prisons, partly with the staff of external counselling services coming into prisons for profitable discussions.

12.2.2 Ranges of services

Beside measures of repression in the meantime it is accepted that external and internal offers of counselling are needed to reduce the demand for drugs. Services for users of illegal drugs can be:

- special areas for abstinent and non-addict inmates (drug free departments),
- information, counselling and motivation for therapeutic measures,
- support for the application for abstinence therapy and referral,
- harm reduction measures (e.g. syringe exchange),
- treatment based on medication (e.g. methadone substitution, treatment with naltrexone),
- check possibilities of „treatment instead of punishment“ in accordance to §§ 35, 36 BtMG,
- crisis intervention,
- single and group contacts during imprisonment
- self-help groups

Self-help groups for example „Alcoholics Anonymous“, were frequented by polytoxicoman prisoners. Generally such groups are welcome inside prisons and have mostly a positive influence to the participating prisoners. The participation normally is free and in the leisure time. Special self-help groups for drug users, for example „Narcotics Anonymous“ are rare inside prisons.

In several federal states substitution treatment in prison is offered officially. Not each of the federal states offers a substitution treatment for longer periods. Often it is only the withdrawal phase which is supported by medicaments. Substitution is also practised to bridge the stay in prison when a person has received methadone before imprisonment, when the stay is short or to prepare release. Hamburg which offered till now substitution for longer periods had to stop this action in 2002. Methadone treatment in prison is now limited to withdrawal phase (Die Tageszeitung 20.08.2002).

Four out of 223 prisons offer needle-exchange (two in Lower Saxony, two in Berlin). Machines offering injecting equipment were closed in Hamburg after the change of the Federal Government and the drug policy. In June 2003 two further needle-exchange projects, existing since 1996 were stopped in Lower Saxony (Stöver, personal communication). The only remaining federal state offering needle-exchange in prisons now is Berlin. Reasons for taking this decision are unknown.

An important aspect of re-socialisation as part of the execution of a sentence is the education of prisoners. Many prison inmates are considerably behind non offenders in education. To avoid in the first place that the youth offender without professional education “gets lost” and criminal behaviours are consolidated education is offered. On the basis of a differentiated concept besides courses at the level of supportive, elementary or primary schools (focus: reading, mathematics, writing in everyday situations) also courses at the level of junior high school and professional schools (theoretical and practical curricular units) are offered. For foreign prisoners partly further education is offered in their own language as far as possible. Leisure time courses for example inform about alcohol and drugs.

12.3 Alternatives to prison for drug dependent offenders

12.3.1 Objectives and organisation

There are different alternatives for convicted drug dependent offenders. If a sentence of an imprisonment is less than two years the person can participate a withdrawal measure instead of going into prison. This measure intends to support rehabilitation for longer period. The prevention of imprisonment supposed to motivate affected people to enter treatment. The risk of entering prison for the rest of the penalty in case of a treatment break off might help to avoid therapy dropouts. After serving a part of the sentence the convicted person can apply for treatment.

§ 31 a of the Narcotic Law allows to stop a running criminal procedure through public prosecutors or through court under the following conditions:

- Little quantity
- limited guilt
- no public interest
- the substance was determined for private use.

In Berlin, Bavaria and Saxony this rule is only used for Cannabis offences.

12.3.2 Access to alternative measures

§ 35 and § 38 of the Narcotic Law (BtMG) allow a delay or a break of an already ongoing imprisonment for illegal drug users if they enter treatment. This is only possible for a sentence of an imprisonment of highest two years (see 12.3.1).

The convicted person has to stay in a facility for rehabilitation or at least needs an appointment for the beginning of rehabilitation. It is also allowed to enter a facility for treatment or prevention of addiction which is recognised by the state. The convicted person has to bring a proof for the admission and for further treatment. Whether the person in treatment or the staff of the facility will record a possible breakdown of the treatment to the penal institution.

In a considerable number of cases this suspension of imprisonment is cancelled again and therapy abandoned. The Federal Ministry of Health and Social Security has awarded a study on this topic (Die Drogenbeauftragte des Bundes 2003).

12.3.3 Information strategies

No information is available about special information strategies with regard to this subject.

12.3.4 Co-ordination mechanism

To leave prison in order to start therapy is a process which in nearly all cases affords an application by one or more public prosecutor’s offices, which decide only after having all necessary papers (proof for a therapy place with admission date, written guarantee for taking over therapy costs, agreement of the responsible court). Delays and change of dates are within this procedure common.

Preparations and arrangements for an inpatient withdrawal treatment on the basic of §§ 35/36 Narcotic Law could be co-ordinated by extern drug counsellors or from the drug help system of the prisons.

12.4 Evaluation and training

Generally quality and quantity of measures can vary considerably. Drug counselling can be done by specialist with a professional education as social pedagogues or psychologist within

the staff or through external specialised drug counselling centres on request or on the basis of a defined number of hours. In the Federal Laender of Berlin, Hamburg and Lower Saxony syringe exchange has been tested in demonstration projects in small prisons. Measures for safe use like syringe exchange programmes and the distribution of clean material for syringes were introduced (see Meyenberg et al. 1999; Herrmann et al. 2001). Meanwhile this measures have been partly stopped.

12.4.1 Evaluation

Evaluation results concerning the projects in Berlin are meanwhile available. In two prisons of Berlin the project for distributing syringes was implemented. The total number of injection material sets was around 3.500 in the facility Lichtenberg (timeframe: 10/1998 - 7/2002) and around 4.500 (timeframe: 2/1999- 7/2001) in the facility Lehrter Straße. Watched over the whole period, the result was the following: injection materials were requested in both facilities and the measure was accepted well. After the implementation of this measure, needle sharing was seen only in selected cases and only within the first six month after entering the prison.

A project in an open prison (Heinemann and Gross 2001) showed a decrease in needle sharing in i.v. use from 51 down to 26% (N=49) through a syringe exchange programme. However, i.v. use amongst prisoners with 30% was still considerably higher than in closed units, where the prisoners had been before (17%). Experiences have shown that it is not too difficult to integrate needle-exchange projects into the flow of work (Stöver & Nelles 2003).

12.4.2 Statistics and research

There is no regular nationwide monitoring of the drug situation in prisons. A number of several single studies has been described already in the REITOX report 2001. On the basis of a pilot project guidelines for the treatment of drug offenders have been developed in Bavaria.

Risk behaviour in relation to infections

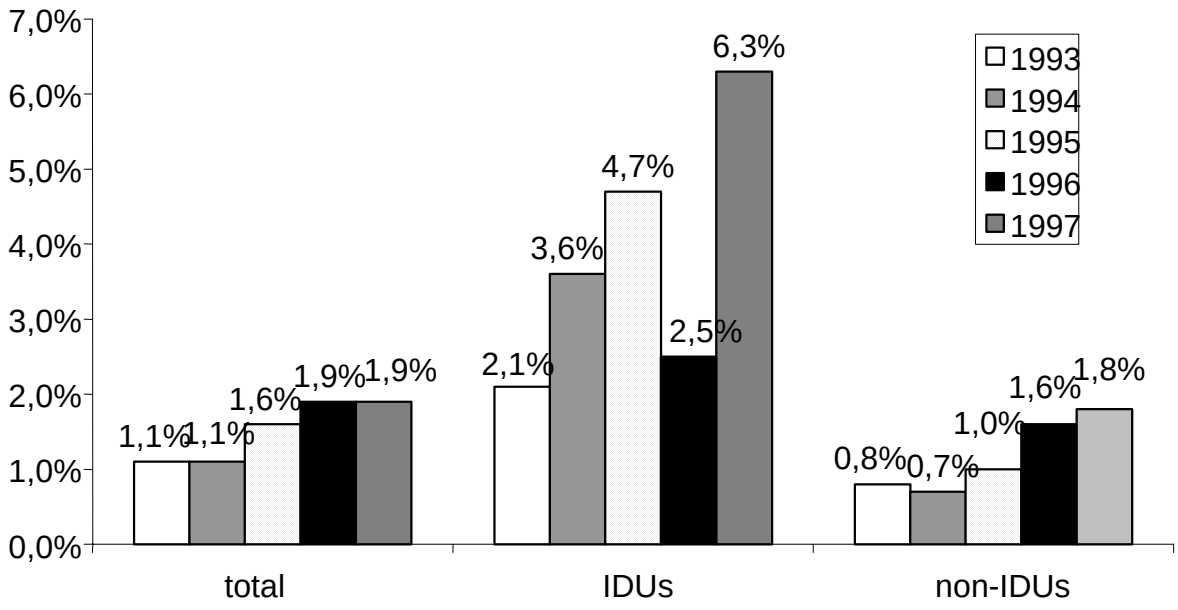
In one of the prisons (Cologne; N=437), which took part in the multi centre network study “European Network on HIV/AIDS and Hepatitis Prevention in Prisons (Rotily and Weiland 1999) from all subjects with i.v. drug use before prison one third (36%) reported i.v. drug use in prison, 27% shared injecting material with others. In the demonstrating project on infection prophylaxis done by Meyenberg et al. (1999) sharing of drugs was reported by 47% of the interviewed prison inmates, sharing of instruments 42%. Female inmates showed even more readyness to do so (drug sharing 71%, sharing of instruments 56%).

Prevalence of HIV, HCV and HBC infections

As imprisonment is under the responsibility of each Federal Land there is no common practise of testing of prisoners in relation to infections. In most Laender HIV-tests are done on voluntary basis as part of the medical examination on admission.

The prevalence of the infectious diseases HIV, hepatitis B and C in Hamburg prisons was researched in a prospective longitudinal study by Heinemann and Püschel (1999) between 1991 and 1997. It was shown that the total prevalence for HIV infections was between 1,1% and 1,9%. The highest prevalence as well as the most visible increase was found for the group of IDUs. Heinemann and Püschel (1999) could also show that there is a significant effect of the duration of drug use on HIV prevalence for i.v. drug addicts. HIV positive addicts had used drugs about double as long as HIV negative persons given the same age at the beginning of drug use (Figure 24).

Figure 24: HIV-Infection amongst prisoners



Source: Heinemann & Püschel (1999)

In a study in Berlin (Stark et al. 2001) prevalence-rates for the most important infectious diseases were 1999/2001 - short time after admission - 18% for HIV, 50 % and more than 80% for hepatitis B and C. No fresh infections were seen during the time of investigation. Four fresh HCV infections were observed; taking the incubation period into consideration, probably only one fresh infection was aquired during the period of the demonstration project. The affected person carried out the so called „frontloading“ with unsterilized syringes (Stark et al. 2001).

Availability of drugs in prison

About the availability of illegal drugs as well as on transport and prices in prison little validated data have been published in Germany until now. Within the institutions structures of demand and supply have been established similar to the drug market outside of them (Trabut 2000; Heinemann and Püschel 1999). The proportion of addict inmates who became criminal and sentenced drug traffickers is high in prison.

Altogether 14% (8.574) of all persons incarcerated at the cut-off date 31.03. 02 have been sentenced because of offences against the Narcotic Law (BtMG).

Due to the shortage and frequent withdrawal states drugs are exchanged and shared. Intravenous modes of application are used to make consumption as effective as possible. Through lack of syringes and insufficient techniques of desinfection high risk practices of use arise.

12.4.3 Training

For the general purpose, what to do with addict inmates, there are no special trainings offered to the prison staff. However corresponding contents are part of the standard training.

13 Quality Assurance

13.1 Description of new trends and developments

Presently different professional bodies are involved in the development of guidelines. These guidelines are prepared for different intervention areas based on the concepts of evidence based medicine. Drafts are already published, the final version is expected for 2004.

Looking at it from the aspect of quality assurance the availability of present scientific insights in research and practice is of crucial importance. Beside the “German Institute for Medical Documentation an Information (DIMDI), which is the central information system in health sector (www.dimdi.de), the archive for drug literature at the University of Bremen (ARCHIDO, www.archido.de) plays an important part also concerning international co-operation, especially within the scope of ELISAD. The centre of drug affairs (www.hls-online.org) of Hesse gives practitioners an understanding of the matter in a clear way with the help of an electronic “research newsletter”

13.2 Formal requirements

The requirements of the different methods for quality assurance are determined by the respective bodies. These are partly professional associations, partly the service providers themselves.

13.3 Criteria and instruments applied in quality assurance.

Quality assurance is part of a comprehensive quality management. The aim is to make appropriate offers at a high quality level for the clients of drug aid. Quality assurance focuses on the effectiveness and efficiency of the achieved service. Adequate structures and a well-tuned co-operation of processes which are targeted and followed by regulations are essential for a high quality result. The aim of a comprehensive quality management is to initiate a process of continuous improvement.

In Germany essentially three instruments for quality assurance are in use. They are also used by drug services.

- ISO 9000 ff,
- the system of self-evaluation of the European Foundation for Quality Management (EFQM)
- and the instruments of quality assurance of the service providers.

13.4 Application of quality assurance procedures and results

Counselling and out-patient treatment and care

In the sector of out-patient drug services nearly solely the EFQM instrument is used. In Lower Saxony “benchmarking” is very successful. Therewith counselling centres enter a quality competition with regard to their different activities and results. Facing the budget shortages in the out-patient sector and the requirement for services to have at least one part

time post for quality assurance, quality assurance is limited to the listing of treatment data and the attempt to collect “customer satisfaction”. Medical rehabilitation in out-patient services is financed by means of pension funds and is subject to supervision of the funding agencies. The applicability of instruments which have been developed for the in-patient centres, still has to be proofed for out-patient centres.

In-patient treatment

The inpatient treatment centres for medical rehabilitation are comprehensively integrated into programmes of quality assurance which have been initialized by pension and health insurances. Among others this includes surveys among patients concerning their satisfaction, an examination of the clinic’s concept and its equipment and the standard realisation of treatment. Quality circles consisting of therapists of comparable treatment centres are established for supervision and the handling is examined in single cases (peer review). However, only few inpatient drug centres initiated certification procedures concerning quality assurance.

Documentation is a basic condition to analyse and to improve the quality of activities. As till now, there is no general documentation programme in treatment centres, there is a lack of necessary records. Though there exists the German core data set which includes the items of the treatment demand indicator protocol (TDI), the problem of data collection is not yet solved completely from administrative side. The technical equipment is available.

Prevention

At the moment due to the federal structure and the subsidiary principle in the German health system there are no unified formal requirements or criteria for quality assurance of measures for demand reduction despite some efforts in the field of prevention have been made. A variety of approaches, methods and instruments are applied in the Laender and local authority districts. However, there are very great differences concerning the resources which are available.

The Federal Centre for Health Education (BZgA) is busy with the planning of new measures and campaigns as well as with the evaluation and further development of existing measures and campaigns based on actual scientific knowledge. The result of this phase of planning is a conception about aims and instruments or measures to reach specific aims. As a part of their main objective they are developing at the moment a standard documentation for activities in the field of prevention. At the moment an expertise for primary prevention is prepared and supported financially by the Federal Centre for Health Education. The objective of the expertise is a synopsis about the current knowledge in this field.

PART IV SELECTED ISSUES

14 Evaluation of Drugs National Strategies

14.1 Existence of evaluation

Attempts for the evaluation of national policy

Evaluation in its classical sense is carried out also in Germany by different working groups accompanying the activities of the ministries with comments and advice. Thus the Commission for Drugs and Addiction of the Federal Ministry for Health and Social Security, consisting of 12 scientists of different subject areas, issued a final report on the improvement of prevention in June 2002. They had investigated the existing strategies and worked out recommendations for their further development.

For the realization of the “National Plan to fight Narcotics” resulting from 1990, an evaluation of the Federal Government was carried out. The measures available for the Federal Government in this area are related basically to legislative actions, activities of the Federal Centre for Health Education (FCHE) and the Federal Criminal Investigation Office, the promotion of model programmes and international cooperation including support of the work of the EBDD. The remaining areas of work are under the responsibility of the Federal Laender.

The above mentioned evaluation is listing a number of legislative amendments and the herewith intended targets. For instance the possibilities for treatment instead of punishment have been enlarged for consumers and measures for survival aid as well as substitution have been legally secured. Moreover, efficiency of prosecution, especially towards drug trafficking, was increased by an improvement of structure and cooperation between Federal Criminal Investigation Office and customs. The legal framework for substitution and consumption rooms is also legally securing a number of quality standards. Model projects for the testing of new attempts in prevention and therapy (e.g. the prescription of heroin, use of the internet for primary and secondary prevention) have been promoted and afterwards partly financed by the Federal Laender. The FCHE was active throughout Germany within the framework of various campaigns. Concerning international cooperation, collaboration with the UNDCP and the EC is very important, measures in relation to the alternative development of producing countries are strongly supported.

Up till now the following further procedures for evaluation have also been used and their results influenced national or also regional strategies:

- Within the context of model programmes regularly new methods of prevention, consultation or treatment as well as new forms of organisation (e.g. Case management”) were tested and evaluated.

- Experts' reports were used to gain an overview about the state of research respectively current developments (example: experts' report on primary prevention).
- Different innovative projects were accompanied by scientists recording procedure and results and carrying out evaluations. In recent times the study about consumption rooms (ZEUS 2002) is an example for this procedure.

The part of evaluation in the Action Plan Drug and Addiction

Strategies showing from the beginning operational target settings and criteria assigned to them from which success or failure can be revealed, have not been used in Germany in national drug policy up till now. The Action Plan Drug and Addiction of the year 2002 takes up this attempt for the first time. For a number of exemplary measures provided for this, indicators and assessment instruments have been nominated for the purpose of indicating their success. However, a fine-tuning as announced in the text is necessary, as up till now only very general target quantities were used, not being connected very close with the objective. Thus an increased health awareness in population is used as a target measure for the quality of action concerning actualisation of training material, the carrying out of exhibitions and the continuation of a national campaign for primary prevention.

The plan emphasizes that success requires furthermore "coordinated activities of the Federal authorities, the Laender and municipalities, responsible and producing bodies of performance as well as free responsible bodies and initiatives". The conference of the Ministers for Health of the Federal Laender has for the most part taken notice of the Action Plan for Drug and Addiction and agreed to it, in some cases, however, rejected some special offers (consumption rooms, prescription of heroin) respectively announced more extensive initiatives (e.g. concerning advertising bans). Moreover, it should be mentioned that the Federal Laender spend considerable financial means in order to maintain and improve measures for addiction aid.

14.2 Methodology of evaluation

As no determined planning for an evaluation of national drug strategies is available up till now, it is too early to ask for a suitable methodology. According to the attempt of evaluation and depth of analysis, different methods can be chosen. In particular there has to be made a decision up to which extent structure, process and/or result of the drug strategy should be object of the evaluation. Depending on this decision the objects of observation as well as the regarded aspects are different. The procedures used up till now raised mainly the question if the planned activities had been realized. The complex question, if for instance desired targets were reached by legislative amendments, could also not be investigated systematically in the field of drug policy.

15 Cannabis problems in context: understanding increasing in treatment demand

15.1 Demand for treatment for cannabis use

15.1.1 Proportion of clients with primary cannabis problems

Cannabis can be found as an additional drug for almost all clients of out-patient counselling centres having problems with cocaine or opiates. At this point persons for whom cannabis is the main problem are of major concern. For this analysis therefore exclusively persons were taken into consideration for whom cannabis is the primary problem. Their diagnosis is either addiction or harmful use (ICD 10) of cannabis. A multiple diagnosis was only considered if cannabis was the primary drug. Within the framework of national treatment statistics there were given details of 454 institutions concerning 95.468 persons in Germany in the year 2002. Thus 44.6% of the existing 1.017 out-patient institutions in Germany were recorded (Federal Ministry of Health and Social Security 2002).

In 2002 6.368 persons with a primary cannabis related problem have started treatment in the reporting institutions. They represent 8,6% of the total clients and are the third biggest group after alcohol (67.0%) and opiates (14.4%) in out-patient treatment. The proportion of men is with 9.5% higher than of women with 5,7%. Differences between the Federal Laender in East and West Germany can hardly be seen. The proportion has continuously increased during the last 3 years (1999: 5.1%, 2000: 6.3%, 2001: 7.1%, 2002: 8.6%). (Table 24).

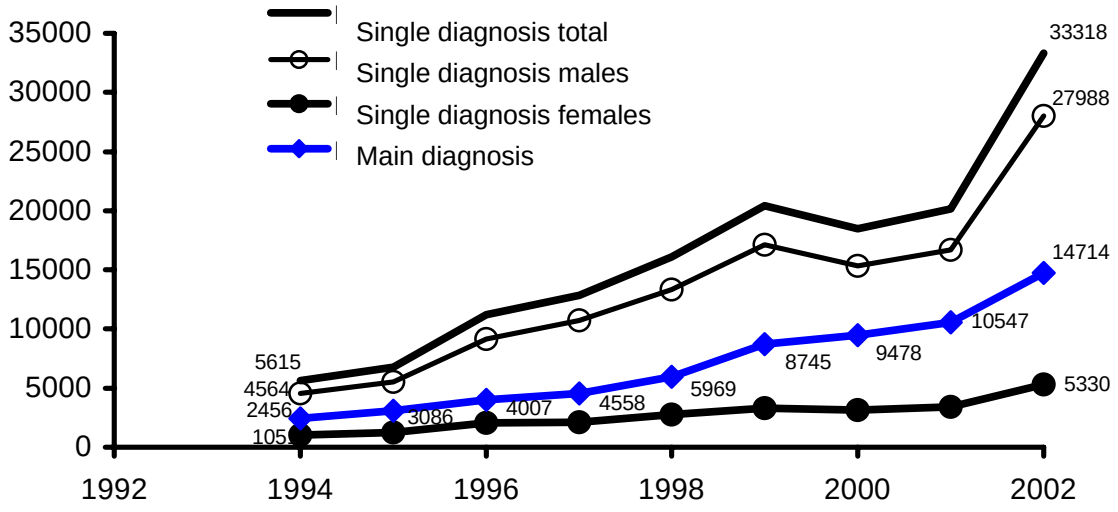
Table 24: Main diagnosis for persons with own disorder

Main diagnosis				2002		2001		2000		1999
	M	F	%	Abs	Total	Abs.	%	Abs.	%	Abs.
Alcohol	67,8%	64,2%	67,0%	49.515	69,2%	35.863	69,5%	40.054	71,5%	47.093
Opioides	14,5%	13,9%	14,4%	10.637	13,6%	7.038	14,4%	8.278	14,8%	9.742
Cannabinoides	**9,5%**	**5,7%**	**8,6%**	**6.368**	**7,1%**	**3.700**	**6,3%**	**3.632**	**5,1%**	**3.343**
Sedatives/ Hypnotics	0,5%	2,1%	0,8%	626	0,9%	462	0,9%	526	0,9%	621
Cocaine	1,9%	1,0%	1,7%	1.231	1,8%	942	1,6%	935	1,8%	1.167
Stimulants	2,0%	2,4%	2,1%	1.541	2,3%	1.185	1,8%	1.029	0,8%	530
Hallucinogens	0,1%	0,1%	0,1%	87	0,2%	114	0,2%	124	0,3%	192
Tobacco	0,4%	1,1%	0,6%	423	0,5%	257	0,4%	242	0,5%	321
Volatile solvents	0,0%	0,0%	0,0%	13	0,0%	11	0,0%	8	0,0%	12
Other psychotr. Substances	0,5%	0,5%	0,5%	386	0,3%	155	0,7%	415	0,3%	195
Total	100%	100%	100%	73.896	100%	51.840	100%	57.621	100%	65.910

Unknown: 21.571 (22,6%) of all clients; basis: EBIS: N= 95.468; source: Strobl et al. 2003

Besides the percentage of increase of primary cannabis cases also a significant increase in absolute numbers is evident. The development of main diagnoses since 1994 is shown in picture 25 – projected to the total number of institutions in 2001. The number of primary cannabis cases has increased about sixfold during the mentioned period. The same applies to the total number of all clients with a cannabis diagnosis – regardless whether this substance was the main reason for the problem or whether it was an additional use. More than 80% of all clients in the year 2002 are male. An increase of cases is more significant for men than for women (figure 25).

Figure 25: Number of admissions of out-patient clients with primary cannabis related problems



Notice: . To improve comparability the values were projected onto the total number of out-patient services in 2001

Source: EBIS reports 1994-2001 (Simon et al, Türk, Welsch); Deutsche Suchthilfestatistik (Welsch 2002); Strobl et al. (2003)

The changes in figure 25 are shown in percentage using the year 1994 as basis.

Table 25: Development of admissions for the most important main diagnosis

Trends	1994	1995	1996	1997	1998	1999	2000	2001	2002
Alcohol	100%	109%	127%	133%	140%	162%	138%	135%	151%
Opioides	100%	112%	130%	118%	137%	163%	139%	129%	158%
Cannabinoides	100%	126%	163%	186%	243%	356%	386%	429%	599%

Unknown.: 21.571 (22,6%) of all clients; basis: EBIS: N= 95.468; Source: Strobl et al. 2003

15.1.2 Demand for treatment and reasons for treatment

Every fourth woman and every fifth man contacts an out-patient institution without negotiation. However a high proportion of these clients has been motivated externally. 24% of men and 28% of women come by intervention of their family. Corresponding to the relatively young age of these clients normally the consumers' parents are involved. Also very often contacts for male clients are made by legal authorities and social administrations as road traffic authorities (Table 26).

Table 26: Mediation

Mediation by	Alcohol		Opiates		Cannabis	
	M	F	M	F	M	F
Without mediation	23,2%	26,9%	39,1%	37,9%	19,0%	23,7%
Relatives / Friends / well-known persons	12,1%	14,8%	11,7%	16,2%	24,2%	28,4%
Employee / company / school	5,2%	3,5%	1,1%	0,9%	5,6%	6,9%
Other counselling services	7,5%	8,4%	4,1%	6,4%	9,3%	12,2%
Legal authority / Social administration	15,2%	4,3%	18,7%	9,2%	30,0%	12,1%
Others	36,8%	62,1%	25,3%	29,4%	11,9%	16,7%
Total	33.215	8.780	6.648	1.753	4.368	752

Source: Strobl 2003

15.1.3 Profiles of clients

Sociodemography

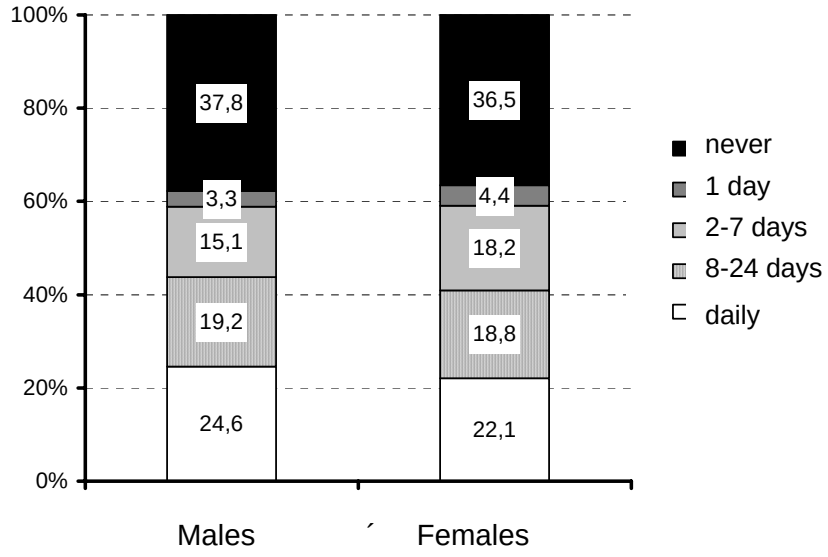
The main age group of cannabis clients in out-patient treatment is between 18 and 25 – among women a little lower. Nearly all clients started with harmful consumption of this substance before the age of 20. In comparison to that the main age group of opiate addicts is between 25 and 35 when starting treatment whereas alcohol clients are still about 10 years older. Only one in five clients with a primary cannabis problem (men 77%, women 80%) had been in addiction treatment before.

Patterns of consumption

The frequency of consuming cannabis at the beginning of treatment by cannabis clients differs considerably. On one hand one third of them indicates that they have not at all consumed cannabis within the last 30 days, on the other hand about every fourth man and every fifth woman uses cannabis daily, 40°% use the substance at least several times per

week. Already the frequency of consumption indicates that the majority of clients cannot be considered as non-problematic (figure 26).

Figure 26: Frequency of cannabis consumption for primary cannabis clients



Source: Strobl et al. 2003

In many cases cannabis clients are also consuming other substances. Especially amphetamines and amphetamine derivates are used to such a degree intensely by every fourth client that there was also made a diagnosis for this. The proportion of male and female cannabis clients is nearly the same. Significantly lower is the number of persons using cocaine (6.9%), crack (5.8%) or heroin (2.1%) besides cannabis (Table 27).

Table 27: Additional consumption of psychoactive substances by cannabis clients

Secondary diagnosis	Men	Women	Total
MDMA	20,0%	17,3%	19,6%
Amphetamines	14,0%	11,3%	13,6%
LSD	8,0%	5,6%	7,6%
Cocaine	11,8%	10,0%	11,6%
Heroin	5,0%	5,4%	5,0%
Alcohol	23,1%	15,8%	22,1%

Unknown.: 0 Pat. (0%) ; Basis: ; EBIS: N= 6.368 Source: Strobl et al. 2003

At present there is an ongoing study in German out-patient institutions of addiction help investigating problems and experiences of clients with a primary cannabis problem. First results are already available, the results of the complete study will be published probably beginning 2004.

Reason for admission

Nearly all female clients start out-patient addiction treatment on a voluntarily base with cannabis problems. This applies to men on in 74% of cases, in almost 19%, however, there are legal reasons. In comparison to persons with a primary alcohol problem in out-patient treatment this is a relatively high proportion. The figures for opiate addicts are similar (Table 28).

Table 28: Reasons for admission

Reason for admission	Alcohol		Opiates		Cannabis	
	M	F	M	F	M	F
Voluntary Treatment	88,3%	94,9%	78,8%	86,2%	71,9%	86,3%
§§ 35 - 38 BtmG	0,3%	0,1%	10,7%	5,8%	7,2%	2,6%
Other criminal basis	4,8%	1,0%	6,0%	3,6%	14,7%	6,5%
Civil law basis	4,5%	2,3%	1,3%	1,4%	3,4%	1,3%
Other reasons	2,1%	1,7%	3,3%	3,0%	2,9%	3,3%
Total	32.179	8.458	5.736	1.592	4.066	694

Source: Strobl 2003

About one fourth of the men and every tenth woman contacting out-patient aid institutions with a primary cannabis problem, are doing this because of a judicial decision or by order of an public authority. In many cases issuing or withdrawal of a driving licence are concerned.

15.1.4 Amendment of legal regulations

The legal situation in relation to car drivers and consumption of cannabis has changed in 2002 by judgement (BVG judgement 1 BvR 2062/96, 1BvR 2428/95). It declared that consumption of cannabis is not a sufficient reason in itself to deny a person's ability to drive a car. If, however, there is a connection between the consumption of cannabis and driving a car (for instance if cannabis is found in a car) the situation is different. It is reported by practitioners that pressure of authorities on consumers of cannabis has decreased a little after this sentence. The rest of the legal framework has remained almost the same for years. However trends indicate that on the whole intensity of prosecution has slightly decreased. Contrary to the presumed effect of these alterations in the legal situation the number of clients has increased significantly also in 2002.

15.2 Prevalence of problematic cannabis use and patterns of problems

15.2.1 Prevalence of problematic cannabis use

Comparative figures concerning consumption of cannabis in the population can be obtained from the Federal Study 2000 (Kraus & Augustin 2001) and the Drug Affinity Study by the Federal Centre for Health Education (2001) . About 10 million people – 19% of the age group between 12 and 59 years – have consumed cannabis once, about 3.4 million (6.4%) during the last 12 months. During the last year about 1.5 million persons (almost 3%) have used cannabis once ore more times according to the Federal Study which can be considered as indication of problematic use. About 0.2 million people are addicted according to DSM IV corresponding to the same study.

A regional study carried out in a relative big sample (NT3.021) with clinical instruments investigated 14-24 year old persons, it found out between 1995 and 1999 that 3.5% of the tested persons fulfilled the criteria of misuse according to DSM-VI and 0.9% criteria of addiction at some time during their life-time (Perkonigg et al 1997).

A population study however found out that consumers of cannabis compared to consumers of other drugs (e.g. hallucinogens, amphetamines) show with 20% the lowest rate of additional drug use (Perkonigg, Lieb & Wittchen 1998).

15.2.2 Car accidents under the influence of cannabis

In a „Roadside“ study investigating a representative sample of car drivers regarding different substances, cannabis could be proved at 0.57% of the tested drivers and alcohol at 5.48%. The respective figures for opiates were 0.15-0.62% (heroin, codeine). Only one out of 2.017 samples showed cannabis really in quantities (>40 ng/ml) causing an acute reduction of performance (Krüger, Schulz & Magerl 1998). The study recommends a rather careful evaluation of cannabis risks in road traffic. However the consumption of cannabis in the population has increased significantly once again after the survey.

15.2.3 Social problems related to cannabis

A number of investigations proved the connection between an intense consumption of cannabis and especially difficulties in adapting and performing. This result is mainly described in studies out of American sources. Kleiber and Kovar (1997) made a review concerning the effects of cannabis consumption. In a study investigating consumers of cannabis in non-clinical settings, Kleiber and Soellner (1998) showed a variety of patterns of consumption and on the whole very complex relations between the situation in the family of origin, social position and drug consumption among the tested persons.

15.2.4 Psychiatric problem related to cannabis

Consumption of cannabis results relatively often in acute affective disorders. Moreover, especially acute but also long-term psychotic disorders appear quite often (Caspari 1998).

Particularly the question concerning relation between the consumption of cannabis and psychiatric, especially schizophrenic disorders, is discussed. The direction of relation, causal connection or the availability of common reasons as well as the thesis that cannabis serves as self medication are examined. Negative effects of a self-medication with cannabis are described by Häfner et al. (2002).

15.2.5 Health problems related to cannabis

German as well as international studies deal with further effects on health. Latest meta analysis are for instance available from Inserm (2002) and Hall and Slowij (1998) about the entire field of negative somatic effects. Kleiber and Kovar (1997) published a summary concerning the consequences of cannabis consumption. Grant (2003) found in a meta analysis about neurocognitive effects negative influences for memory and learning which, however, decreased also significantly after prolongated abstinence.

15.3 Specific interventions for problematic cannabis use

Specific interventions for problematic cannabis use can hardly be found. With the exception of an institution in Berlin dealing with cannabis clients for many years, drug counselling centres take care of persons with primary cannabis problems. In spite of their quantity they are not specially considered as target group, however. An exception are special driving licence groups in which the clients of counselling centres are treated in common who are obliged to visit a number of sessions.

16 Co-morbidity

The concept of co-morbidity means that a substance use disorder and an additional psychiatric disorder exist at the same time. The simultaneous existence of different disorders caused by psychotropic substances does not fall under this concept. For this purpose terms like polyvalent or multiple drug use and dependency on multiple substances have been established. The presentation below follows this understanding.

Investigations at hand about the prevalence of co-morbid disorders lead to different results. The cause might be the practise of different diagnostic instruments or difficulties in setting a diagnosis, especially for laymen, as well as the time factor (e.g.: lifetime-prevalence, month-prevalence). Altogether data on co-morbidity in mental health and substance use are insufficient. From psychiatric experience and from different studies it is known, that a great deal of individuals who show psychiatric symptoms also use drugs and fulfil partly criteria for harmful use and dependency diagnosis respectively. Apart from this highly selective group of individuals data are available on a limited scale from treatment centres and surveys. In treatment centres normally social workers are not supposed to set up psychiatric diagnosis. Also interviews (face to face or in written form) have methodological limitations reducing the reliability of identifying disorders.

For the incidence of co-morbid mental disorders, different hypothesis are under discussion and partly complement each other.

- Drug use supports the incidence of mental disorders.
- Drug use is the attempt of self-medication in the presence of other psychotic disorders.
- Drug use is the attempt to reduce side effects of psychotropic drugs, especially of neuroleptic drugs.
- There is a common basis for the vulnerability of psychotic disorders and disorders in connection with drugs.

16.1 Main diagnoses and prevalence

16.1.1 The most common types of mental disorders diagnosed among drug users and prevalence

Different studies show that personality disorders (50-90%) are common co-morbid diagnoses in drug users. Affective disorders are in second place with a prevalence between 20 and 60%, psychotic disorders are to be found in 20%. Between 20 and 50% of the patients which have been examined show more than one co-morbid disorder (Uchtenhagen and Zieglgänsberger 2000). Altogether men are more often affected than women and young patients more often than elder ones.

On the basis of data from the Early Developmental Stages of Psychopathology (EDSP) study selected mental symptoms in ecstasy users were examined. The symptoms had not to fulfil the criteria of misuse and dependency. Ecstasy users appeared already in this younger age group with a clearly increased risk for depressive symptoms and also for nearly all DSM-IV-anxiety disorders. The group was compared with coeval non-drug using individuals from the same sample. Effects of sex and socio-demographic characteristics were controlled (Lieb, Isensee 2002) (Table 29).

Table 29: Anxiety disorders and depressive symptoms in ecstasy users aged 14 and 24.

Diagnosis	Odds ratio	95% confidence interval
Depression		
Major Depression	2.7*	(1.8 – 4.0)
Dysthymie	2.6*	(1.2 – 5.6)
Anxiety disorders		
Panic disorder	5.6*	(2.1 – 14.3)
Agoraphobia	1.6	(0.7 – 3.6)
Specific phobia	1.8*	(1.2 – 2.7)
Social phobia	1.2*	(0.6 – 2.2)
Generalized anxiety disorder	4.3*	(1.8 – 10.4)
Posttraumatic stress disorder	4.3*	(1.8 – 10.4)
Obsessive compulsive disorder	2.4	(0.7 – 8.1)

Sample: adolescent and young adults aged between 14 and 24 years, (N = 211/ Ecstasy and related drugs; N=1329 / no drug)
*p<0.05

Kessler et al. (2001) analysed studies carried out with a standardised instrument (CIDI) in six countries. The sample covered 28.000 individuals and showed for participants with problem drug use an accumulation of anxiety disorders and affective disorders. Chronologically, the psychiatric disorder appeared in most cases primarily, hence the authors concluded that psychiatric disorders might influence the appearance of drug problems. Shedler & Block (1990) demonstrated the complexity of this subject by means of a follow-up study carried out accurately. The study investigated the correlation between mental health and drug use in youth. Individuals who didn't take drugs in youth and individuals who were consuming intensively drugs showed problems in mental health later. People who were consuming experimentally were rated best. The epidemiological interrelationship between schizophrenia and problematic use of cannabis is known and proved. The causality is still unknown (Andreasson 1989). For an in-depth discussion see e.g. Häfner et al. (2002).

16.1.2 Prevalence in different sub-populations

Opiate dependants in different treatment centres

Within the scope of a 5-years follow-up study 351 opiate dependants were investigated in respect of co-morbid disorders. They all were in contact with treatment centres in Hamburg. The life-time prevalence of mental disorders was assessed with the CIDI according ICD 10 and represented 55% of the 272 participants. Personality disorders were disregarded first. Diagnoses dominated with 43% in the group of stress and somatoform disorders. In 31% affective disorders were diagnosed. Split personality disorders were uncommon (5%). 5% of the opiate dependants suffered from eating disorders (table 30).

As diagnostic instrument for personality disorders in opiate dependants the Personality Disorder Questionnaire was used. This questionnaire is in line with the criteria of DSM-III-R (axis II). About one third of the participants had at least one personality disorder. Most opiate dependants had personality disorders like paranoid, antisocial and borderline disorders (Krausz 1999).

Table 30: Lifetime-Prevalence of mental disorders according ICD-10 in opiate dependants (multiple diagnoses, details in %, N=351)

disorder		men	women	total[a]
F 20	Schizophrenia	3	2	3
F 25	Schizoaffektive disorder	2	3	2
F 2	Schizoid and paranoid disorder	5	4	5
F 31	Bipolar affektive disorder	2	2	2
F 32	Depressive Episode	12	23	16**
F 33	Relapsing depressive disorder	7	16	10*
F 34	Persistent affektive disorder	11	20	14*
F 3	Affektive disorder	26	44	32**
F 40	Phobic disorder	28	43	32**
F 41	other anxiety disorders	10	22	14**
F 44	Dissoziative disorders	1	7	3**
F 45	Somatoform disorders	9	12	10
F 4	Neurotic, stress and somatoform disorders	38	55	43**
F 50	Eating disorders	2	11	5**
F 5	Conspicuity in behaviour with somatic disorder	2	11	5**
	No mental disorder	50	31	45*
	Average number of diagnoses	1.0	1.8	1.3**

a)χ^2 -Test:*p<0.05;**p<0.01, source: Krausz 1999

IDUs in substitution treatment

Table 31 shows co-morbid disorders in a group of 200 HIV-infected intravenous consuming drug users, who were in substitution treatment between 1996 and 2000. No comments were given on the kind of diagnostic instruments they used. Mainly narcissistic and borderline personality disorders were found in the context of psychiatric co-morbidity.

Table 31: Psychiatric co-morbidity in 200 HIV-infected intravenous drug users in a treatment centre in Berlin 1996-2000 (multiple response)

Diagnosis	Percentage	Number
No psychiatric disorder	10	20
Adolescent crisis	4	8
Anxiety neurosis	14	27
Dissocial personality disorder	8	15
Narcissistic personality disorder	31	62
Borderline personality disorder	24	48
Psychosis	10	20

Source: Gölz 2000

16.1.3 Studies about drug-related risk behaviour among mentally ill drug users

For this subject there are no studies available.

16.2 Impact of co-morbidity on services and staff

16.2.1 Research and practice reports

Clients with co-morbidity make special demands to the staff of therapeutic centres. Individuals with psychotic disorders have difficulties in being abstinent and need a different proceeding and different concepts as they are usually necessary in drug services. They often need a long-term medication for stabilising the psychiatric disorder. This fact has to be in line with the demand to do without psychotropic substances. Furthermore, a therapy concept of a piece has to be traced. A very important aspect in particular is the interaction in case of recurrences. The integrated treatment concept – see 16.3.4 - tries to provide a differentiated treatment offer.

In general there is always the danger with co-morbidity to blind out one disease. Especially with substance use disorders, where the affected people tend to deny the problem, also the physician has to take care not to overlook this fact. The staff reports often about excessive demands caused by clients. They experience supervisions as being helpful, where they discuss about problems coming up with clients and with colleagues. Employees also experience that prejudices with regard to mentally ill people, were transferred to them (Hofmann 1002).

16.2.2 Professional qualifications in mental health and training needs of staff

In Germany neither for therapists and physicians nor for nurses special professional qualifications are available. In line with a two years course in tandem with work, nurses have the chance to look into this subject. Furthermore, adequate institutions offer advanced trainings in an interdisciplinary setting.

16.3 Service-provisions

16.3.1 General problems in treatment

Clients with non-organic psychosis, personality disorders or affective disorders and drug dependency often show a strong dynamic between the substance misuse and the mental disorder, furthermore, there is high risk of a chronic proceeding. Moreover a frequent re-entry into inpatient treatment is recognised. The risk of sliding back into drug addiction is also high due to a reduced compliance with treatment. There is also an increased risk with regard to drug specific additional disorders and follow-up disorders, for example hepatitis or HIV-infections as well as increased mortality risk. Furthermore, professionals report from an increased risk of social disintegration and criminality within this group (Uchtenhagen und Zieglgänsberger 2000).

The expert literature discuss two fundamental questions (Mueser et al. 1997) regarding treatment of co-morbid psychiatric disorders in drug abusers:

- Should it be a parallel/sequential or an integrative treatment?
- Should it be a disorder specific or a comprehensive treatment ?

In case of sequential and parallel treatment of a person with co-morbidity the treatment will take place with two therapists or therapy teams whether simultaneous or successive. In case of integrative treatment both disorders will be handled by one therapist or by one therapy team. For the client this form of treatment has the advantage that he is not confronted with twofold messages. Drake and Mueser (2000) argue clearly for the integrative treatment since otherwise clients with serious personality disorders are in danger to fail therapy due to defence mechanisms such as splittings.

The second problem field affects the choice between a disorder specific treatment and a comprehensive treatment. A disorder specific treatment concentrates predominantly on the needs of a specific group of clients. One effect of this kind of treatment is the exclusion of different groups of clients. In addition each treatment is a disorder specific treatment as far as each adequate psycho-pharmacological treatment is adjusted to the disorder.

16.3.2 Legal provisions for treatment of mentally disturbed drug users

There are no specific legal rules for this group of clients.

16.3.3 Policy of referral of clients

Drug counselling centres and in-patient drug treatment centres normally try to refer clients with co-morbidity to specialized drug services. Due to the small number of available treatment spots this is often not possible.

16.3.4 Co-operation between treatment services

In principle specialized drug services and mental health services are intended to co-operate with each other. Although different professions, agencies and modes of financing make co-operation difficult. Local working groups in the field of drug addiction and similar bodies are often an important medium of exchange.

In order to fulfil the needs of these clients psychiatric competences are requested as well as psychological-therapeutic competences. General practitioners are often swamped with clients with co-morbidity. The multidisciplinary co-operation of these competences is not sufficiently developed in the out-patient sector nor in the in-patient sector.

Clients with co-morbidity are mostly treated in general psychiatric institutions or in drug services. Networking between the two systems is still not developed sufficiently. Yet in traditional therapeutic settings clients are in danger to become losers. Therefore co-operation with both disciplines is requested urgently.

16.3.5 Availability and access to treatment

In Germany drug services and services for people with mental disorders are traditionally divided into two different systems standing relatively isolated side by side. The two systems are also made up of different professions. The main focus of therapy is already given with the choice of the institution – psychiatric hospital or drug service. Although in recent years some specialized departments were opened for this kind of clients, treatment offers for co-morbidity are rare.

Normally the general practitioner, the medical specialist, the polyclinic or the day hospital refer clients to the adequate institution.

16.4 „Examples of best practice“ and recommendations for future policy

Meanwhile there is an agreement that each comprehensive supply system for co-morbid clients has to allow an integrated treatment. This means that drug therapy and psychiatric therapy have to be available at the same time. First initiatives started about 20 years ago. Since then, specialized complementary facilities have been provided increasingly. Institutional experience show that the integrative approach has established in treatment (Landschaftsverband Rheinland 2001). The advantage of this approach is that substance use is recognised in all therapy aspects and also in further help. Concerning the decrease of psycho-pathologic symptoms (Schönell und Closset 2002) the integrative method does not create expectances that are to high.

As shown before treatment supply for co-morbid clients is still rare. Therefore it is not possible to make already general conclusions about the effects.

16.4.1 Current discussions with regard to co-morbidity

Professionals request for a better integration of co-morbid clients in psychiatry and drug services. The involved staff who is responsible for treatment has to take the special situation of co-morbidity into consideration and the divided medical care systems (the professional and financial splitting) which exists in this form since decades, has to be improved by co-operation. In order to create adequate treatment services, professionals demand on distinct and individual supply. One important area which should be improved is diagnostic skills, e.g. the clinical inventory of general practitioners.

16.4.2 Recommendations for improving future treatment supply

The improvement of the treatment of co-morbidity still need action. Existing services are not enough. They are also not based sufficiently on evaluated and operationalised concepts for treatment and aid. The Laender program in North-Rhine-Westphalia against addiction has looked into these problems and recommends the following:

- Drug services should be placed at regional level and inside or close to communities to make it possible to integrate clients - also difficult clients - in the long run.
- In small regions drug aid supposed to be integrated into exisiting supply for drug services and psychiatric services.
- Specialized institutions should be placed in crowded areas due to financial aspects.
- Development of low-threshold supply especially for co-morbid clients.

Acting on these general statements a set of measures is recommended.

The first recommendation underlines that the provision of qualified drug-therapeutic and psychiatric treatment in out-patient centres should be sufficient. Further on, a higher qualification of general practitioners and psychotherapists is necessary due to the needs of co-morbid clients. Moreover, the responsible bodies of out-patient drug services and out-patient psychiatric services should take co-morbid clients more serious. They should see them as a target group and should adapt supply accordingly. Rehabilitation of co-morbid clients is important and has to be improved. In most cases these are serious disease patterns with a high risk of a chronic proceeding. Therefore a qualified medical rehabilitation is very necessary. Especially with regard to the living situation one has to bear in mind that for co-morbid clients it is often difficult to stay abstinent. This problem should not drop them out from drug services.

Annex

17 References

17.1 Brochures

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17.3 Websites

Beside the addresses of the most important institutions, specially websites of innovative offers in the field of demand reduction were chosen. This list is, like the reference list too, only an extract from a huge number of addresses, available in this field.

Website	Contents
www.bmgsbund.de	Federal Ministry for Health and Social Security (Bundesministerium für Gesundheit und Soziale Sicherung (BMGS)
www.bzga.de	Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung; BZgA)
www.dbdd.de	German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction (Deutsche Refe-renzstelle für die Europäische Beobachtungsstelle für Drogen und Drogensucht; DBDD)
www.dhs.de	German Council against Addiction Problems (Deutsche Hauptstelle gegen die Suchtgefahren; DHS)
www.dialog-jugendhilfe-drogenhilfe.de	Supports the dialogue between young people and drug help
www.drugcom.de	BzgA Information for young people and party visitors
www.drugscouts.de	Laender Project in Saxony for young people
www.emcdda.eu.int	European Monitoring Centre for Drugs and Drug Addiction
www.ift.de	Institute for Therapy Research(IFT)
www.lehrer-online.de	Support for teacher concerning internet
www.partypack.de	Special offer for young people attending the techno- and party scene
www.rki.de	Robert-Koch-Institute
www.suchtvorbeugung.de	Association of prevention services for drug addiction in NRW (North-Rhine Westphalia)
www.suchtvorbeugung.de	Computergestütztes Lernen im Strafvollzug