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For a Holistic and Sustainable Drug Policy

Foreword by the editors Heino Stöver & Bernd Werse
Translated from German by Laura Steeghs

In 2021, the key issue in the 8th Alternative Drug and Addiction Report is alcohol control policy. The report reveals that Germany's attitude towards both alcohol and tobacco control policy is clearly very industry-friendly with little focus on a health-based approach. Several contributions will demonstrate the high price we will have to pay for this.

For the 8th time, the Alternative Drug and Addiction Report offers a critical and at the same time constructive view of current developments in the field of drugs and addiction in Germany. Renowned authors report on exemplary projects and innovative approaches, point out shortcomings and barriers, and design strategies for a holistic future drug policy.

Using the example of this year's key issue, alcohol control policy, shortcomings of past policies will become evident. We live in a society with a high affinity for alcohol and many opportunities to avert the various, multi-levelled harms that affect consumers, their surroundings and society as a whole remain unexplored. As a result, we suffer the health and social costs. Alcohol-related accidents, acts of violence, sexual assaults and the like are by far the greatest risks associated with the use of psychoactive substances in the public sphere (Steckhan, et al., 2020). German alcohol control policy cannot be considered consistent, especially since taxation measures do not even remotely steer towards a health-based policy. On the contrary, alcohol in Germany is still extremely cheap compared to other countries thanks to particularly low tax rates. Moreover, advertising restrictions on alcohol are not even being discussed.

The situation with regard to tobacco control policy is equally alarming. A few figures show the extent of the problem: 127,000 people die prematurely every year as a result of tobacco-related illnesses. On a yearly basis, over 450,000 people are hospitalised for treatment of tobacco-related disorders. Tobacco-related issues cost society 97 billion euros a year. In a European comparison among 36 participating countries, Germany is ranked lowest. Once more, one cannot speak of a consistent control policy using behavioural and situational preventative measures. Worse still, measures such as the recently passed tobacco tax on e-cigarettes actively lead us in the wrong direction: smokers are not motivated to switch to the far less harmful vaping if these products are taxed at a similarly high rate as traditional cigarettes, which are by far the most dangerous form of nicotine intake.

The German Cancer Research Centre has released a strategic plan to make Germany "tobacco-free" by 2040. Their goal is to have less than five percent of adults and less than two percent of adolescents use tobacco products, e-cigarettes or related products by the year 2040 (DKFZ, 2021). With a smoking prevalence of about 28% in Germany today, this is a very ambitious goal that cannot be achieved without using harm reduction measures. The strategy, however, does not mention harm reduction at all. As always, an exclusively abstinence-oriented approach dominates the plan, which, considering everything we know, is a completely unrealistic concept.

Whereas progress in the situational prevention of legal drugs is stagnating at a very low level, the criminalisation of illegal substances continues to spiral unabated. In 2020, the increase in police investigations into offences under the Narcotics Act continued: with 365,753 police investigations that year, Germany has never registered so many "drug-related offences". This development continues to be caused predominantly by the increase in offences related to personal consumption. Since drug-related offences are typically crimes with a low reportability rate (in Germany known as *Kontrolldelikte*), the high numbers can only be explained by increased police activity in the narcotics field. In this report, professionals in the addiction field will present the underlying motives for this approach and demand our current state of knowledge to be improved through social science research.

The accomplishments of harm reduction in many areas of drug addiction support are thus still counteracted by the damage caused by the criminal prosecution of people who use drugs. The steadily increasing number of prosecutions relating to acquisition and possession of small amounts of drugs for personal use is not only an enormous waste of resources in the police force and criminal justice system. It is also a missed opportunity to introduce regulation and quality control through controlled distribution of substances, thereby minimising harm and enabling the best possible protection for youth and consumers.

The number of drug-related deaths in Germany has steadily increased over the past 10 years as well. In 2020, it reached a new high with 1,581 cases, the highest it has been in 20 years (2001: 1,835). This development and the current health policy response to it are no longer acceptable. A plan to achieve a sustainable reduction of drug-related deaths in Germany will therefore be presented in this report. Conditions must be changed in such a way that the risks for drug users are kept to a minimum.

The plan emphasises the importance of continuous treatment of opioid-dependent people with substitute medications. However, a supply crisis looms in the next few years as a high number of general practitioners currently prescribing opioid replacement therapy will be retiring. The necessary countermeasures require massive changes, especially on a structural level, which the report will elaborate on.

There is also a lot of catching up to do in terms of combating infectious diseases such as HIV/AIDS and hepatitis C (HCV) among drug users. Although there are positive developments in the field of HIV and HCV treatment in the general population, we are still a long way off meeting our goals for vulnerable groups such as injecting drug users or prisoners.

Overall, the 8th Alternative Drug and Addiction Report presents many examples and ideas for a sustainable, holistic drug policy. A policy which must be implemented at last in order to prevent further suffering, further health and social harm and the resulting further waste of resources.

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Roadmap to a Sustainable Reduction of Drug-Related Deaths in Germany

Heino Stöver & Dirk Schäffer
Translated from German by Laura Steeghs

Introduction

The number of drug-related deaths in Germany has steadily increased over the past 10 years. In 2020, it reached a new 20-year high with 1,581 cases, the highest it has been since 2001 (1,835). This development and the current health and drug policy response to it are no longer acceptable. At this point, expressing sympathy and indicating a continued support for harm reduction measures are not sufficient. Instead, the federal government and individual states must make a concerted effort to develop a catalogue of concrete strategies on how to avoid the deaths of thousands of people due to the consumption of illegal substances.

First, the current findings will be summarised in the context of the strategies and measures described below.

Nationwide Distribution of Naloxone

The share of drug-related deaths under the influence of or involving opioids has been between 35-60% in recent years.
The active substance naloxone is an opioid antagonist that can quickly and safely prevent the potentially fatal effects of an opioid overdose. It is therefore important to implement structures that aim to provide all opioid users and the currently 81,700 men and women on opioid replacement therapy (ORT), as well as persons who are in contact with opioid users, such as partners and relatives, with an antidote in the form of a nasal spray. This also includes appropriately equipping staff from low-threshold to high-threshold addiction services and those working in custody facilities (police custody, remand and prisons). In addition, forensic psychiatric institutions ("detoxification centres" as per § 64 of the German Penal Code, Forensic Psychiatry [*StGB*, *Maßregel-vollzug*]) should be suitably supplied as well.

To this end, the German Medical Association, the regional medical associations and the Confederation of Addiction Medicine as well as offender and probationary support services must send clear signals to surgery-based addiction specialists and general practitioners providing primary care in order to ensure the proactive prescription of an appropriate antidote for their patients and persons belonging to the target groups

mentioned above. An important step in this direction is the Federal Ministry of Health's three-year project commencing on 1 July 2021: "Conception, Execution and Evaluation of a Scientific Pilot Project for the Implementation of Quality-Assured Take-Home Naloxone Training Courses throughout Germany (NALtrain)".

Non-Fatal Overdose: Immediate Measures

Rapid expert intervention and support after a non-fatal overdose avoids or reduces the risk of another drug-related emergency.
Organisations such as AIDS and drug support services as well as offender and probationary support services should receive safer-use training, be familiar with first aid treatment, and be taught about drug consumption control programmes with the aim of risk management. This will enable them to deliver appropriate support to drug users.

Structural Reform for Opioid Replacement Therapy

Over the last 40 years, opioid replacement therapy has become the most successful form of treatment and as such has become the method of choice in the treatment of opioid dependence. ORT significantly contributes to reducing opioid-related deaths, decreases the use of illegal substances and leads to a considerable reduction in infectious diseases. In order for substitution therapy to continue to generate these positive effects, a structural reform of this method of treatment is inevitable. At the moment, only about 50% of opioid users are being reached. To increase this number, treatment methods must be individualised considerably. This includes among others:

- Low-threshold access to treatment
- Drug support services offering substitution treatment
- Using the entire range of available substitution drugs
- Giving the substance diamorphine equal status as a first-line medication
- The personalisation of treatment through telemedicine and access to treatment close to home
- Ensuring continuity of care when someone moves (on release, in detention, in therapy and so on)
- Reform of the healthcare reimbursement system

Focus on Amphetamine and Methamphetamine Use

The rising number of drug-related deaths under the influence of amphetamines and their derivatives, as well as the steady increase in people using amphetamines and

methamphetamines without receiving targeted, medical and social support, require the implementation of rapid and effective measures.

In order to do so, the substitution of amphetamine addiction must be studied scientifically.
In addition, drug testing services in combination with counselling must be made available close to the drug scene. A joint initiative of politics, professional associations, science and those affected must do everything in their power to discuss the legal and political issues currently standing in the way of reforms and then agree on a shared strategy.

Establishment of Drug Consumption Rooms in All Federal Provinces

Drug consumption rooms provide safe conditions for the hygienic and safe consumption of illegal and legal psychoactive substances for many thousands of drug users every day.

Over the last 30 years, despite millions of consumptions of drugs with largely unknown active ingredients, it is due to the quick and professional intervention of staff that there have only been two drug-related deaths in consumption rooms. These, however, were attributed to serious pre-existing illnesses of the persons concerned.

The incident reports of many facilities show that drug consumption rooms provide medical help in life-threatening emergencies in about 1,000 cases per year. Therefore, the annual number of drug-related deaths would be significantly higher without drug consumption rooms. This means that an expansion of this type of service would be invaluable to the prevention of drug-related deaths and should at the very least be implemented in all provincial capitals and large cities. Moreover, these facilities are often the first contact with support services many users have. Their successful referrals to further social and medical services also contribute to risk reduction. We call for the issue of "drug-related deaths and reduction measures" to be put on the agenda of the health ministers' conference.

Public Health Monitoring

Scientific analysis of public health involves the continuous and systematic collection, analysis and interpretation of health-related data, which are necessary for the planning, implementation and evaluation of public health measures. The pilot study DRUCK 2.0, which is currently being implemented, must be a first step towards a continuous knowledge monitoring of the behaviour of drug users. Only continuous observation will enable us to establish tailor-made support for the prevention of drug-related emergencies and deaths.

Supporting People in the Criminal Justice System and in Forensic Psychiatric Care

The high prevalence of drug use among persons who are in prison or in a forensic psychiatric institution must lead to a progressive implementation of substitution treatment for opioid-dependents in these facilities. The aim is to provide treatment for 50% of drug users, same as the number of people reached outside the correctional system, as opposed to the current approximate 24%. Although widely recognised, forensic psychiatric institutions are very reluctant to use this evidence-based therapy. An expansion would be an important step in the right direction. Nationwide substitution would significantly reduce the risk of drug-related deaths in the criminal justice and forensic psychiatric care systems. In addition, all prisoners who are known users of illegal substances should receive a brief intervention and be provided with a naloxone nasal spray in preparation of their release.

Opioid Replacement Therapy in Medical Rehabilitation Facilities for Addicts

For approximately 40 years, inpatient medical rehabilitation of addicts (detoxification treatment) has been reserved for those drug users who set themselves the goal of permanent abstinence from legal and illegal substances or those who were ordered to do so. The fact that many drug users do not succeed in this and that medical rehabilitation has remained closed to many opioid dependents has led, after much discussion, to a few facilities also accepting patients receiving ORT. Even today, a valued goal in these facilities is for patients to taper off their substitute medications during the therapy period. Similar to the situation after a prison-release, a premature or timely termination of rehabilitation treatment poses a high overdose risk in case of relapse due to a lack of opioid tolerance. Most of these facilities, however, remain closed to people on ORT despite the fact they could offer valuable support and coping strategies to persons receiving substitution treatment. In order to open all medical rehabilitation facilities to patients on ORT as well, it is important to work together with pension insurance providers.[1]

In addition, efforts should be made to ensure that persons leaving inpatient rehabilitation receive an antidote (naloxone) after a brief educational intervention.

[1] In Germany, pension insurance providers not only pay out your pension, but they also facilitate rehabilitation to ensure people can (re-)integrate into working life. As such they have an influence on rehabilitation programmes.

Opioid Replacement Therapy - Meeting the Looming Supply Crisis with Structural Changes

Dirk Schäffer & Urs Köthner
ranslated from German by Laura Steeghs

Summary

This article discusses the structures of opioid replacement therapy (ORT) in Germany and presents alternatives to current care models. The aim is to secure care for patients currently receiving substitution treatment and establish a framework that will enable us to provide a previously unreached group of opioid users with high quality care that takes into account their individual life circumstances.

The Current Situation

The current report by the Federal Institute for Drugs and Medical Devices' (BfArM) on the national ORT registry (January 2021) shows a further decline in the number of general practitioners (GPs) prescribing ORT. The average age of GPs who prescribe ORT is almost 60. Since many of them are clearly older, a retirement from professional life is to be expected in the next few years. However, the recorded number of 2,545 prescribing GPs is also deceptive. In reality, every fifth practitioner (563 in total) uses the so-called consultation regulation (*Konsiliarregelung*) which allows GPs who have not completed the mandatory primary addiction care training to consult ORT patients as long as they liaise with a certified practitioner. They currently treat only 1,5% of patients. The fact that roughly 14% of practitioners prescribing ORT treat half of the ORT patients (about 41,000 people) shows just how alarming the situation really is. If a number of these GPs retire for age-related or other reasons, some cities and regions could be in danger of developing profound problems in providing care to ORT patients resulting in unforeseeable consequences.
At the same time, the number of ORT patients has risen to 81,700. This means we are currently only reaching about 50% of those eligible for ORT treatment due to their opioid dependence.

We have to face reality. The unfortunate truth is that all measures implemented to attract GPs have had little success in recent years. Over the last 35 years, the structures of ORT have barely changed even though the numerous reforms of the regulations for prescribing narcotics (BtmVV: *Betäubungsmittel-Verschreibungsverordnung*), especially those in 2017, have significantly improved and expanded the scope of treatment and the legal security of GPs. They now allow for a very person-centred approach, adapted

to a patient's circumstances. Many GPs are not fully aware of these new options and do not take advantage of, for instance, the range of take-home possibilities, local care provision, or the variety in substitute medications available in order provide a more person-centred and patient-oriented treatment. We have a shared responsibility to discuss and implement alternative treatment models in the doctor's surgery. If we establish that we will be unsuccessful in convincing a large number of GPs to start prescribing ORT in the medium term, we will have to change the existing rigid structures of substitution therapy in doctors' surgeries. The aim is to create time and space for some of the approximately 80,000 opioid users who may decide to undergo substitution treatment in the future.

What Could Alternative Models of Opioid Replacement Therapy Look Like?

There are a variety of alternative models for substitution treatment in doctor's surgeries and many ideas for changes in treatment regimens. Below, some of these alternatives will be presented. It is important to note that many of these models are already being implemented successfully.

Creating Low-Threshold Access

When talking to people who have not tried ORT yet, they often mention uncertainty about whether they can cope with the demands associated with treatment in a doctor's surgery. Many opioid users have had no contact with a GP for years or decades, let alone with a specialist. The 'doctor's surgery' is a foreign concept to them. This influences the factor 'trust', which is highly important to drug users. In the drug scene, word spreads quickly. Particularly when it comes to bad experiences with the healthcare system. This leads to many users being confronted with reports of sanctions due to using drugs on top of an opioid prescription, which makes them even more uncertain of whether they can live up to expectations. Moreover, these sanctions have an extremely deterrent effect, as many users have been confronted with punishments and sanctions throughout their entire lives.

During the corona pandemic, a new model of substitution treatment was set up in Hamburg. There, the *Drob Inn* offered opioid users, many of whom were homeless and uninsured, very low-threshold access to ORT in a familiar environment, in their 'Drobs' (from *Drogenberatungsstelle* meaning local drug counselling services). Located right in the middle of the drug scene where they spend time every day. Within a few months, 300 people were admitted to treatment. Irrespective of the corona pandemic, this demonstrates that although people with particularly complex needs are currently not reached by the conventional system of substitution treatment, there is an identifiable

need for alternative services. Such a model could be a great addition to existing structures, especially in a metropolitan context.

Substitution Treatment Outside the Classic Doctor's Surgery

The lack of GP surgeries prescribing ORT has already led some drug support services to establish their own substitution treatment service. For example, the drug support service in Bielefeld has created two options for substitution treatment by reaching a partnership agreement with a prescribing GP. This practitioner offers low-threshold ORT consultation hours outside of their surgery, in two clinics operating in two different locations of the Bielefeld drug support service. The concept, in terms of different kinds of settings, is remarkable. One treatment option, for instance, was established in a counselling centre.
Stable patients, often those in employment, who do not want any contact with the drug scene are treated there. Alternatively, the low-threshold centre with an outreach service, drug consumption room, and so on, treats those patients who are there daily or multiple times a week anyway to take advantage of what the drug support service offers. This model demonstrates the major advantages of having medical treatment and psychosocial care under one roof. In addition, patients who occasionally use cocaine or other substances on top of their prescription are offered the possibility to use under controlled and hygienic conditions. In this setting it is important the GP is supported by a team from the counselling service and is to a large extent relieved of any accompanying documentation duties. Thanks to the close cooperation between the outpatient clinic and the drug support service, very flexible dispensing windows and methods can be realised. While prescribing GPs are urgently needed everywhere, Bielefeld has succeeded in recruiting several prescribers who had already retired.

Treatment Close to Home: Increasing Involvement Pharmacies and Care Services

Tens of thousands of patients still have to accept travelling long distances for treatment every day. Narrow dispensing windows lead to crowding in front of and inside surgeries. The majority of patients is older, in poor overall physical condition and not very mobile, suffering from for instance COPD, (open) leg wounds and severe overweight. Therefore, we have to ask ourselves why we make thousands of these patients travel to a surgery every day instead of having pharmacies, care services or drug counselling services dispense the medication close to home.

Individual Take-Home Dispensing

The corona pandemic shows that for a large number of patients, being responsible for taking their own medication works much better than previously assumed. The BtmVV regulations for prescribing narcotics and the current exemptions offer the opportunity to gradually and safely test autonomous use of substitute medications. Going from daily dispensing in the surgery to collection visits three times and then twice a week would also mean a considerable relief for both prescribers and patients. Additionally, take-home dispensing can contribute to an overall improvement in treatment, because it facilitates a way for patients to participate in work, social life and family commitments, which in turn will promote their independence.

Alternative Ways of Contact such as Telephone, Skype and Zoom

The pandemic has clearly changed our methods of communication. Even if the face-to-face conversation continues to be the best way to communicate, under current substitute treatment conditions we must establish and use alternative methods of conversation and contact. For example, patients who used to come to the surgery every day and now only twice a week can receive additional support via telephone or Skype. Some surgeries already established this kind of arrangement successfully during the lockdown.

Depot Medication in a Supporting Role

For some time now, prescribers and patients have had access to another alternative treatment method using a depot formulation of buprenorphine. This new treatment option should be examined further to establish whether it can help relieve prescribers and simultaneously treat patients safely and successfully. Every fifth patient is prescribed buprenorphine. If these patients are interested, a switch to a weekly depot formulation should be assessed.
This option would also ease the concerns of those who fear a feeding of the grey market through increased take-home dispensing. The Centre for Interdisciplinary Addiction Research (*Zentrum fuïr Interdisziplinaïre Suchtforschung*) report on the evaluation of the reform of BtmVV narcotics regulation, however, actually showed the increased use of take-home prescriptions did not lead to an increased availability of substitute medications on the black market. While prescribing the weekly depot, prescribers could arrange opportunities for contact once or twice a week.

Summary

A closer look at these structures reveals that many places, even after ten or twenty years of treatment provision, lack the flexibility and the will to get involved in something new and to try alternative treatment methods. This has to change.

Alternatives to our currently still very rigid treatment models already exist. In the interest of patient satisfaction and the continuous, reliable supply of care, we really need to address these and any other structural changes. Many places are insufficiently aware of the existing possibilities through the last reform of the BtmVV narcotics regulation and the additional flexibilisation through the SARS-CoV-2 Medicinal Products Supply Ordinance (*Sars-Cov2-Arzneimittelversorgungsverordnung*) and are therefore used too sparingly. If we can convince prescribers in the short term to use the whole range of substitute medications and be flexible with dispensing, then we could succeed in securing our supply chain and increasing the diversity of treatment options. This will enable us to treat opioid users who want to start substitution therapy, even if the number of treatment providers remains the same. Let us not forget that currently only about 50% of the people who are eligible for ORT are in treatment. The corona pandemic has worsened the living conditions of drug users and it is to be expected that more opioid-dependents will opt for substitution therapy, if they can find a treatment place. It is our joint responsibility to facilitate this.

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Cannabis as Medicine: Self-Medication and Stigmatisation

Bernd Werse
Translated from German by Laura Steeghs

Summary

This article presents the results of a qualitative study on experiences of stigmatisation as described by a sample of 31 interviewed persons who self-medicate with cannabis. Many of the respondents have experienced stigmatisation in the healthcare system, where they were often met with categorical rejection of cannabis and occasionally even subjected to prolonged suffering because their medication was considered an addiction. In addition, all interviewees are affected by the risk and psychological burden of the threat of criminal penalties, especially those who need relatively large amounts of cannabis daily and therefore grow it themselves. Some were also affected by disapproval in their social environment. These experiences, and the fact that generally there are still people who are forced to obtain their medication illegally, speak for the urgent need to significantly liberalise the regulations for medical cannabis.

Introduction

The following results are based on the outcomes of a qualitative study conducted by the Centre for Drug Research (CDR) of the Goethe University in Frankfurt alongside a quantitative online survey which was part of the "Medical Cannabis in Frankfurt am Main" project, funded by the drug control unit of the city of Frankfurt, from late 2018 until the end of 2019 (Werse, et al., 2020). Thirty-one medical cannabis users in Frankfurt, most of whom obtain their supply on the black market, were interviewed for this study. Highlighted below are the experiences of stigmatisation endured by self-medicating cannabis users over a long period of time and often to this very day. It should be noted that the Cannabis as Medicine Act 2017 (BfArM, 2017) and its implementation have remained practically unchanged since the interviews were conducted.

Self-Medication: Numbers and Characteristics

The group of 31 respondents consisted of 42% females and 58% males. The average age was 37 and all subjects lived in Frankfurt. Various kinds of pain were the most frequently mentioned reason for using cannabis as a medicine. This was followed by AD(H)D, sleeping disorders, depression and numerous other physical and psychological

complaints, the majority of which were medically diagnosed. For more than four out of five respondents the first time they used cannabis was for recreational purposes, usually in adolescence. The respondents seldom noticed a medicinal effect at this point; generally, it took a process lasting several years for them to become aware of this. The amount consumed varied just as much as the symptoms to be combated: from occasional consumption of small amounts on an as-needed basis to more than five grams per day. A majority also use the substance for “recreational reasons”. Not infrequently, psychoactive effects are embraced as a welcome side-effect even when medical purposes are the main motivation for using.

Experiences of Stigmatisation

For various reasons, slightly more than half of the interviewees never applied for a prescription for their cannabis medication. Partly because they did not want to, partly because they did not have the energy to look for an open-minded doctor and partly because they did not think they had a chance of getting a prescription anyway. Some do have a prescription, but the costs are not covered by their health insurance. The remaining respondents have already tried to obtain a prescription from several doctors but were often met with categorical refusal. Quite a few doctors are thus very critical of or even firmly opposed to medical cannabis:

"She (the doctor) got all pissed off and said: 'Cannabis addicts come to me all the time and want a prescription, but I am absolutely against it. I won't prescribe drugs' and she practically chased me out of the practice." (Konrad, 28) - "A young doctor, of whom I actually thought: 'OK, he could be open-minded', told me: 'Mr. Müller, no, on principle we don't do that. If you just want to forget about your ADHD, just get stoned.' Sorry, but I was just speechless." (Müller, 50)

These accounts clearly describe a source of many stigmatisation experiences: even after prescriptions for medical cannabis became available in 2017, reservations in medicine were and still are widespread. In the preceding ten years, cannabis medication was reserved for a small group with special permits only (BfArM, 2009). Before that, the medicinal use of cannabis was not legally possible in Germany, which has had a decisive impact on the lives of many of the older respondents.

This is particularly evident in the case of a respondent who described complex connections between psychological and physical complaints, cannabis use and stigmatisation. According to her, she had unconsciously used cannabis as a medication for a long time, in particular to deal with her attention deficit disorder (ADD). In the meantime, she had recurrent feelings of guilt in addition to her already existing psychological problems:

"...there were always periods where I thought, this is not good for me. I stopped using and then experienced the full scale of issues." (Anna, 47)

For a long time, she was not consciously aware of this. Therefore, after her social environment voiced concerns about her *"addictive"* use and she experienced a severe burnout, she started an inpatient withdrawal treatment (*"Because at that time I thought that my problems came from cannabis"*). Initially, she experienced this stay in the clinic as positive, because it meant taking a break from her professional environment. Until, in the end, she was advised to start long-term withdrawal treatment and simultaneously take psychotropic drugs (which her psychiatrist had previously advised against because of her low tolerance):

"And that's when, for the first time, I thought, wait, somehow I'm being told I can take these psychotropic drugs all my life but not this. (...) Why can't I take the harmless one with fewer side effects? And psychotropic drugs for the rest of my life? And that's when I slowly started to wake up." (Anna, 47)

At that moment she first noticed the negative consequences of stopping her cannabis medication on her general condition and distanced herself from long-term therapy. Nevertheless, she took up withdrawal treatment again later since it was a supposed condition for accessing a certain psychosomatic clinic that would help her cope better with her various complaints. She underwent this withdrawal in another clinic, where supervision was stricter and thus the pressure higher:

"Several times I then had to pee under supervision. (...) ...that is something so humiliating. They also tested me in the evening. Then I wanted to close the door and the lady said, no, leave it open. So this year I had to pee under supervision all the time. And I realised that this goes against my human dignity." (Anna, 47)

She stopped the treatment not only for this reason, but also because of her deteriorating general health. It is worth mentioning here that her ADD also manifests itself physically through increased tension: *"then my spine, my muscles spasm (...) I have three slipped discs in my neck"*, and a lack of concentration: *"in this completely over-excited state I lose my footing. I must have twisted my ankle eight times between 2010 and 2012. But that has a psychological cause, not orthopaedic."*

Only after this second withdrawal treatment she finally realised that she had been self-medicating for a long time. Nevertheless, she felt the healthcare system had prevented her, on the one hand, from engaging in the aforementioned psychosomatic treatment due to the abstinence requirement, and on the other hand, from trying out another medication, namely methylphenidate (Ritalin® or Medikinet®) which is often used for AD(H)D.

"Well, that makes me an addict. To them, I'm addicted. And therefore, I don't get any medication for it. I would have to be abstinent for a long time, then I would get the other drug. And then I decided a while ago, no, I won't do that. I have hardly any side effects except for a little weight-gain from eating more, which is actually good for me[2]". (Anna, 47)

The respondent thus endured a decades-long process before she was even diagnosed. Throughout she had to struggle with a variety of related psychological and physical complaints and her regular cannabis use was labelled an "addiction" by her environment and ultimately by herself as well. Her continued self-medication, even in the context of her psychological condition, apparently still thwarts regular cannabis treatment despite the fact that her attempts at withdrawal were clearly unsuccessful.

The case described here is to be considered particularly extreme and complex. Nonetheless, various other respondents also reported long-standing inner conflicts related to their self-treatment with cannabis medications. Not infrequently, these were deepened by the reluctance of medical staff to accept cannabis as a medicine (see above).

Apart from these experiences with the healthcare system, which are perceived as stigmatising, the risk of criminal prosecution naturally also plays a major role. One respondent, for example, had his homegrown cannabis plantation confiscated by the police. Due to a severe regression of his disease and lack of financial means for his daily doses he had to increase cultivation. For this he turned to various authorities but without success. This experience, in addition to his primary disease, had a negative effect on his psychological condition:

"I have an incredibly serious illness and it's so severe and they blame it on smoking. When you hear something like that, I almost break down. (...) [Interviewer: Are you worried about another house search or punishment?] Yeah, I'm really afraid. I have psychological problems because I am so afraid. (...) I have to see a probation officer. The probation has only just... I'll have one year in October. And it's three years." (Winnie, 46)

Another respondent had had a similar experience with the confiscation of her homegrown cannabis. At that time, she already had a doctor's prescription for the daily consumption of about five grams of cannabis to treat her epilepsy. Since she had to pay for her prescription privately, she had also tried in vain to obtain a cultivation permit so she would be able to afford the high quantities consumed. The house search of this respondent was more dramatic than the one described above (*"door kicked in"*).

[2] The respondent is very slim.

Furthermore, the police refused to allow her to take her medication for hours, until medical staff finally convinced the police officers of the necessity.

Besides these cases, and some that resulted in less severe penalties, there were several respondents who reported losing their driving licence due to their cannabis use. Some interviewees are particularly concerned about their driving licence because of their profession (*"I am a freelancer, I depend on my car*"; XY, 32), others because of possible direct consequences on their employment:

"Since I got the job offer at XY, I have been afraid of punishment. Every little thing counts, even if I'm not penalised and only get fined 100 euros, it's still reported directly to the employer." (Konrad, 28) – "Of course I have a deep fear of the future. So if I commit an offence because of cannabis, I know I can forget about my civil service. (Tessa, 27)

Another respondent describes his inner conflicts and fears while he was growing cannabis *"every now and then":*

"... because I think it's rather silly to drive to the dealer and have large amounts of weed on me. Because then you get caught and then you... Well, then you have a lot of weed with you. That's why I kept switching back to growing it at home and then I always... I almost felt even worse. Whenever the doorbell rang, I remember one time when the police rang and they just wanted to know something about my father, and my heart dropped. So, every time you come into contact with the police, you feel like... I'm a criminal. Although I actually obey every law.
I try not to park illegally, I never park in a disabled parking space, I pay my taxes, I pay my health insurance, I pay everything. (...) Yeah, I feel like a criminal, although I'm not really." (Mike, 35)

Mike discusses his thought processes in terms of a risk assessment in which he apparently always considers the method of procurement he is engaging in at that time (buying from a dealer versus home cultivation) to be particularly risky. Therefore, it is true for this and many other respondents in this sample, that the worry of getting caught is a *"permanent condition"*.

Apart from criminalisation by law enforcement, driving licence authorities and consequences for employment, there are also various concerns about stigmatising views in the social environment, which affects work as well as private contacts. In this context, two of the interviewees mention a 'general suspicion' of medical cannabis users, a similar sentiment to that expressed by many in the medical field:

"There is not only the stigma of being a pothead, but there are also a lot of people who don't believe that you do it for medical reasons". (Jenny, 28) –

"This is such an issue because of all the misinformation and fake studies that people have been reading for years. Because of that, people are judgmental every now and then, some have also turned their back because they think I'm addicted, and they can't see the medical benefits yet." (Sirius, 43)

However, given that experiences of stigmatisation and disapproval in the social environment are mentioned rather rarely, and not taking into account rejection within the healthcare system, the risk of criminalisation seems to be the greater problem by far. The latter clearly depends on the amount required. Those using several grams per day need to finance these large quantities themselves, unless their health insurance covers it. This is usually done through home cultivation which entails a greater risk of criminal prosecution from the outset. Conversely, those consuming rather small amounts report such worries noticeably less often, apart from the risk of losing their driving licence.

Conclusion

The interviewees quoted here have often endured a lot of suffering. The permanent threat of prosecution under criminal or traffic law, the disregard and belittlement of cannabis medication on the part of medical professionals, as well as the self-doubt partially reinforced by their social environment contributed massively to the deterioration of their physical and psychological condition. Such issues were often particularly pronounced in some of the AD(H)D patients in the sample. At the same time, patients with AD(H)D often experience difficulties obtaining a cannabis prescription in the first place, let alone getting it covered by their health insurance. It should be emphasised that the sample consisted almost exclusively of people who not only had a clear diagnosis of their condition but could also describe exactly how cannabis alleviates their symptoms. It is a disgrace that due to Germany's unsatisfactory legal requirements these physically and often also psychologically impaired people are still subjected to the added burden of stigmatisation and criminalisation. The Cannabis as Medicine Act urgently needs to be revised in such a way that those who rely heavily on this substance in their everyday life can get their medication covered by their health insurance, more easily and without questionable bureaucratic restrictions (such as being tied to a certain brand of medical cannabis). At the same time, it must become easier and, above all, cheaper to obtain cannabis via private prescriptions. Many of those who need medical cannabis only occasionally and/or in rather small amounts would gladly procure their medication themselves at a reasonable price. Sadly, however, the state has not succeeded in enabling domestic production over the last four years, and the nonsensical, excessive pharmacy surcharges on medical cannabis still exist.

Many of these problems could easily be solved by simply legalising cannabis in general. It is to be hoped that this will be possible under the future federal government. Then, at the very latest, it is time to actually offer support to patients affected by stigma and criminalisation, instead of making their lives even more difficult through abstinence requirements and the threat of punishment.

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