

## Mental health services in Germany – Structures, outcomes and future challenges

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### ABSTRACT

This narrative review provides an overview of the structure, financing models, and challenges facing the German mental healthcare system for adults. The German mental healthcare system is divided into distinct sectors, including inpatient, outpatient, rehabilitation, and regional complementary services, each with its own financing mechanisms. Statutory health insurance, covering about 88% of the population, funds the majority of the system. Germany allocates 13% of its GDP to healthcare—one of the highest proportions globally—with over 10% of this directed toward mental health. Key challenges include an overemphasis on inpatient services, poor coordination between inpatient and outpatient sectors, insufficient severity-based treatment allocation, limited adherence to clinical guidelines, and a lack of digitalization and routine outcome evaluations. The COVID-19 pandemic led to a temporary reduction in service use and intensified issues with inter-sector collaboration. In the long-term, a healthcare workforce shortage further complicates care delivery. Proposed solutions include regional budgets for integrated care, outcome-based quality assurance, stepped-care models to optimize treatment allocation, and digital infrastructure improvements for better data sharing and transparency. These reforms aim to enhance patient-centered care, improve outcomes, and make more efficient use of resources.

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### Introduction

This narrative review aims to provide an overview of the structure, financing models, and challenges of the German mental healthcare system for adults. With regard to the methods, we selected and summarized literature based on expertise and (non-systematic) PubMed searches for the different subtopics. Within the Germany mental healthcare system, separate systems exist for child and adolescent psychiatry, as well as forensic psychiatry. Due to differing historical developments (Salize et al., 2007), the structural organization and financing of the German mental healthcare system are complex. The system comprises distinct sectors funded by various sources. The main sectors include the inpatient and day-clinic systems, the outpatient medical system, regional outpatient complementary structures, and the rehabilitation

system. The first part of this review outlines each of these sectors and their financing mechanisms. The second part assesses research on the system's performance. The third part offers a brief overview of changes and challenges during the COVID-19 pandemic. Lastly, the final part discusses current and future challenges, particularly their connection to organizational structures and incentive models, and suggests potential solutions.

### Sectors of the German mental healthcare system and their financing schemes

#### Health insurance and coverage of mental health services

Approximately 88% of the population is covered by mandatory, non-profit statutory health insurance

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funds ('Gesetzliche Krankenversicherung' or GKV), while 11% have private insurance (Destatis, 2019), which is an option only for those with a net income above €69,300 (in 2024) (Bundesregierung, n.d.). A small portion of the population (about 1%) remains uninsured, primarily due to unstable income or homelessness (Destatis, 2019). Public health insurance covers most inpatient and outpatient mental health services, including outpatient psychotherapy. Uninsured individuals can access urgent mental health care funded by the social system, though long-term services are often not covered.

Regional outpatient complementary services are financed and governed by local and regional bodies rather than health insurance. Rehabilitation services are mainly reimbursed by public pension funds, although, in some cases, health insurance covers them. In 2022, Germany spent approximately 13% of its GDP on healthcare, the highest in Europe and one of the highest globally (World Health Organization, 2022b). Of this, 11–13% was allocated to mental health services (OECD, 2021). In 2020, mental disorders accounted for direct healthcare costs of around €56.4 billion (Destatis, 2020). Approximately 51% (€28.6 billion) of this amount was spent on inpatient and rehabilitation services, 17% (€9.7 billion) on inpatient psychiatric hospitals (including day clinics and pre- and post-inpatient treatment), 15% (€8.4 billion) on outpatient doctors (Destatis, 2020), 6% (€3.4 billion) on outpatient psychotherapy (Bundesministerium für Gesundheit, 2020), and 4% (€2.3 billion) on medications for mental disorders (Destatis, 2020). In summary, in comparison to other countries, Germany allocates a high percentage of its GDP to healthcare, with a significant portion devoted to mental health, and more than 50% of that amount allocated to inpatient services.

## **The inpatient and day-clinic system**

### **Inpatient and day-clinic services**

In the 1970s, West Germany was relatively late in reforming large and understaffed psychiatric asylums, following the 'Psychiatrie-Enquete' expert consensus (Bundesregierung, 1975). East Germany underwent a similar process, known as the 'Rodewischer Thesen', although it faced limitations due to resource shortages (Salize et al., 2007). After reunification, East Germany largely adopted West German service models. As of 2022, Germany had 403 psychiatric and psychotherapeutic hospitals and departments within general hospitals, with a capacity of 57,011 beds and

16,957 day-clinic places (23%) (Destatis, 2023). A distinct feature in Germany (as well as in Austria and Switzerland) is the presence of 279 additional hospitals and departments for psychosomatic medicine and psychotherapy, offering a further 12,844 beds and 2,592 day-clinic places (17%) (Destatis, 2023). Initially aimed at treating somatic disorders with psychological components, these facilities now primarily provide inpatient treatment for depressive and anxiety disorders, obsessive-compulsive disorders, stress-related disorders, and eating disorders. These departments generally do not handle emergency cases or treat psychosis or organic mental disorders.

Between the 1970s and the early 2000s, the number of psychiatric hospital beds (excluding psychosomatic facilities) in Germany steadily declined—from 117,596 beds in 1972 to 55,480 beds by 2002 (though the definition of psychiatric hospital beds evolved over time) (Salize et al., 2007). Recently, however, there has been a slight increase in the number of combined psychiatric and psychosomatic hospital beds. Between 2012 and 2022, the number of such beds rose from 63,044 to 69,855. This includes a 5.7% (+3,062) increase in psychiatry and psychotherapy beds and a 41% (+3,749) increase in psychosomatic medicine beds (Destatis, 2013, 2023).

In 2021, Germany had the second-highest number of psychiatric hospital beds in Europe, with 131 beds per 100,000 inhabitants. Comparable countries, such as Belgium, had 141 beds, the Netherlands had 112, Switzerland had 95, Austria had 75, and Denmark had just 5 (eurostat, 2024a). Germany also had relatively long inpatient stays, averaging 25 days for mental disorders in 2021. This was the 10th longest in Europe, compared to countries like Belgium (9 days), the Netherlands (20 days), Switzerland (24 days), and Austria (19 days) (eurostat, 2024b). However, these numbers do not account for psychosomatic medicine departments, where the average inpatient stay in 2022 was 44 days (Destatis, 2023).

In summary, in comparison to other European regions, fewer individuals in Germany are hospitalized for mental disorders, but those who are tend to have longer stays. Unfortunately, no comparative studies exist on the outcomes of these differing approaches to inpatient care. Interestingly, day-clinic treatment is less common in the growing psychosomatic sector, despite its lower cost and the reduced disruption to patients' daily lives. Psychosomatic departments primarily treat less severely ill patients with somatoform, depressive, and neurotic disorders, which generally do not involve acute risk to self or others (Destatis, 2023; Wiegand et al., 2020).

Unlike the German DRG (Disease-Related Group) system used for somatic departments, psychiatric and psychosomatic departments and hospitals are reimbursed under the PEPP (Pauschalierendes Entgeltsystem für psychiatrische und psychosomatische Einrichtungen) system, which provides degressive, case-severity-dependent daily lump-sum payments (Regierungskommission, Regierungskommission für eine moderne und bedarfsgerechte K, 2023). Some exceptions exist for ‘regional budget’ model projects, which aim to reform inpatient services. The incentives set by this remuneration system, along with the division between inpatient and outpatient sectors, are often blamed for the increasing inpatient capacity and the relatively long durations of inpatient treatment compared to other European regions.

### *Inpatient equivalent treatment*

Since 2018, inpatient departments have been able to offer intensive, multi-disciplinary home treatment services, known as ‘inpatient equivalent treatment’ (Stationsäquivalente Behandlung, StäB, §115d SGB V) (Weinmann et al., 2021), for cases that would normally require traditional inpatient care. These services are generally well-received by patients and healthcare personnel and have shown to be superior to inpatient treatment in evaluation studies (Weinmann et al., 2022). However, the current model has faced criticism for its rigid structure—such as the requirement that a mental health professional from the StäB team must have daily contact with a patient during the treatment sequence (Gottlob et al., 2020)—as well as a high documentation burden. There is also insufficient evidence on potential side effects, such as encouraging psychological regression rather than promoting evidence-based treatments like exposure therapy or group therapies (Steinert, 2022).

### *Psychiatric and psychosomatic outpatient treatment by hospitals*

Psychiatric-psychotherapeutic departments, and to a lesser extent psychosomatic-psychotherapeutic departments, not only provide inpatient and day-clinic services but also offer outpatient treatment through their psychiatric and psychosomatic ambulances, known as ‘Psychiatrische Institutsambulanzen’ (PIA). Psychiatric PIAs exist in all 16 German states, while psychosomatic PIAs are available in only five states (Regierungskommission, Regierungskommission für eine moderne und bedarfsgerechte K, 2023). These outpatient services are reserved for certain, more severely ill, diagnostic groups. The reimbursement of

PIA outpatient services varies by region, with the most common model based on quarterly lump-sum payments. This approach is criticized for incentivizing minimal therapeutic contact, which can hinder the provision of guideline-oriented psychotherapy for those most in need (Regierungskommission, Regierungskommission für eine moderne und bedarfsgerechte K, 2023). An alternative pay-per-service model—mostly used in Bavaria, Saxony, and Saxony-Anhalt—allows for more intensive psychotherapeutic treatments. However, there has been no evaluation to determine whether routine treatment within these models is more aligned with clinical guidelines.

### *Staffing regulations for inpatient services*

Before the psychiatric reforms of the 1970s, psychiatric hospitals and departments were understaffed. A major step in addressing this was the introduction of minimum staffing requirements in the 1990s through the ‘psychiatric personnel directive’ (PsychPV=Psychiatrie Personalverordnung) (Salize et al., 2007). Recently, this directive was replaced by updated staffing standards under the PPP-RL (‘Personalausstattung Psychiatrie und Psychosomatik-Richtlinie’) (Regierungskommission, Regierungskommission für eine moderne und bedarfsgerechte K, 2023). However, these new staffing standards have been criticized for being largely based on outdated requirements from the 1990s, which do not account for the intensive psychotherapeutic inpatient interventions developed since then. Those psychotherapeutic interventions are now recommended by modern treatment guidelines for most mental disorders (Berger et al., 2015; Bohus et al., 2016; Wiegand et al., 2020).

Interestingly, psychosomatic medicine and psychotherapy departments appear to achieve guideline-oriented psychotherapy more effectively than psychiatric and psychotherapy departments. This is likely because psychosomatic departments are not required to allocate resources for emergency services, allowing them to focus more on psychotherapy. As a result, more severely ill patients with conditions such as severe and psychotic depression or schizophrenia, who are treated in psychiatric departments, receive less intensive inpatient therapy compared to moderately ill patients treated in psychosomatic departments (Friederich et al., 2018; Wiegand et al., 2020).

### *Model projects for reforming inpatient services (§64)*

Since 2013, hospital operators have been able to negotiate ‘regional budgets’ (‘Regionalbudgets’) as part of model projects (often called ‘§64 model projects’,

referring to the paragraph of the underlying law), with health insurance funds. In these projects, hospitals do not receive the typical daily lump-sum payments for inpatient care, which decrease with longer stays. Nor are they bound to a predetermined number of beds negotiated with health insurance funds and federal states. Instead, hospitals negotiate a fixed budget for a specific time period to provide inpatient care in their region. This model incentivizes hospitals to reduce inpatient stays and implement modern, cost-effective care methods such as home treatment or intensive outpatient care. However, hospitals are still bound by ‘mandatory care’ (Pflichtversorgung), meaning they must treat anyone in their region with a mental illness who meets the criteria for inpatient care, whether or not they are participating in the model project.

Evaluations of this model have shown that it reduces inpatient stays, decreases time spent on sick leave, and improves patients’ health-related quality of life during treatment (Baum et al., 2020, 2022; Neumann et al., 2021, 2024). Proponents argue that it helps shift the focus away from inpatient care and reverse the trend of ever-growing psychiatric and psychosomatic hospital bed numbers in Germany. Critics, however, warn that the model creates incentives to shorten inpatient stays and reduce hospital admissions, without providing sufficient motivation to improve the quality or guideline adherence of care. They also criticize the risk of incentivizing delayed inpatient care for the most severely ill patients and in some cases a lack of personal standard (Kliemt & Häckl, 2020). Additionally, the regional budget system does not extend to the private and regional complementary outpatient sectors, leaving unresolved issues related to the lack of cooperation between inpatient and outpatient care.

### *The RECOVER model project*

To demonstrate the feasibility and effectiveness of a trans-sectoral, easily accessible, coordinated, and evidence-based stepped-care model within the German healthcare system, a consortium of service providers, health insurance funds, health insurance authorities, and professional associations, led by the University Medical Center Hamburg-Eppendorf (UKE), developed and evaluated the RECOVER model. This model, detailed by Lambert et al. (2020), Lambert, Karow, et al. (2019), Lambert, Kraft, et al. (2019), provides an accessible point of contact for individuals with mental disorders, evaluates their treatment needs, and allocates them to a stepped-care system based on severity. The model includes e-mental health solutions

for mild cases and inpatient care for severe cases, integrating assertive community and outreach treatment where possible to prevent inpatient admissions.

A study with 891 participants showed that the model achieved similar or better treatment outcomes, 22% lower annual total costs, and 50% lower hospital costs, resulting in significantly better cost-effectiveness (Lambert et al., 2024). Although guideline orientation was a goal of the project, results on this aspect have not yet been published. The self-governing body of the healthcare system, ‘Gemeinsamer Bundesausschuss’ (G-BA), which funded the study, ultimately decided not to recommend the project for routine care. The reason given was that ‘although the evaluation of the project showed positive trends, it was only able to demonstrate minor, non-significant effects with regard to the patient-relevant endpoints examined’ (translation by the authors (Innovationsausschuss des GBA, 2023)).

## *Psychiatric outpatient treatment*

### *General practitioners and family doctors*

In 2022, Germany had 37,912 outpatient general practitioners (GPs), either employed or in private practice (Bäk, 2023). In 2018 (the latest available data), GP density ranged from 60 to 74 per 100,000 inhabitants across federal states (Zi, Z. für die kassenärztliche V. in der B.D., 2018a). Depression alone accounts for 10% of their cases, and 60% of individuals with depression receive their first diagnosis from a GP (DGPPN, 2018a; Melchior et al., 2014). Most GPs work in private practices within the framework of statutory health insurance. Along with other private outpatient doctors, they are organized within regional chambers of statutory physicians (‘Kassenärztliche Vereinigungen’). These chambers are legally mandated to ensure sufficient care for a given region and negotiate budgets with the health insurance funds. While the quality of mental healthcare provided by GPs shows room for improvement—studies indicate less guideline adherence compared to mental health specialists (medical doctors with a specialization in psychiatry, psychotherapy or psychosomatics, see outcomes section)—GPs, along with emergency departments and some social psychiatric and crisis services, remain the most easily and rapidly accessible providers of mental healthcare within the German system (Table 1).

### *Outpatient psychiatrists*

In 2022, there were 8,954 mental health specialist doctors practicing in outpatient settings in Germany, either

**Table 1.** Financing of mental healthcare services in Germany.

Statutory health insurance, private health insurance	Statutory pension insurance	Federal states and municipalities
<i>Inpatient, and day clinic mental healthcare, inpatient equivalent treatment</i>	Psychosomatic-psychotherapeutic or psychiatric-psychotherapeutic rehabilitation services	Social Psychiatric Services and Crisis Services
Psychiatry and Psychotherapy	Addiction rehabilitation services	• Services for Social Participation and Reintegration
Psychosomatic Medicine and Psychotherapy	• Inpatient rehabilitation centers (Rehabilitation psychisch Kranker, RPK)	
<i>Outpatient Mental healthcare</i>		
GPs		
Mental health specialist doctors		
Psychotherapy		
Psychiatric and psychosomatic ambulances of inpatient institutions		
Outpatient Psychiatric Nursing		
Occupational Therapy		
Sociotherapy		
<i>(addiction rehabilitation services)</i>		
<i>Prevention programs</i>		

privately or in employment (1,244 in ‘Nervenheilkunde’, 4,942 in Psychiatry and Psychotherapy, and 2,768 in Psychosomatic Medicine and Psychotherapy) (Bäk, 2023). In 2018, there were between 6 (in Hesse) and 11 (in Berlin) mental health specialists per 100,000 inhabitants across federal states (Zi, Z. für die kassenärztliche V. in der B.D., 2018b). These physicians are essential pillars of outpatient mental healthcare, yet the system is often criticized for its lack of cooperation with other mental health services and for the reimbursement model, which incentivizes minimal quarterly patient contact and short session times.

### Outpatient psychotherapy

Since the introduction of the Psychotherapist Law (‘Psychotherapeutengesetz’, PsychThG) in 1998, outpatient psychotherapy has been reimbursed by statutory health insurance not only when provided by physicians but also by psychological psychotherapists (postgradual training, examination and licensure). This law significantly increased the availability of psychotherapy services, with the number of reimbursed sessions rising by 41% between 2005 and 2021 (GKV-Spitzenverband, 2022). In 2022, there were 6,009 physician psychotherapists and 32,601 psychological psychotherapists offering psychotherapy under statutory health insurance. Regional availability in 2018 ranged from 21 (Brandenburg) to 65 (Berlin) psychotherapists per 100,000 inhabitants (Zi, Z. für die kassenärztliche V. in der B.D., 2018c).

Germany is one of the few European countries, alongside Spain and Sweden, that offers psychotherapy access without co-payments or session limits for most people with mental disorders (as a data journalism project has shown: (Bernardo et al., 2021)). This is a strength of the system, as psychotherapy is a central, evidence-based recommendation for a wide range of psychiatric disorders, including Major Depression,

Anxiety Disorders, Borderline Personality Disorder, Posttraumatic Stress Disorder, Schizophrenia, and Bipolar Disorder (Bäk et al., 2022; Bandelow, 2021; DeGPT, 2019; DGBS and DGPPN, 2020; DGPPN, 2022, 2019). However, structural issues limit this strength. These include discriminatory access modalities for people with severe mental disorders, problematic incentives for therapists to prioritize less severely ill patients (Melchior et al., 2014; Wiegand et al., 2020), insufficient integration with other mental health sectors, and waiting times exceeding 3 months, despite several reform efforts (Pantle et al., 2024, 2023).

### Outpatient psychiatric nursing, occupational therapy, sociotherapy

Since 1995, physicians in outpatient settings have been able to prescribe home-based mental health nursing services. However, the absence of unified implementation guidelines means these services are not available nationwide. A comprehensive overview of where and how these services are provided is unavailable. Outpatient physicians can also prescribe occupational therapy (ergotherapy) and sociotherapy (Bramesfeld, 2023).

### Interprofessional coordinated and structured outpatient care

Since 2021, outpatient psychiatrists, psychotherapists, and other specialists can collaborate in interprofessional treatment networks (‘KSVPsych-RL’) (GBA, 2021). These networks are designed for patients with severe mental disorders, with one psychiatrist or psychotherapist serving as the coordinator for each patient. The treatment team must include at least one other therapist or physician, and they must maintain shared documentation. The care providers receive additional funding for coordinating treatment and conducting interprofessional (tele-) case reviews. This

program aims to improve care coordination within the outpatient system and foster better collaboration for patients with severe mental disorders. While this approach is generally viewed as a step in the right direction, experts remain skeptical about its ability to address the system's most significant challenges. These include insufficient guideline adherence, limited access to acute and specialist outpatient care for the most severely ill, the absence of severity-based allocation of therapy intensity, long inpatient hospitalizations, poor integration between inpatient and outpatient care, and a shortage of qualified personnel. Since this program is still relatively new, no evaluations have been conducted yet.

### **Complimentary regional psychosocial structures**

#### **Social psychiatric services and crisis services**

In all regions of Germany, social psychiatric services ('Sozialpsychiatrische Dienste'), funded by the federal states rather than health insurance, offer counseling, crisis intervention, and outreach services. These services vary by region in terms of scale, resources, and tasks. They are typically well-connected with other regional outpatient complementary structures, as well as psychiatric hospitals and departments. Additionally, Bavaria and Berlin have implemented crisis services ('Krisendienste'), which provide low-threshold telephone and in-person counseling for individuals in mental health crises.

#### **Services for social participation and reintegration**

People with severe mental disorders and a certain degree of disability are eligible for services supporting social participation and reintegration ('Leistungen zur sozialen Teilhabe, Eingliederungshilfe') provided at the regional level. These services, which vary significantly across regions, are funded by the social welfare system and include outreach assisted living, sheltered accommodations, day-care services ('Tagesstätten'), and protected employment services ('Leistungen zur Teilhabe am Arbeitsleben'). Between 2000 and 2015, the number of places in outreach assisted living services grew from 27,000 to 90,000, and places in sheltered accommodations increased from 37,000 to 60,000. Vocational training centers (28 'Berufsförderungswerke' and 23 'Berufstrainingszentren') provide training for reintegration into the mainstream job market, while some individuals with mental disorders work in sheltered workshops for people with disabilities (Bramesfeld, 2023). Although these services offer a

comprehensive social safety net for individuals with severe and chronic mental disorders, they are criticized for their variability in quality, the inconsistent qualifications of staff, and the lack of evaluation and routine outcome monitoring.

### **Rehabilitation services**

Germany has seen a growing capacity for inpatient psychiatric rehabilitation services. In 2021, 212 departments offered psychosomatic-psychotherapeutic or psychiatric inpatient rehabilitation services, providing 21,568 beds. Additionally, 30 inpatient rehabilitation centers (Rehabilitation psychisch Kranker, RPK) with 1,150 beds offer services aimed at reintegrating people with mental illness into the workforce. Long-term addiction rehabilitation is provided by 130 departments with an additional 9,742 beds (GBE, 2023).

### **Prevention**

Approximately 3.4% of health insurance spending is allocated to prevention measures, which primarily focus on health education, behavioral prevention programs, vaccinations, and preventive medical check-ups. However, specific figures for mental healthcare are not available. This centralized system, which largely excludes local providers (except for vaccination and preventive check-ups), has been criticized for emphasizing behavioral prevention programs that predominantly benefit the well-educated and affluent (Kurz & Osterloh, 2023). In terms of mental health, prevention remains underdeveloped in Germany. Potential areas for improvement include mental health education in schools, workplace behavioral and structural prevention programs (World Health Organization, 2022a), and nationwide early detection and intervention services for mental disorders. Currently, these initiatives exist only as pilot programs (Bühning, 2018).

### **Digitalization**

#### **Telemedicine services**

During the COVID-19 pandemic, both inpatient and outpatient providers invested in telemedicine infrastructures, which were widely and successfully used. However, many providers have expressed an intention to scale back these services, citing regulatory barriers (Fehr et al., 2024; Wiegand et al., 2022). Following the pandemic, a restriction was introduced, limiting video consultations to 30% of total outpatient consultations for psychiatrists and psychotherapists (KBV, n.d.). Data on post-pandemic usage is not yet available.

### Digital health applications

Since 2019/2020, physicians and psychotherapists can prescribe app- or online based digital health applications ('Digitale Gesundheitsanwendungen, DiGA') which are financed by health insurance. Since their introduction, prescribing has grown (Techniker Krankenkasse, 2022), but the applications are still rarely used in routine mental healthcare (Weitzel et al., 2023). A 2023 scoping review identified 17 such DiGAs for mental disorders. The innovative potential of DiGAs has been largely appreciated, and digital solutions have been successfully implemented in resource-effective stepped-care approaches for mental disorders, like in the RECOVER model project (Lambert et al., 2024). However, it has been criticized that many certification studies show a high risk of bias and methodological deficits (Schreiter et al., 2023).

Since 2019/2020, physicians and psychotherapists have been able to prescribe digital health applications ('Digitale Gesundheitsanwendungen, DiGA'), which are funded by health insurance. The use of these applications has increased since their introduction (Techniker Krankenkasse, 2022), although they remain underutilized in routine mental healthcare (Weitzel et al., 2023). A 2023 scoping review identified 17 DiGAs for mental health conditions (Schreiter et al., 2023). While the innovative potential of these applications is widely recognized, and they have been successfully integrated into resource-efficient stepped-care models such as the RECOVER project (Lambert et al., 2024), the certification studies for many of these applications have been criticized for high bias risks and methodological shortcomings (Schreiter et al., 2023).

### Digitalization of structures and data

Germany is in the process of implementing digital prescriptions and electronic certificates of incapacity to work. However, the country lacks unified electronic documentation systems and standards for digitizing clinical psychiatric data. This challenge is compounded by the variety of incompatible software systems used by outpatient and inpatient providers. The absence of easily shareable medical records and standardized digital psychiatric data is impeding the delivery of coordinated, integrated care, as well as the collection of nationally comparable clinical outcome data and the use of data-driven decision support systems.

### Indicators of the system's performance

So far, no systematic, countrywide evaluation of mental health services in Germany has been conducted.

However, morbidity and service utilization can be considered indicators of system accessibility. Mortality rates among people with mental illness, especially suicide rates, are influenced by societal and social factors but can also serve as indirect measures of a health-care system's performance. Since direct outcome studies are broadly lacking, the most examined indicators tend to be process indicators that relate to established treatment and guideline standards.

### Morbidity studies

The 'Study on the Health of Adults in Germany' (DEGS), conducted by the Robert Koch Institute (RKI), indicated stable prevalence rates compared to previous studies. In the DEGS study, 27.7% of adults between 18 and 79 had been diagnosed with a mental disorder within the previous 12 months: 15.3% had anxiety disorders, 9.3% had affective disorders, and 5.7% had substance use disorders. Additionally, 40–50% had more than one mental health diagnosis (Jacobi et al., 2014). The BURDEN WHO 2020 study identified dementias, anxiety disorders, depressive disorders, and alcohol-related disorders as among the top 17 disorders with the highest disease burden (measured by disability-adjusted life years) in Germany (Porst et al., 2022).

### Mortality and suicide rates

In line with most other European regions and contrary to trends in the United States, suicide rates in Germany have significantly decreased over the past few decades, dropping from 18,825 in 1981 to 9,215 in 2021 (Destatis, 2021), despite population growth from 78,407,907 to 83,196,078. However, 2022 saw an almost 10% increase in suicides, reaching 10,119. It remains to be seen whether this rise represents a statistical fluctuation or a reversal of the long-term trend. International studies have shown that severe mental disorders, such as schizophrenia, are associated with significantly increased mortality. A register-based study using routine healthcare data from 2012–2014 from all statutory health insurance funds in Germany found that the 2-year odds of mortality increased by 2.38 for individuals with psychotic disorders, 2.3 for those with borderline personality disorder, 1.52 for those with bipolar disorder, and 1.40 for individuals with severe depression. Life expectancy was reduced by 8.2–11.5 years for individuals with psychotic disorders, 5.7–7.1 years for those with borderline personality disorder, 3.3–5.3 years for those

with bipolar disorder, and 3.1–4.8 years for those with severe major depression (Schneider et al., 2019).

## Process indicators

### Utilization and availability of services

Studies suggest relatively low but increasing rates of mental health service utilization among individuals with mental disorders—between 30–50% for depressive disorders (Mack et al., 2014; Rommel et al., 2018). This rise may be attributed to increases in healthcare capacity and the destigmatization of mental disorders. However, the availability of specialist mental health services remains problematic. A study that combined cross-sectional survey data on the prevalence of mental disorders with regional data on the density of specialist physicians revealed substantial regional variations in specialist availability, which could not be explained by differences in mental disorder prevalence (Jacobi et al., 2016). These findings suggest inefficiencies in the allocation of licenses for practicing within the public health insurance system by the regional chambers of statutory physicians. Waiting periods for psychotherapy, as well as consultations with mental health specialists, are common. Studies of psychotherapy waiting times—whether surveying psychotherapists (BPtK, 2018), patients (Pantle et al., 2024, 2023), or using routine data (Wiegand et al., 2020)—indicate that patients often face delays of over 3 months, leading many to give up on seeking treatment. The current appointment allocation mechanism, which places the responsibility of finding an appointment on patients themselves (who may be hindered by their mental health condition), tends to favor less severely ill patients over those with more severe conditions.

### Guideline orientation of routine care

Recent studies have examined the guideline adherence of treatment sequences in statutory health insurance routine data, primarily focusing on major depression treatment. While these data are primarily collected for reimbursement purposes and have limited validity, they are the best available source for examining long-term treatment sequences in large populations in Germany: A 2011 study of a large routine dataset of six million insured individuals found that a quarter of patients with moderate or severe major depressive disorder (MDD) received no treatment or treatment that was not guideline-concordant. For individuals with severe MDD, 18% received no treatment and 56% received either non-guideline-concordant

medication or psychotherapy monotherapy instead of the recommended combination of both. Additionally, only 12% of patients with chronic MDD (defined as a diagnosis of MDD in 6 out of 8 consecutive quarters) received guideline-concordant treatment (Melchior et al., 2014). An analysis of 2012 routine data from a sample of over 7.5 million individuals found that, despite clear guideline recommendations for psychotherapy in severe depression, only 23% of individuals with severe depression received at least 1 hour of psychotherapy in the index year, compared to 30% of those with moderate depression (Wiegand et al., 2016).

A 2015–2016 study of data from 9.4 million people examined outpatient maintenance treatment following inpatient care. The German National Guideline on Unipolar Depression recommends at least maintenance therapy in such cases (Bäk et al., 2022). However, only 8% of individuals with severe depression received the indicated follow-up outpatient maintenance therapy with both medication and psychotherapy. Interestingly, 15% of individuals with moderate depression received psychotherapy, while only 12% of those with severe depression did—again indicating that less severely ill individuals received more psychotherapy, even though guidelines recommend psychotherapy more strongly for severe episodes. Indicators of guideline orientation of follow-up care after inpatient treatment were associated with lower mortality and lower re-hospitalization rates. However, 1 year re-hospitalization rates were astonishingly high with around 20% and a significant excess-mortality was detectable in comparison to the general population (Wiegand et al., 2020).

In a 2018 study of 1.6 million insured individuals in Lower Saxony, 41.1% of those diagnosed with severe depression had at least one contact with a psychiatric specialist and 9.2% with a psychological psychotherapist. Additionally, 60.3% received at least one antidepressant prescription per year, while 10.7% received inpatient treatment for depression. For those with moderate depression, the rates were 25.8% for contact with a psychiatric specialist, 9.7% for contact with a psychological psychotherapist, 48.1% for antidepressant prescriptions, and 1.4% for inpatient treatment. Similarly to the Melchior and Wiegand et al., 2016 and 2020 studies, the number of 9.2% in psychotherapy despite the guidelines recommendation for medication and psychotherapy is astonishingly low, especially considering that the rate of much more resource intensive inpatient treatment was even higher in this population (Stahmeyer et al., 2022).

A study analyzing the outpatient medication history for patients admitted for inpatient MDD treatment found that a large proportion of patients did not have guideline-oriented treatment optimization before inpatient admission: e.g. 22% did not receive pharmacotherapy at all despite a severe depressive episode, only 30% of those with unsuccessful first-line pharmacotherapy had a recommended therapeutic drug monitoring, of those with a continuous (but unsuccessful) pharmacotherapy 84% had no change of medication despite the lack of treatment success and stayed on average 36.6 weeks on the same medication (despite a change being recommended after 3–8 weeks of non-response). The 15.7% of patients that had a change of antidepressant medication had to wait on average 71 weeks for this change. Thereby, this detailed analysis showed largely insufficient outpatient treatment with a lack of timely treatment outcome evaluation and reactions to non-response. In many of those cases a guideline-oriented outpatient treatment might have prevented a need for (resource intensive) inpatient treatment (Herzog et al., 2017). A cross-sectional survey study of primary care physicians and their patients showed that only half of the depression cases (according to a depression screening questionnaire) were detected by primary care physicians. Of the detected cases with severe depression 60.5% received a guideline-oriented combination of psychotherapy and pharmacotherapy (Trautmann & Beesdo-Baum, 2017). However, these numbers might overestimate guideline orientation of primary care treatment, as half of the cases might not have been detected and only physicians with a certain degree of interest and awareness for mental disorders might have participated in the survey.

In summary, these evaluations consistently reveal significant deficiencies in Germany's mental healthcare system's ability to provide guideline-oriented care, especially for the more severely ill, and particularly when multiple providers (e.g. hospitals, outpatient physicians, and psychotherapists) must work together. These studies primarily focus on major depression, with little data available on other mental disorders. Likewise, long-term outcome studies that follow patients with severe mental disorders over several years to assess functional outcomes, quality of life, and patient satisfaction are lacking. Given the substantial regional variations in service delivery, it would be useful to compare patient outcomes across different regions within Germany, as well as with other socioeconomically comparable countries, such as Denmark, Sweden, the Netherlands, or Switzerland.

### *Coercive measures*

In this review the term 'coercive measures' is used both referring to measures of forced placement in mental health institutions, including measures of physical restraint, and compulsory treatment measures (Helmchen, 2021). In Germany, two laws govern the use of such coercive measures in psychiatry. The federal guardianship law ('Betreuungsrecht') permits coercive restraint and—since a 2017 ruling by the Federal Constitutional Court, with strict requirements—medical interventions when ordered by a guardian and approved by a judge. State-level 'mental health assistance acts' ('Psychisch-Kranken-Hilfegesetze' or 'PsychKHG') in each federal state also allow for restraint measures, with judicial approval. In accordance with the Universal Declaration of Human Rights (UN General Assembly, 1948) and the UN Convention on the Rights of Persons with Disabilities (UN General Assembly, 2006), reducing the use of coercive measures in mental healthcare is an important goal (DGPPN, 2018b). The number of restraint measures is therefore a critical process indicator. However, due to differing state laws and a lack of transparent routine data, no comprehensive nationwide statistics on coercive measures in mental healthcare are available (Steinert et al., 2022). Regional and hospital network-based studies indicate a slight reduction in the use of coercive measures compared to older studies, with 10.7% of all psychiatric inpatient admissions being involuntary, 7–8% involving coercive measures, and 0.6% involving forced medication (Adorjan, Steinert, et al., 2017; Flammer & Steinert, 2019).

### *Utilization, outcomes and experiences of ethnic minority populations*

In 2023 24.9 Million (29.7%) of the 83.9 Million inhabitants of Germany had a so called 'migration-background' which means that they were either first or second generation migrants. Approximately half of them had the German citizenship (Statistisches Bundesamt, 2024). Prevalence rates of mental disorders seemed to be higher in these populations (Bermejo et al., 2010). However, systematic reviews on utilization of the different mental healthcare systems' sectors are lacking and the few existing studies report inconclusive results (Klein & Von Dem Knesebeck, 2018). A recent scoping review identified two studies on 'immigrant and ethnic minority patients' reported experiences in psychiatric care' and found mixed results with one study reporting a higher and one a lower satisfaction (Kjøllesdal et al., 2023).

In a qualitative study, the lack of financing for interpreters, a lack of multilingual therapists and the consequences for proficient diagnosis and treatment were highlighted as mental healthcare barriers for migrants (Forray et al., 2024). Several studies examined mental healthcare access of the sub-population of refugees and reported significant access barriers (Schoenberger et al., 2024). Important factors are language barriers and that financing of more-than-emergency (mental) healthcare is only provided after a period of 18 months (BZgA, 2025). Several university hospitals have established different healthcare models for refugees with trauma-related mental disorders (Adorjan, Kluge, et al., 2017).

### The German mental healthcare system during the COVID-19 pandemic

The COVID-19 pandemic posed significant challenges to the mental health of the population. While many people demonstrated resilience during the early stages of the pandemic, certain vulnerable groups experienced an increased mental health burden (Ahrens et al., 2021; Mauz et al., 2022; Schäfer et al., 2022). The effects on individuals with pre-existing mental disorders were mixed, with some studies reporting deterioration, particularly among patients with psychotic or substance-related disorders (Schäfer et al., 2022). The pandemic also strained mental healthcare systems, affecting both service utilization and organization.

An unpublished systematic review identified 10 studies that examined the utilization of mental health services during the pandemic in Germany (Erdekian & Wiegand, 2023). These studies found reductions in admissions during lockdowns ranging from 24–40% for inpatient care % (Adorjan et al., 2021; Baum et al., n.d.; Fasshauer, Bollmann, Hohenstein, Mouratis, et al., 2021; Zielasek et al., 2021) and 60% for day-clinic treatment (Baum et al., n.d.). The largest reductions were seen among patients with affective disorders, with less pronounced effects on psychotic disorders (Baum et al., n.d.; Fasshauer, Bollmann, Hohenstein, Mouratis, et al., 2021; Wiegand et al., 2022; Zielasek et al., 2021). Overall, inpatient admissions declined by about 14% for the entire year of 2020 (Engels et al., 2022), and inpatient length of stay did not change significantly (Baum et al., n.d.; Engels et al., 2022). However, although the absolute number of involuntary and emergency admissions fell, their relative proportion increased (Fasshauer, Bollmann, Hohenstein, Hindricks, et al., 2021; Wiegand et al., 2022). Emergency department contacts for mental

health disorders also decreased (Kippe et al., 2023; Seifert et al., 2021), while trends in psychiatric pharmacotherapy showed no significant pandemic-related (Baum et al., n.d.; Engels et al., 2022). Outpatient care was also impacted, with some studies reporting initial reductions in contact (Fehr et al., 2024; Mangiapane et al., 2021). However, the number of new outpatient diagnoses fell by 14–22% during the lockdown phases (Baum et al., n.d.).

A survey of psychiatric department heads revealed that the substantial reductions in inpatient and day-clinic treatment were primarily due to protective measures, such as creating isolation capacity for individuals with severe mental disorders and co-morbid COVID-19 infections, as well as financial incentives to keep hospital beds empty (Wiegand et al., 2022). This survey, along with a similar one of outpatient mental health specialists, highlighted issues such as exacerbations and loss of patient contact, resulting from the lack of cooperation between sectors. The outpatient system was unable to compensate for these reductions in inpatient care. Both surveys also indicated that many inpatient and outpatient providers introduced telemedicine services during the pandemic, with positive feedback. However, many planned to discontinue these services due to regulatory constraints (Fehr et al., 2024; Wiegand et al., 2022).

A significant challenge during the pandemic was the lack of real-time service utilization data. As a result, the pandemic's effects, hygiene measures, and changes to financial incentives could not be assessed promptly. Instead, these trends were detected only through studies published with a 1–2 year delay (Baum et al., n.d.; Wiegand et al., 2022). Aside from the above-mentioned surveys, no comprehensive evaluation of the pandemic's long-term impact on inpatient mental healthcare has been conducted, likely due to data access difficulties.

## Current and future challenges

### Challenges

Taken together, Germany has an elaborate mental health care system and devotes significant and increasing financial resources for (mental) health care. In comparison to socioeconomically comparable countries in Europe, the health insurance funded part of the mental health care system devotes a lot of resources for the inpatient system with a comparably high and even increasing number of hospital beds and comparably long inpatient stays. The recent capacity increases, e.g. in hospital beds and outpatient

psychotherapy were mostly devoted to moderately ill populations. It is unclear, whether this focus of resources on inpatient treatment leads to better outcomes as compared to socioeconomically comparable countries with a focus on outpatient treatment. However, some of the above-mentioned observations indicate that resources are not always being used effectively. From the above analysis, we conclude that the following challenges exist for the German mental healthcare system:

Germany's mental healthcare system is elaborate, with significant and increasing financial investment. Compared to other socioeconomically comparable European countries, the German health insurance-funded mental healthcare system allocates a considerable portion of its resources to inpatient care, resulting in a high—and growing—number of hospital beds and long inpatient stays. Recent increases in hospital bed capacity and outpatient psychotherapy offerings have primarily benefited moderately ill populations. It remains unclear whether this emphasis on inpatient treatment leads to better outcomes than the outpatient-focused approaches of other comparable countries. Some observations suggest that resources are not being used effectively. The following key challenges emerge from this analysis:

#### **Challenge 1: lack of guideline orientation**

There is a clear lack of *orientation to clinical guidelines* in both inpatient and outpatient care. Despite the availability of up-to-date national clinical guidelines for mental disorders (Bäk et al., 2022; Bandelow, 2021; DeGPT, 2019; DGBS and DGPPN, 2020; DGPPN, 2022, 2019), implementing these guidelines in routine practice remains a challenge. Some studies have suggested negative outcomes due to the lack of guideline orientation, such as increased rates of hospital readmissions and higher mortality due to insufficient follow-up care (Wiegand et al., 2020).

#### **Challenge 2: lack of centralized access and treatment allocation**

Another challenge is the absence of regionally centralized institutions that provide an *easy access to the mental healthcare system, evaluate individual treatment needs and ensure severity-based, guideline-oriented treatment allocation*. This can be seen in the inpatient sector, where long-duration stays with low treatment intensity are common among severely ill patients, while moderately ill patients receive more intensive care in psychosomatic units (Wiegand et al., 2020). Modern, cost-effective treatment formats such as

crisis resolution teams and assertive community treatment play only minor roles (Lambert et al., 2020). This issue is also present in outpatient care, where severely ill patients often receive low-intensity psychiatric care or PIA (Psychiatrische Institutsambulanz) treatment, while high-intensity psychotherapy is more common among moderately ill patients. Many mildly ill patients receive specialist psychotherapeutic treatment, for which supported digital solutions or GP-led care might suffice (Melchior et al., 2014; Wiegand et al., 2016). Long waiting times, limited access to specialized care for severely ill patients, and a lack of outcome monitoring (e.g. PROMS—Patient Reported Outcome Measures) may contribute to worsening of conditions and chronicity. This system not only leads to worse outcomes for patients but also represents an *inefficient use of resources*.

#### **Challenge 3: lack of responsibility for coordinated care and provider-centricity**

A major challenge is the *lack of coordination and integration between different sectors* of the mental healthcare system, especially between inpatient and outpatient care, complementary services, and the rehabilitation system. This lack of integration is particularly problematic for the most severely ill patients. The *responsibility* of organizing integrated multi-provider treatment sequences is mostly with the patient (which might be impaired to do so by the mental illness, especially if severely ill) and not with the system. The few existing studies suggest that care delivery is driven more by providers' financial incentives than by patient needs. This *provider-centric focus* is also evident in the structure of healthcare governance bodies, such as the 'Gemeinsamer Bundesausschuss' (GBA, n.d.), and in the absence of mandatory system-wide longitudinal outcome measurements (PROMS) (Clark et al., 2018).

#### **Challenge 4: shortage of qualified personnel**

A critical and growing issue is the shortage of qualified and specialized mental healthcare personnel. Psychiatry, psychotherapy, and psychosomatic medicine are among the disciplines with the most severe staffing shortages, and this gap is expected to widen in the coming years (Wolfgang, 2019). This reinforces the need for more coordinated, severity-based resource allocation and a shift from labor-intensive inpatient care to more labor-efficient outpatient services (Bschor, 2023; SVR Gesundheit & Pflege, 2024, SVR Gesundheit & Pflege, S. zur B. der E. im G., 2018).

### Challenge 5: lack of comprehensive data on treatment and outcomes

Germany lacks easily accessible, representative data on long-term treatment sequences and outcomes. This data is crucial for evaluating the mental healthcare system and assessing the effects of crises like the COVID-19 pandemic or political reforms. Compared to other countries, Germany is far behind in providing access to such data for research and policy development. To date, only small and selective sections of routine mental healthcare have been evaluated. Efforts have been made to overcome these barriers, including initiatives to consolidate data in a centralized institution and provide transparent access for research purposes. After more than a decade of planning, the 'Health Data Lab' ('Forschungsdatenzentrum Gesundheit'), which will consolidate routine health insurance data, is set to open for research in 2024 (BfArM, 2024). The next step will be linking this data with clinical study data, outcome data, and patient-reported data. However, system-wide PROMS and PREMS (Patient Reported Outcome and Experience Measures), which focus on patient perspectives, are still lacking. A contributing factor might be a strong focus on data protection in Germany. However, this prioritization of data protection over improving clinical practice may be contributing to excess mortality caused by insufficient treatment practices. In our view this seems to be an ethically questionable choice.

### Underlying structural factors

The challenges in the German mental healthcare system are largely rooted in its *organizational and financial incentive structures*, rather than the actions of individual providers. While of course not all providers are driven solely by financial motivations, as profit-oriented entities operating in a highly regulated market, they must generally follow the incentives set by the system. Unfortunately, these incentives often contribute to the issues discussed. For instance, the current system encourages inpatient providers to expand low-intensity services, outpatient physicians to limit contact time with patients, and psychotherapists to favor less severely ill patients. The system does not adequately incentivize the provision of integrated, guideline-oriented, and resource-efficient stepped-care services with clear access points and responsibilities for care delivery. As service expansions drive up costs, the political response has been to introduce more *detailed regulations and documentation requirements*. These measures, in turn, contribute to a *growing administrative burden* and further consume resources

(Regierungskommission, R. für eine moderne und bedarfsgerechte K, 2023). To address these issues, it is essential to realign both structures and financial incentives with the goal of delivering integrated, patient-centered, and guideline-compliant care.

### Solutions and implications for policy makers and practitioners

The following solutions could address the current and future challenges of the German mental healthcare system. Implications for practitioners and researchers can be found in Table 2. For policy makers we would recommend:

- *Global (Regional) Budgets*: Implement global budgets that cover both inpatient and outpatient care. This would encourage providers to focus on cost-effective, integrated care across settings.
- *Centralized Regional Access, Evaluation and Crisis Resolution Services*: Establish centralized regional services that provide 24-hour access to diagnostic assessments, crisis resolution, and care coordination. This model has been successfully tested in the Hamburg RECOVER project.
- *Stepped-Care Approaches*: Introduce stepped-care models that offer a range of services, from e-mental health solutions to outpatient, crisis resolution, assertive community, day-clinic, and inpatient care. These approaches, which have been tested in the RECOVER model, are also recommended by international organizations such as the WHO (World Health Organization, 2001), OECD (OECD, 2021) and by the German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN) (DGPPN, 2024).
- *Digital Infrastructures*: Develop digital infrastructures that enable immediate, cross-sector communication between inpatient and outpatient

**Table 2.** Implications for practitioners and researchers.

Implications for	
Practitioners	Researchers
Engage in dialogue forums with patients and their relatives	Engage in dialogue forums with patients and their relatives for
Engage in cooperation and formation of networks of service providers	defining relevant research topics and discussing outcomes
Support digitalization of standardized clinical data and multiprofessional cooperation	Systematically assess long-term outcomes
Use transparent therapy-response and outcome	Develop evidence based quality indicators and service goals as a basis for making regional mental healthcare services' performance transparent

providers regarding therapeutic measures, recommendations, and outcomes. This system should be based on standardized, digitalized psychiatric and psychotherapeutic data.

- *Nationwide Transparent Quality Indicator Reporting System*: Create a transparent, nationwide system for reporting quality indicators. This system should integrate routine measurements of guideline orientation with patient-reported outcome measures (PROMS) and patient-reported experience measures (PREMS). These indicators should be used for individual therapy planning, quality management for providers, and performance evaluation across mental health regions. Public reports on these indicators would highlight regions where integrated care is successful and where it is lacking—as a transparent tool for citizens, patients and politicians. The indicators could also influence regional budgets, with a portion of the budget being reimbursed only if certain targets (e.g. guideline orientation, timely access for severely ill patients, patient satisfaction) are met. This would create financial incentives for providers to work together to achieve quality goals, fostering better outcomes without adding bureaucracy (Regierungskommission, R. für eine moderne und bedarfsgerechte K, 2023).
- *Dialogue Forums*: Involve patients and their relatives in the organization of mental healthcare, particularly in interpreting regional quality and outcome reports. Dialogue forums, which bring together patients, family members, and professionals, could ensure that the voices of those directly affected by the system are heard (Aktionsbündnis Patientensicherheit, n.d.; DGPPN, n.d.).

Such a ideas would shift incentives away from expanding inpatient capacity and toward delivering integrated, guideline-oriented, and severity-based stepped-care treatment sequences. It would also encourage cooperation among independent, profit-oriented providers. By aligning structures and incentives with patient needs, the German mental healthcare system could achieve better outcomes, greater transparency, improved patient orientation, and more cost-effective care.

### Disclosure statement

All authors are employees of departments of psychiatry and psychotherapy. They have no further interests to declare.

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