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SPECIAL ISSUE

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Mental health care in Germany

Current state and trends

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Abstract Germany turned towards community-based mental health care in the mid seventies, during a general climate of social and political reform. The continuing deinstitutionalisation process and the implementation of community mental health services was considerably affected by the reunification of East and West Germany in 1990, which required dramatic changes in the structure and quality of the mental health care system of the former German Democratic Republic (GDR). Overall, German mental health care is organised as a subsidiary system, where planning and regulating mental health care is the responsibility of the 16 federal states. So German mental health care provision is spread among many sectors and characterised by considerable regional differences. A key characteristic is the particularly wide gap between inpatient and outpatient services, which are funded separately and staffed by different teams. In 2003 the total number of psychiatric beds was a mere two thirds of the overall bed capacity in 1991, the first year as a re-unified Germany, when psychiatric beds in East and West Germany totalled 80,275. From 1970 onwards the number of psychiatric beds was cut by roughly half. So the momentum of the reform has been strong enough to assimilate the completely different mental health care system of the former German Democratic Republic and, in the course of a decade, to re-structure mental health services for an additional 17–18 million new inhabitants. In an ongoing struggle to adapt to changing administrative set-ups, legal frameworks, and financial constraints, psychiatry in Germany in currently facing specific problems and is seriously challenged to defend to considerable achievements of the past. A major obstacle to achieving this aim lies in the fragmented system of mental health care provision and mental health care funding.

Key words psychiatric reform · community mental health care · cost of care · mental health care funding · mental health care planning

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Background

Mental health care reform in Germany started later than in other industrialised countries. To a considerable degree, this was a late consequence of the Nazi regime's reign of terror, during which a massively corrupted mental health care system assisted in the murder of 90,000–140,000 people with mental illness between late 1939 and 1945 (Faulstich 1990). After World War II, psychiatric hospitals and mental asylums in Germany were not as overcrowded as those in the UK or USA, so that there was no significant pressure to implement new services for the mentally ill. A widespread suppression of public discourse of the mass-murder and feelings of shame regarding what had happened to people with mental illness contributed to the neglect of and indifference towards the basic medical and social needs of patients with mental illness during the 1950s and 1960s. Care was mostly restricted to large, old-fashioned institutions in remote areas (Rössler et al. 1996).

In the mid-seventies, in a general climate of social and political reform, Germany turned towards community-based mental health care. In 1975, a federal

expert commission's report on the quality of West German mental health care concluded that (a) psychiatric inpatient care was provided almost exclusively by large and inadequately staffed state mental hospitals or asylums, (b) that there was an almost complete absence of both psychiatric wards at general hospitals and of other community mental health services, and (c) that there was a significant separation between mental health care and the general health care system (Deutscher Bundestag 1975). Consequently, the commission recommended the urgent improvement of the old mental asylum system and defined four basic principles supposed to steer a far reaching structural reform:

- the principle of community based mental health care delivery,
- the principle of needs-based and comprehensive care for all people suffering from mental disorders,
- the principle of needs-based coordination of mental health care in defined catchment areas,
- the principle of quality standards and access to mental care similar to standards of and access to somatic care (Deutscher Bundestag 1975; Bauer et al. 2001).

The mental health care reform process which followed brought about substantial change in terms of deinstitutionalisation processes in psychiatric hospitals, with the discharge of many people with chronic mental illness from hospitals in one hand, and introduction of community mental health services on the other. Psychiatric day hospitals were introduced, the number of office-based psychiatrists increased, and hospital-based outpatient services and social psychiatric services were implemented.

Integrating East German mental health care

From 1990 onwards, the reform process was affected by the historic process of the reunification of East and West Germany. As a general rule, the unification treaty stipulated the adoption of the legal, economic and administrative structures of West Germany by the "new" federal states. This implied dramatic changes in the structure of the mental health care system of the former German Democratic Republic (GDR). The mental health care system in East Germany had seen attempts to reform community psychiatry, and there had been progress in the provision of integrated community mental health services in some parts of the country during the 1960s and 1970s. The so-called Rodewisch Theses reflected a marked emphasis on mental health care reform in the GDR during the 1960s (Richter and Nollau 2000; Rodewischer Thesen 1965). Outpatient clinics and community services were opened. Attempts, however, were hampered by a lack of resources (Bauer 1994). The financial burden of restructuring East Germany's mental health care system was immense, and there has been substantial investment in structural improvement. While the conversion of services in the new states ("Länder") of the Federal Republic has generally been accomplished, an east–west divide still persists in some sectors of mental health care, e.g. there is an under-provision of office-based psychiatrists in East German outpatient mental health care.

Overall system characteristics

Germany has no National Health Service financed and/or managed by a federal authority or administration. Instead, mental health care is organised as a subsidiary system, with federal authorities being entitled to organise service provision only in the event that private, volunteer, or other organisations are unable to provide the service. Planning and regulating mental health care is the responsibility of the 16 federal states, that do so by passing state-level health legislation. The national government provides a basic legal framework by passing general health care or welfare legislation. As a result, German health care provision—particularly the provision of mental health care—is spread among many sectors and characterised by considerable regional differences.

Mental health care reporting standards

This diversity affects the standards of mental-health reporting. On a national basis, data are available only for a limited number of mental health care indicators, that are compiled from heterogeneous sources and often ignore regional differences. Almost all national averages presented in this article share this shortcoming and may be affected by methodological bias. Political awareness of improved health reporting standards is limited.

Mental health care planning responsibilities

Psychiatric bed rates are specified and regularly adapted by the federal states, whereas local authorities organise and steer the entire range of usually independent community mental health services, including vocational services and sheltered accommodation services. This division in the planning responsibilities emphasises one of the key characteristics of the German health care system: the wide gap between inpatient and outpatient care, which are clearly distinct from each other, funded separately and staffed by different teams (Rössler et al. 1996). New mechanisms for coordinating services, e.g. case management, regional mental health care trusts, managed care, or integrated funding systems are constantly being developed and tested at a regional or national level without having proven that they can overcome the fragmentation of the system (Roick and König 2005).

Mental health care funding modalities

Generally, health care in Germany is funded on a fee-for-service basis and is largely dominated by health insurance plans into which enrolment is mandatory. However, health insurance companies directly reimburse only the costs of inpatient care and the cost of medication. Global outpatient budgets are transferred regularly from health insurance companies to medical management organisations of physicians in office practice (called "Kassenärztliche Vereinigungen"), which control these budgets and distribute them autonomously among the contracted physicians. In addition, pension funds usually pay for rehabilitative care, as it is intended to prevent early retirement.

Mental health care funding is even more complex. Health insurance companies reimburse the costs of acute medical treatment for the mentally ill if they are eligible for benefits, which, due to unemployment or early retirement, they often are not. Disability funds, pension funds, or the Federal Bureau of Labour cover the costs of rehabilitative care, aiming thereby to prevent the loss of work skills.

To make it even more complicated, sheltered accommodation, re-integration measures, or other complementary treatment for mentally ill is usually funded by the social welfare system. Social welfare also pays for acute psychiatric inpatient, outpatient, or rehabilitative treatment if patients do not qualify for by health insurance or pension fund benefits.

Available cost information

Due to this complexity, overall analyses of the cost or the cost-effectiveness of mental health care are scarce. It is known from administrative data that in 2002, expenditures for treating mental disorders in Germany (direct cost of care) rose to approximately 22.4 billion €, which was 10% of the total German health care budget of 223.6 billion €, or roughly 1% of the gross domestic product. Expenditures broke down into 2.8 billion € for schizophrenia, 5.6 billion € for dementia, 3.0 billion € for addiction disorders, 4.0 billion € for depression and 7 billion € for other mental disorders (Statistisches Bundesamt 2004). These figures, which are based on highly aggregated health insurance or pension fund data, probably underestimate the actual cost of care, especially in the case of addiction disorders.

Another top-down cost study claimed that two thirds of expenditures for mentally ill were covered by health insurance (inpatient and outpatient mental health care), while one third was funded by social welfare (sheltered accommodation and most other forms of rehabilitative care). Breakdown of health insurance payments resulted in 5.1 million € being directed into hospital care and 3.3 million being spent on outpatient mental health care (with 75% of outpatient care spending covering psychotherapy sessions) (Melchinger et al. 2003). The financial burden on the families or relatives of the mentally ill is largely unknown but most probable considerable (Mory et al. 2002).

Bottom-up cost or cost-effectiveness studies on the care for patients with schizophrenia have increased during recent years (Kilian and Angermeyer 2004; Kilian et al. 2003; Salize and Rössler 1999; Kissling et al. 1999; Salize and Rössler 1996), whereas health economic research on depression or addiction disorders is only in its initial stages (Salize et al. 2004; Friemel et al. 2005).

Future challenges for the funding system

During the early stages of mental health care reform, potential cost-savings such as those induced by the reduction of psychiatric beds were never analysed. Any such savings probably were neutralised by a considerable increase in psychiatric hospital staff on the basis of a new federal directive on staffing of psychiatric hospital services (Psych-PV) that went into effect in the early 1990s (Kunze 2004). Although de-institutionalisation has put a higher financial and care burden on outpatient services, any transfer of hospital budgets into outpatient care is prevented by the fact that budget responsibilities are split among these sectors. Due to such system-based obstacles, both the potential and the incentives for cost savings are generally low, and any "ring-fencing" of overall mental health care budgets in periods of service transformation is virtually impossible. As a consequence, there is heated public debate on how to reform the complex German funding system. More flexible comprehensive budgets that cover both inpatient and outpatient mental health care are currently being assessed, but it is not clear yet whether these so-called "integrated funding" or "managed care" models will prove to be cost-effective (Roick 2004). While DRG-based funding has become mandatory for general hospital care in 2005, psychiatry was exempted from this shift, mainly in order to avoid dysfunctional incentives that lead to inappropriate shortening of inpatient treatment episodes.

Research funding

Due to a low priority that was given to evaluate the overall shift to community care and the efficacy or interactions of the new community services during 1970s and 1980s, research findings neither on the costs nor on the effectiveness of the complex, multi-provider German model of community mental health care are scarce.

During the 1990s, the majority of psychiatric research grants were directed not into mental health services research but into biological research programmes, which dominates psychiatric research networks in Germany, which are currently funded by the German Federal Ministry of Education and Research (BMBF). Four major mental health research networks

("Kompetenznetze") were implemented in recent years, each of which focuses on a major mental disorder (schizophrenia, depression, dementia, or addiction disorders). Each of these networks is funded by a 6-year grant of 13–20 million €, and together they provide a platform for multi-centre and collaborative studies by renowned researchers from across the country. However, the demand for evidence on mental health service provision still outnumbers the research activities in this field.

Involvement of user organisations

Twenty-five years ago, user and family organisations were rare in the mental health care field in Germany. The psychiatric reform has raised public awareness and strengthened the position of users and relatives so that by the year 2000, user associations were active in all federal states. However, financial support is not available across the country, and delegate status for representatives of user associations at meetings of state-level mental health care advisory boards is not general routine (Hölling 2001).

Structure (input) data

Inpatient care

From the start of the mental health care reform process in the mid-1970s, hospital care for people with mental illness has been transferred from traditional psychiatric hospitals to general hospital psychiatric wards/departments/units which provide community-based inpatient care. The same is true of psychiatric hospitals, which have been transformed in terms of their infrastructure, staffing levels and therapeutic culture and procedure. The Psych-PV (see above) brought about greatly improved the levels of staff in inpatient services. There is, approximately, a 50:50 divide in terms of the overall numbers of inpatient care episodes between general hospital psychiatric units and psychiatric hospitals (Bauer et al. 2001). Although very few psychiatric hospitals have been closed, most of them have decreased significantly in size and changed their focus towards regionalised acute hospital care alongside a growing number of psychiatric wards at general hospitals (see Table 1). Though mental hospital beds still outnumber general psychiatric ward beds, psychiatric hospitals in Germany today have less in common with the old-fashioned asylums of the pre-reform days, and are well-equipped and well-staffed facilities providing specialised psychiatric care.

Psychiatric beds

In 2003, the total number of psychiatric beds in Germany was 54,088 (including beds for addiction treatment, and excluding child and adolescent psychiatry), corresponding to a rate of 6.55 inpatient psychiatric beds per 10,000 population. This is a mere two third of the overall bed capacity in 1991, the first year as a re-unified Germany, when psychiatric beds

Table 1 Mental health services in Germany 2003—input data

Facility	Year	Number of services	Number of beds or places	Beds/places per 10,000 population	Services per 100,000 population
Hospital care					
Total psychiatric inpatient care (adults):	2003	405	54,088	6.55	0.49
Psychiatric hospitals	2003	190	32,324	3.91	0.23
Psychiatric wards at General Hospitals	2003	215	21,764	2.63	0.26
Psychiatric day or night hospitals (adults)	2003	339	8,539	1.03	0.41
Forensic psychiatry[a]	2003		7,299	0.81	
Child and adolescent hospital care	2003	113	4,669	0.57	0.14
Psychosomatic hospital wards	2003	90	3,183	0.46	0.11
Outpatient care					
Psychiatric outpatient departments (adults)	2002	523			0.63
Psychiatric outpatient departments (child and adol.)	2002	80			0.10
Social Psychiatric Services	2000	586			0.71
Rehabilitative care					
Rehabilitative services for the mentally ill (RPK)	2000	42	827	0.10	0.05
Sheltered workshops for the mentally ill[b]	2000	236	23,836	2.88	0.28
Psychosomatic rehabilitation centres (approx.)[c]	2003		15,000	3.26	
Residential care (sheltered accommodation)					
Total sheltered accommodation	2000		63,427	7.71	
Residential homes (staffed 24 h)	2000	1,180	36,580	4.45	1.42
Other types of sheltered accommodation	2000		26,847	3.26	

Data sources (except where otherwise indicated): hospital care: Federal Statistical Office (Statistisches Bundesamt 2005), outpatient care, rehabilitative care, residential care: Arbeitsgruppe Psychiatrie 2003

[a] Data source: Osterheider and Dimmek 2005

[b] Incomplete data (covering only 12 out of 16 Federal States)

[c] Data source: Berger 2005

in East and West Germany totalled 80,275 (10.4 per 10,000 population). Time series from 1970 onwards indicate a considerable and constant drop during a 35-year period, in which the number of psychiatric beds was cut by roughly half (see Fig. 1). However, definition criteria for psychiatric beds have changed slightly over time and may contribute to some outliers in the time series. The regional variability among the number of psychiatric beds is still high. There are large differences in bed rates, not only between East and West German federal states (due to the re-unification process), but also at the state level in general (due to the autonomy of the federal states in terms of mental health care planning). The bed rate varies between 5.3 and 6.4 with three outliers: Schleswig-Holstein (6.9), North-Rhine Westphalia (the most populated state, 8.2) and the City State of Bremen (10.6). The bed rate in child and adolescent psychiatry varies from 0.3 to 1.1 per 10,000 population. Additionally, as in most other countries, the provision of psychiatric beds differ considerably between urban and rural areas. This variety applies not only to psychiatric beds, but to all sectors and types of mental health care services as described below.

Long-stay beds

Due to unclear definitions and varying criteria, it is hard to quantify the number of long-stay beds. A recent estimate suggested that the proportion of long-stay beds among all psychiatric hospital beds had decreased from 17% in 1990 to a mere of 2.5% in 2000 (Arbeitsgruppe Psychiatrie 2003), although this seems to overestimate the decline. However, during the de-institutionalisation process, a considerable proportion of long-stay wards in psychiatric hospitals were re-designated as sheltered residential facilities for people with mental illness, which implied a change in staff and in the intensity of care, but not in the number of residents. Additionally, in 2003, a total of 8,539 beds in 339 *psychiatric day or night hospitals* were available. These beds or places usually are defined as belonging to the hospital sector, but are not counted as inpatient beds, thus day or night hospital capacities were not included in the figures and time series above.

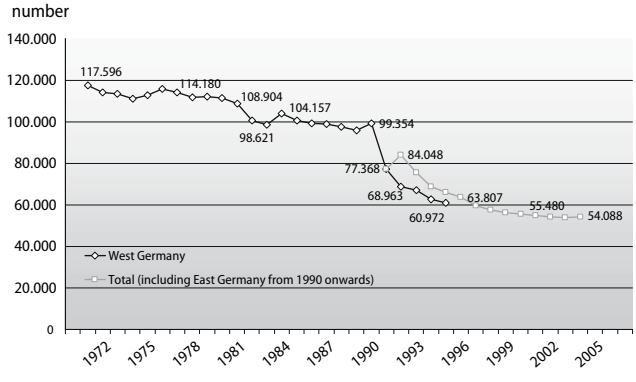

Fig. 1 Total number of psychiatric beds in Germany (varying definitions, source: Federal Statistical Office, Germany)

Psychiatric hospital or ward staff

Exact data on the number of psychiatrists working in the hospital sector vary across sources. According to the Federal Statistical Office, there were 3,715 graduated psychiatrists working in psychiatric hospitals or wards in 2003 (1,756 on general hospital psychiatric wards, the remainder working in psychiatric hospitals). Roughly 80% were employed full-time (Statistisches Bundesamt 2005). The German Chamber of Physicians ("Bundesärztekammer") confirmed this figure when counting 3,722 hospital-based physicians with specialities connected to mental health care ("Ärzte für Nervenheilkunde", "Ärzte für Psychiatrie", "Ärzte für Psychiatrie und Psychotherapie") in 2003 (Bundesärztekammer 2003). Overviews of mental health care staff numbers regarding psychologists, nurses etc. are not available at a national level.

Child and adolescent psychiatry

During the last 30 years, *child and adolescent psychiatry* in Germany has become a faculty and medical speciality of its own, and child and adolescent psychiatric care is provided by 43 wards at psychiatric hospitals and by an additional number of approximately 70 wards at general hospitals (including university hospitals, adding up to a total of 4,669 beds in 2003 (Statistisches Bundesamt 2005). According to the German Chamber of Physicians, the hospital sector comprised 565 fully graduated child and adolescent psychiatrists in 2003 (Bundesärztekammer 2003).

Forensic psychiatry

Mentally ill offenders are placed and treated in a strictly separate sector of forensic psychiatry care (Salize and Dressing 2005). Having increased rapidly during recent years, the number of beds in this sector ("Maßregelvollzug") totalled 7,299 in 2003 (including beds in forensic detoxification centres) (Osterheider and Dimmek 2005). With a forensic bed ratio of 0.81 per 10,000 population, Germany is among the European Union member states with the largest forensic psychiatry sector (Salize and Dressing 2005; Priebe et al. 2005).

Psychosomatic hospital care

A unique feature of the German mental health care system that distinguishes it from the systems of mental health care provision in most other western

countries is a large number of beds for *psychosomatic hospital treatment* (in 2003: 3,183 beds in hospitals and approximately 15,000 beds in rehabilitation centres). The phenomenon originated in the 1920's and is rooted in the strong German tradition of psychotherapy, which was soon re-installed as an influential medical discipline after World War II, despite a significant drain of experts during the Nazi-regime. Having originally been designated for the treatment of patients suffering from somatic disorders with a strong component of psychosomatic or psychological co-morbidity, these psychosomatic inpatient services or rehabilitation centres now compete increasingly with the psychiatric care sector for patients suffering primarily from mental disorders or syndromes, e.g. depression or anxiety disorders (Berger 2005). Currently, there are efforts to extend inpatient capacities within the psychosomatic care sector. Without proper coordination, this trend might threaten to counteract basic principles of de-institutionalisation and community-based mental health care. However, professional organisations of psychosomatic care providers may have different views on this, and debate on this issue is ongoing (Diefenbacher 2005; Bell and Deutsche Gesellschaft für Psychosomatische Medizin und Psychotherapie 2004).

Outpatient care

Psychiatric outpatient departments

Many inpatient facilities (general hospital psychiatric wards and psychiatric hospitals) run *psychiatric outpatient departments* ("Institutsambulanz") for specific mental disorders, particularly for patient groups with severe mental illness, i.e. ongoing psychotic disorders, and patients for whom multiprofessional community care is required. These services were first implemented in psychiatric hospitals in the late 1970s. A revision of the Social Security Act in 2000 extended the permission to provide community care in such psychiatric outpatient departments to general hospital psychiatric wards. The number of outpatient departments increased from 27 (in three federal states) in 1980 to a total of 304 in 2002. Outpatient departments were complemented by another 219 similar services (labelled "Ermächtigungsambulanz"), which are only eligible to treat patients with specific problems, referred from psychiatrists in office practice (see Table 1). As a rule, psychiatric outpatient departments provide psychiatric treatment for patients with severe and persistent mental disorders. In order to be able to provide comprehensive care packages, teams include nursing staff, social workers and other professional groups (e.g., occupational therapists), along with psychiatrists. Outreach activities and home visits are provided. Psychiatric outpatient departments might, in certain instances, be seen as competing with psychiatrists in office practice, who dominate medical outpatient care for people with mental illness in Germany (see below).

Social psychiatric services

Social Psychiatric Services ("Sozialpsychiatrische Dienste") are additional specific outpatient services for people with chronic mental illness. These services were first implemented during the mid-1970s in order to bridge the gap between hospital care and psychiatric outpatient treatment. Although being specialised in limited tasks, social psychiatric services are functionally integrated into community mental health care. They differ from community mental health centres (CMHC) in other European countries in that they do not focus primarily on psychiatric treatment, that being the responsibility of psychiatric outpatient departments and psychiatrists in office practice. The role of social psychiatric services is considered to be complementary to other (inpatient and outpatient) services, and their aims include long-term rehabilitative care. Social psychiatric services in most German federal states are directed by psychiatrists and staffed by social workers or psychiatric nurses. They provide a wide range of care and support for patients and their families, including outreach or day care activities. Care offered by social psychiatric services is essential in the case-management of people with chronic mental illness, particularly in view of the fragmentation in the mental health care system. In 2000, 586 social psychiatric services were provided in Germany (Arbeitsgruppe Psychiatrie 2003). Team size is 5 or 6 staff members, on average, the overall number of professionals working in these services is not available.

Outpatient psychiatrists

In 2003, 5,518 *psychiatrists in office practice* ("Nervenärzte", 0.66 per 10,000 population) were registered in Germany, providing outpatient care for adults with mental disorders (KBV 2005). Thus, their number had increased by a factor of about three from a total of 1,403 (0.22 per 10,000 population) in 1980, in the then "old" Federal Republic of Germany (pre-unification) (Table 2). Despite the strong increase in numbers, the number of specialists required to meet the mental health care needs of the German population is estimated to be up to three times higher (Berger 2005). Psychiatrists in office practice are not based at inpatient or outpatient psychiatric services, but are economically independent within a statutory framework, contracting with the "Kassenärztliche Vereinigungen"

Table 2 Mental health care staff in Germany

Professionals	Year	Total number	Rate per 10,000 population
Hospital care			
Hospital-based psychiatrists[a]	2003	3,715	0.45
Outpatient care			
Psychiatrists in office practice ("Nervenärzte")[b]	2003	5,518	0.66
Physicians specialised in Psychotherapy[c]	2003	3,606	0.43
GPs and Family doctors[b]	2003	58,975	7.15
Psychologists in office practice[d]	2003	12,000	1.45

[a] Data source: Federal Statistical Office (Statistisches Bundesamt 2005)
[b] Data source: KBV 2005
[c] Data source: KBV 2005, number overlaps with psychiatrists in office practice to an unknown degree
[d] Data source: Berger 2005, figure is estimated

(KVs). These are autonomous physician-run management agencies (acting, however, within a statutory framework and obliged by law to ensure outpatient healthcare for the population in a given region) which negotiate global budgets for outpatient care with health insurance companies and distributing them among contract physicians according to specific formulae.

Although this traditional organisational feature may add to the numerous obstacles to the adequate coordination of mental health care or case management, office-based psychiatrists usually are an integral link in local mental health care networks (Table 2).

General practitioners and family doctors in mental health care

German general practitioners are also office-practice-based and reimbursed in a similar way. The 58,975 *family doctors* and *general practitioners* contracted to the KVs in 2003 play an important role in German outpatient mental health care (KBV 2005). Since an estimated quarter of GP-patients may suffer from mental disorders (Berger 2005; Üstün and Sartorius 1995), GPs and family doctors in Germany must be regarded as major entry points into mental health care. Currently, the position of GPs and family doctors as gatekeepers to specialised care is strengthened by the Federal Ministry of Health, which has stipulated that referral slips to specialised care must be issued by a GP before any specialist may be contacted. The German Society of Psychiatry, Psychotherapy and Nervous Diseases (DGPPN) has developed guidelines which define the criteria and pathways for an appropriate referral of patients with major mental disorders from primary to specialised mental health care (Härter et al. 2003). However, recent studies suggest that there is a proportion of patients with mental disorders in primary care whose diagnoses have been missed or are erroneous (Wittchen et al. 2000a). These findings suggest that GPs must become even more involved in German mental health care, and the DGPPN considers collaboration with primary care a high-priority issue.

Outpatient psychotherapy

Alongside about 3,606 psychiatrists (0.43 per 10,000 population) in 2004, who are specialised in psychotherapeutic techniques ("ärztliche Psychotherapeuten", KBV 2005), outpatient psychotherapy is currently provided by approximately 12,000 outpatient psychologists as well (about 1.4 per 10,000 population). The number of psychologists in outpatient psychotherapy who were funded by health insurance has increased exponentially since restrictions for outpatient psychotherapeutic treatment were eased in 1999. Thus, the number of (medical and psychological) psychotherapists now available for outpatient care amounts to two to three times the number of psychiatrists in office-based outpatient care. As a consequence, a larger share of the health care budget is currently spent on psychotherapy for a minority of patients than on the basic mental health care for the vast majority of people with mental illness (Melchinger et al. 2003; Berger 2005).

Sheltered accommodation and residential care

While medical or psychotherapeutic outpatient care is provided by psychiatrists, psychologists, or outpatient departments as described, a wide range of additional services offer rehabilitative and complementary care. As the number of inpatient psychiatric beds have decreased, the number of *sheltered accommodation beds* has risen steadily. Both "old" patients with chronic illness and "new" chronically ill persons are to be found living in a range of non-hospital residential facilities, including homes staffed 24 h a day, group homes, halfway houses, or sheltered apartments. In 2000, a total of 63,427 sheltered accommodation places of all types were provided for people with mental illness (7.71 per 10,000 population), 57% of which were beds in fully staffed homes (24-h staff coverage). In 2000, the total number of homes for the mentally ill which were staffed 24 h a day was 1,180, averaging 31 beds (Arbeitsgruppe Psychiatrie 2003). There is an overall tendency towards smaller units, although during the downscaling of psychiatric hos-

pitals a considerable number of relatively large old hospital wards were re-designated as residential facilities for people with mental illness without them moving to new accommodations off the hospital premises.

Daycare

Daycare for people with mental illness is another component of the care system that helps to bridge the gap between inpatient and outpatient care which is characteristic of the German mental health care system. Daycare services range from drop-in day centres to highly specialised rehabilitative services offering vocational therapy or other specific treatments. In contrast to day hospitals, which include psychiatric staff and, in terms of funding by health insurance, are considered part of the inpatient sector (see above), *day centres* are facilities with varying structural characteristics that depend on regional conditions or funding arrangements. Usually, they do not provide psychiatric or psychotherapeutic treatment but offer a wide variety of day activities. Some operate on a low-threshold policy and are open to a wider group of patients who drop in at their own convenience (on an on-demand basis). Other day centres may serve a clearly defined clientele with mandatory attendance. In 2000, there were 536 day centres offering daycare on a 5-days-a-week basis (daily attendance being required by the funding bodies) and a total of 7,558 places. An additional 1,013 day centres for people with mental illness were less prescriptive (regarding terms of use) and had no defined capacities in terms of the number of places (Arbeitsgruppe Psychiatrie 2003).

Rehabilitative care

Rehabilitative care for the mentally ill in Germany is provided by a wide variety of facilities offering vocational training, occupational therapy, or other treatments aiming to restore the work skills of mentally disordered people or to foster their reintegration into community life. These services may range from full-scale inpatient rehabilitation facilities or sheltered workshops to outreach services that provide support for training on-the-job or self-help companies run by people with mental illness. Sheltered education services for training the educational skills of clients are a part of this sector. For most of these services, regular attendance is mandatory.

For the comprehensive rehabilitation of people with chronic mental illness, a new type of inpatient service was implemented during the late 1980s that integrates psychiatric care with vocational rehabilitation and other specific treatments. Considered to be effective in meeting the complex needs of severely ill patients, these services, labelled "Rehabilitative Services for Mentally Ill" (RPK), have increased only slowly in number. In 2000, only 42 RPK services had been implemented throughout Germany, offering a total of 827 places (Fritze et al. 2005). The slow increase is mainly due to difficulties in funding.

Among the ca. 200,000 places in so-called "Sheltered Workshops for the Disabled" (WfB) in the year 2000, about 12% (23,836 or 2.88 per 10,000 population) were specifically designated for mentally ill persons. In addition, an approximate number of 4,000 sheltered workplaces for the mentally ill were provided by so-called integration companies ("Integrationsfirmen"), which usually are small-scale businesses partly competing in the first labour market (Arbeitsgruppe Psychiatrie 2003). Beneath that level there are a variety of small regional or local services offering opportunities to people with mental disorders to work part-time or earn (usually small) salaries.

Process data

For Germany, hardly any national activity data of the mental health services are available. Health-reporting routines usually do not update mental health service utilisation data on a regular basis, which constitutes a massive obstacle to mental health service planning and evaluation. The only exception is the hospital sector, where a number of indicators are described in more detail is the annual reports of the Federal Statistical Office (see below). A standardised documentation system for psychiatric hospitals and wards ("Basisdokumentation") has been developed for national use but has not been implemented across the country (Cording and Gastpar 1997). The complexity and fragmentation of Germany's system of providing outpatient mental health care is a serious obstacle to the identification of trends, the quality of care, interdependencies, overlapping care systems, or undersupply. In community (or complementary) care, documentation systems with a potential to cover the whole range of services in outpatient mental health care have been developed (Kallert and Becker 2001; Salize et al. 2000; Aktion Psychisch Kranke 2005). However, due to the time documentation entails, the acceptance among staff members is low, and high documentation standards have been achieved only in a few selected regions. Apart from regular hospital data, there are annual updates of reports on the nationwide consumption of pharmaceutical drugs, which may allow changes in psychopharmacological drug use or cost to be assessed (Schwabe and Paffrath 2004). These reports are essential for mental health care since psychiatrists in office practice (and of course their patients) are faced with serious restrictions limiting their prescriptions of atypical antipsychotics. Compared to the US or the UK, the rate of prescription of traditional neuroleptic drugs is still high in Germany, and prescribing practice does not always comply with guidelines (Berger and Fritz 2004).

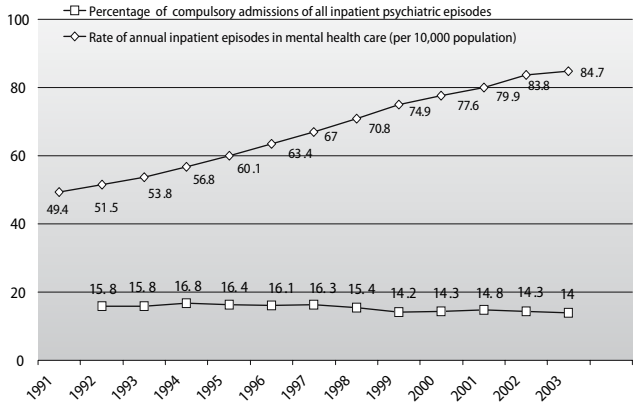

Fig. 2 Rate of annual inpatient episodes in mental health care in Germany (per 10,000 population), percentage of compulsory admissions on all episodes (data source: Federal Statistical Office, own calculations)

Hospital admission rates

Along with the decrease of psychiatric hospital beds, the total number of annual admissions to psychiatric hospital care and the admission rate has continued to rise during the last decade (see Fig. 2). This correlates with a steady reduction in the length of stay (see Fig. 3), which may indicate that the de-institutionalisation process is still in progress (time series in Fig. 3 refer to all inpatient cases with a psychiatric diagnosis, irrespective of whether they were treated in psychiatric wards or elsewhere, e.g. internal-medicine wards).

The contribution of psychiatric hospitals and general hospital psychiatric wards to this overall trend is complex. Although more beds are provided by psychiatric hospitals (see Table 1), the frequency of admission to either type of facility is rather similar due to shorter episodes in general hospital psychiatric wards. The longer mean length of stay in psychiatric hospitals may indicate a (unknown) proportion of long-stay patients who are still being cared for in these facilities.

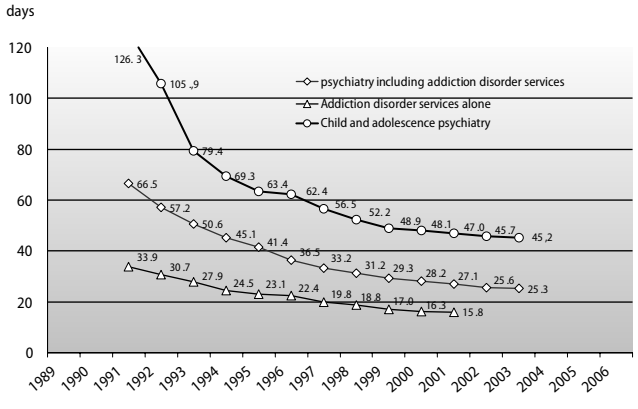

Fig. 3 Average length of stay in inpatient mental health care in Germany (days per year) (data source: Federal Statistical Office, Germany)

Compulsory admission

The proportion of involuntary inpatient treatment episodes is rather stable over time (see Fig. 2). It is currently debated among German experts whether this stable trend suggests a basic level of coercion that is hard to avoid in mental health care, or whether this finding indicates that psychiatry has failed to implement appropriate treatments to reduce compulsory placements or even make them obsolete. However, there is insufficient data on this controversial subject. Despite the stability of involuntary placement proportions at the national level, there are considerable regional differences caused by varying compulsory admission acts on a federal state level or by differing routine practices (Spengler et al. 2005; Dressing and Salize 2004). Compulsory outpatient treatment for people with mental illness is rarely applied in Germany at the moment and does not play any significant role.

Quality-of-care studies

Although mental health services research is not sufficiently funded in Germany, a number of quality-of-care studies have been conducted during the last decades. A limited number of research institutes are active in this field, and studies cover a wide variety of aspects and problems (Holzinger and Angermeyer 2002). The selection of research issues appears to follow mechanisms that are not easily identifiable since a number of pressing issues in mental health care provision are hardly addressed. From a methodological point of view, RCTs or the analyses of the integration of services do not suffice to tackle problems in this field of research (Kallert 2005).

Schizophrenia studies

A majority of studies assess various aspects of care for patients with schizophrenia. Aims, methods, and approaches are so heterogeneous that it is hard to describe an overall trend or to highlight the most significant results here. Studies on the care of patients with schizophrenia are usually restricted to small or selected samples, which is an overall shortcoming of patient-based mental health service research. Results often reflect only regional circumstances and thus should not be generalised to the national level.

Depression studies

With regard to depression, however, some recent population studies did include larger samples. In a 1998 national health survey, a 4-week prevalence of 6.3% or a 12-month prevalence of 11.5% for affective disorders in German adults between 18 and 65 years of age was identified, a finding which is in line with

international data (Wittchen et al. 2000b). Additional studies have shown that GPs or family doctors, who see the majority of patients with depression, do not detect affective disorders properly or may apply inappropriate treatments (Linden et al. 1996; Wittchen et al. 2000a). One study suggests that depression is diagnosed by GPs in only 54% of all affected cases (Wittchen et al. 2000b). User-satisfaction studies are conducted increasingly in the context of quality-of-life research (Hofmann 2004; Holzinger and Angermeyer 2002). However, findings in the field are clouded by varying concepts of the quality of life or treatment satisfaction as perceived by patients and professionals (Meyer and Franz 2005; Angermeyer et al. 2001).

Stigma studies

Most recently, a large number of papers deal with the stigmatisation of mentally ill persons, and this research has been (and is being) stimulated by national and international anti-stigma campaigns (Angermeyer et al. 2004; Angermeyer and Matschinger 2004, 2005; Gaebel et al. 2002; Gaebel and Bauman 2003). However, the degree to which these studies or programmes contribute to the overall improvement of mental health care provision is open (Angermeyer and Holzinger 2005). There is a serious shortage of large, naturalistic follow-up studies or trials analysing the long-term effectiveness or consequences of specific treatments or the most common models of mental health care. This affects all major mental disorders: depression, schizophrenia, anxiety disorder, addiction disorder and dementia. Due to the fragmentation of the care system, a holistic research perspective is essential in order to tackle the complex interdependencies of services and treatments. Only a few quality-of-care studies have so far made use of the needs-for-care concept, which has the potential to cover all services and possible multi-service interaction (Salize et al. 1999; Kallert and Leisse 2001; Kallert et al. 2004).

Conclusion

On the whole, the current state of German mental health care development may be characterised as having more or less successfully accomplished the shift from hospital-based to community mental health care since the start of the psychiatric reform in the 1970s. The momentum of the reform has been strong enough to assimilate the completely different mental health care system of the former German Democratic Republic and, in the course of a decade, to re-structure mental health services for an additional 17–18 million new inhabitants. In an ongoing struggle to adapt to changing administrative set-ups, legal frameworks and financial constraints, psychiatry in Germany is currently facing specific problems and is seriously challenged to defend the considerable achievements of the past. A major obstacle to achieving this aim lies in the fragmented system of mental health care provision and mental health care funding. This serious split in responsibilities has been labelled the "German disease" due to its potential to hamper mental health care planning and cause an under- or over-supply. It also favours unhealthy competition among service providers that are supposed to collaborate in the care of specific patient groups. Fragmented care provision and limited funding levels in the field of health service research reduce the potential for rapid and creative change and innovation in the mental health care system. This is a strategic weakness of German mental health care which is in need of adapting to:

- a current shift towards DRG-based funding arrangements for all non-psychiatric hospital treatment that is likely to have serious repercussions for psychiatric inpatient facilities that for the time being are exempted from DRG-financing,
- an expanding sector of psychosomatic-rehabilitative medicine, which is competing for less severely mentally disordered patients and limited mental health budgets, and holds some potential to threaten well-established care concepts for people with chronic mental illness,
- a strengthening role of the GPs as gatekeepers to specialised mental health care, which must be compensated by improving their skills at appropriately identifying, treating and referring mentally ill patients to specialised care,
- continuous cuts in budgets for office-based psychiatrists who are not adequately reimbursed for specific treatments and hampered in their attempts to offer adequate treatment,
- a trend to privatise federal or state psychiatric hospitals, with unknown consequences for the structure and quality of inpatient mental health care,
- continuous cost-containment interventions in mental health care budgets or changes in the general set-up of mental health care provision by federal states or national authorities (with unforeseen or even paradoxical effects),
- the necessity to develop effective strategies for mental health promotion and mental ill health prevention as currently favoured and promoted by the European Commission.

These are only some of the challenges German mental health care will face in the immediate future. In the long run (and looked at from a more conceptual perspective), reform activities should aim to reduce fragmentation within the system. Bridging the significant gap between inpatient and outpatient care for people with mental illness appears to be one of the most pressing problems.

During the past, German mental health care has proven its ability to deal with unexpected developments and to adapt to new situations. Joined forces are required to uphold this standard in the future and to guarantee a continued high level of care for the mentally ill.

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