JA ImpleMENTAL

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Country Profile Germany

Community-based Mental Healthcare Networks: Key Facts and National Priorities

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health (MH) structures, services, capacity and outcomes in participating countries in two specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices – the MH reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in participating EU-countries. JA ImpleMENTAL comprises six Work Packages (WPs) in total, including four horizontal WPs and one dedicated to each best practice. WP5 on community-based mental health (CBMH) care, aims to implement elements from the Belgian MH Reform, which is based on the principle of deinstitutionalisation, i.e., the transition from care primarily provided in institutions to community-based care in order to improve MH outcomes and quality of life and avoid unnecessary hospitalisations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorisation, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

The present country profile is one of the major deliverables of the JA, presenting key facts about the national and local MH system. It summarises results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities while also outlining next steps necessary to scale-up and promote national/regional CBMH care services. The country profile forms a basis for strategy formulation, decision-making and commitment. This country profile is based on a situation analysis conducted in two parts and a subsequent needs-assessment (SANA) as well as on additional literature/sources. For the situation analysis, two questionnaires have been developed by WP5: one for the analysis of the situation regarding the overall health system and CBMH care at national level, and another one for the analysis at the implementational level. Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of CBMH care.

1 Situation Analysis (SA)

1.1 Country, Health and Social System at national level

The Federal Republic of Germany is a federal parliamentary republic with 16 federal states (*Bundesländer*), which each have their own constitution and are in many aspects autonomous regarding their internal organisation. It is located in central Europe with Berlin as capital.

Table 1 - Population structure in Germany in 2021, expressed as number of persons, by age and sex

Age group	Male	Female	Total
<18	7,063,395	6,680,549	13,743,944
18 - 64	25,940,597	25,198,854	51,139,451
65+	8,022,527	10,249,109	18,271,636
Total	**41,026,519**	**42,128,512**	**83,155,031**

Table 2 - Life expectancy, risk of poverty, income inequality and total healthcare expenditure in Germany

	Germany	EU	Year	Source
Life expectancy at birth	83.4 y / women 78.6 y / men	80 y	2020-2022	(2) (3)
Risk of poverty or social exclusion	20.9 %	21.6 %	2022	(4)
Income inequality, expressed as the Gini coefficient	28.8 %	29.6 %	2022	(5)
Total healthcare expenditure relative to the GDP	12.82 %	10.87 %	2020	(6)

The proportion of numbers of Years lives with disabilities (YLD) due to mental and substance abuse disorders to number of YLD due to all causes is 14.1% (7).

Germany has a statutory social health insurance (SHI) scheme and a private health insurance scheme (PHI). Health insurance is compulsory, but people with an income above a fixed threshold or belonging to a particular professional group (e.g. self-employed people or civil servants) can opt out of SHI coverage and enrol in (substitutive) PHI. About 89% of the population are covered by the SHI scheme; about 11% are privately health insured. Health insurances are public insurers as well as private companies. The multi-payer SHI scheme consists of 103 sickness funds and the PHI scheme of 41 private insurance companies, and the three biggest sickness funds cover more than one third of the German population (8).

SHI covers a comprehensive basket of benefits that go beyond essential services, and benefits are the same for all insured persons. Persons covered by substitutive PHI usually enjoy benefits that are equal to or better than those covered by SHI (depending on their chosen insurance package). The health insurance covers basic costs of illness for diagnosis, treatment, medication and rehabilitation as well as sick leave and under specific conditions costs of travel to health facilities (8).

Germany has a complex and decentralised health system, with governance divided between the federal and state levels, and self-governing corporatist bodies (sickness funds and associations of providers). This means that the legislative is divided between the federal (national) and the state (regional) level. The federal government defines only the legal framework and is responsible for supervision of main self-governing corporatist bodies. The states supervise the self-governing bodies at the regional level and are responsible for hospital planning and investments, as well as medical education. They are also responsible for provision of public health services (8).

Public health, ambulatory care, hospital care and long-term care are regulated by different legislation, and as a consequence, are separate and organised differently in terms of planning, financing, and governance. Moreover, the health system follows the principal of self-government, which also means that sickness insurance funds and providers of health care, respectively their organisations on the national level, are important partners in decision making concerning health care (8). Regulatory details related to health care coverage and standards of care are specified in directives issued by the Federal Joint Committee (G-BA), the highest self-governing decision-making body in the country in which these corporatist bodies are represented.

All in all, the described structures result in a strong fragmentation of the health system in Germany. which presents challenges for (mental) health care in terms of coordination and continuity of care, quality of services for patients and efficiency in allocating resources.

1.2 Mental Health System at national level

Germany does not have a national MH plan, however according to the division of competence described above, varying strategies, plans, and/or laws related to MH exist at the level of the federal states, leading to a high diversity of MH care offers across the country. All of them promote the key principles of community-based care (deinstitutionalisation, recovery orientation, participation of users and/or families in decision-making and promotion of respect for the human rights of people with MH conditions and psychosocial disabilities and at-risk). The coalition agreement of the current federal government foresees a number of measures in the area of MH including the development of suicide prevention measures as part of a national prevention plan, a nationwide destigmatisation campaign of mental illnesses, support to children/adolescents in families with parents affected by mental illnesses or addictions as well as improvements towards better coordinated and person-centered outpatient care for people with complex needs or serious illnesses. There is no stand-alone policy, strategy or plan for child and/or adolescent MH in Germany, but improvements in MH care of children/adolescents is a focus topic of the initiative of the Federal Ministry of Health on „Promotion of children's health“ which supports projects in this area[1]. The recommendations formulated in the 2019 report of the interministerial expert working group on „Children of parents with mental illnesses and addictions“ mandated by the German Parliament have also prompted a number of initiatives and projects to improve the situation of this target group at various levels.

The current laws of the German states (*PsychKG)* promote the transition towards MH services based in the community, include provisions to promote the right of persons with MH conditions and psychosocial disabilities to exercise their legal capacity, to supported decision-making and to advance directives. They also contain provisions to prevent coercive practices and promote alternatives, incl. voluntary admission, informed consent to treatment and strategies to avoid and end seclusion and restraints. Finally, the laws foresee procedures to enable people with MH conditions and psychosocial disabilities to protect their rights and file appeals and complaints to an (independent) legal body.

Mental health care covered by health insurance (under Social Code Book - SGB - V) comprises medical and rehabilitative ambulatory, inpatient and day care as well as day-structuring and complementary assistance (like ambulatory nursing care). This includes coverage of basic costs of illness for diagnosis, treatment (incl. psychotherapy), medication and rehabilitation as well as sick leave and under specific conditions costs of travel to health facilities (8). There are no specific conditions/diagnoses or treatments/interventions/services that are excluded from this coverage, but many people with mental illness do not receive adequate treatment. For example, of people with severe depression only 26% receive guideline-based treatment and only about 10 % receive guideline-based psychotherapy (13).

Waiting times for outpatient psychotherapy are not recorded objectively and systematically, however, surveys of psychotherapists and patients indicate waiting times of between 3 and 20 weeks for an available treatment place (14)(15). In 2021, appointment services (created in 2016) were able to provide 74% of requests for outpatient psychotherapy on time, i.e. within four weeks for a psychotherapeutic consultation and within two weeks for a psychotherapeutic treatment (16).

Care covered by the health insurance is complemented by rehabilitative care and specific support services for social participation and inclusion (laid down in SGB IX) for persons with a diagnosis of mental illness being at risk of or with an intellectual disability.

[1] See the relevant webpage of Federal Ministry of Health: https://www.bundesgesundheitsministerium.de/themen/praevention/kindergesundheit/kindergesundheit.html

In addition to this standard system of care, the different federal states, in particular the municipalities with their "social-psychiatric services"[2] provide low-threshold preventive, counselling and support services for people with a MH issue who cannot find access to the standard care system on their own. They also provide psychiatric crisis interventions (9) and are responsible for care of persons who have fallen out of the standard care system due to a criminal offence (9). The social-psychiatric services are usually responsible for coordinating collaboration between local stakeholders, whereby their focus lies on collaboration between support services for social inclusion and the inpatient health sector (9).

Already since the 1970s various mechanisms promoting the development of CBMH care in Germany have been introduced in different steps and anchored in legislation with the aim of testing and establishing better coordinated, integrated and person-oriented care, including outpatient and mobile forms of care. These mechanisms are:

- Model projects (according to §64b SGB V) that enable flexible forms of ambulatory (mobile), day and inpatient care (10);
- Contractual agreements about "Special forms of care" (*Besondere Versorgungsformen*) according to §140a SGB V that allow health insurers to conclude contracts with care providers about interdisciplinary and cross-sectoral care approaches;
- So-called "ward-equivalent psychiatric treatment" (*StäB*) according to §115d SGB V that allow hospitals to provide mobile care by multidisciplinary teams in the social and living environments of the patients;
- Projects funded within the framework of the national Innovation Fund (§§92 a & 92b SGB V) (11) that enable to test innovative, cross-sectoral and patient-oriented new forms of care.

All in all, these mechanisms allow for the set-up of very diverse forms of community-based, cross-sectoral and person-oriented mental heath care but their application remains voluntary which contributes to a fragmentary and heteregeneous implementation of CBMH throughout the country. Further, existing initiatives that are financed from health insurance funds do not systematically integrate collaboration with others than the health care sector.

Improvements towards better integrated and person-centred care was achieved recently with the launch of a new programme for outpatient care for people with complex needs covered by the health insurance in October 2022. It is intended to help severely mentally ill people with a complex need for psychiatric or psychotherapeutic treatment to live as stably and independently as possible. The concerned persons are closely monitored by interdisciplinary teams of health care specialists (12) in the frame of an individual comprehensive care plan and with support by a care referent responsible for care coordination. Cooperation with other sectors and professionals outside the health care sector however only remains an option within this program (9).

According to Eurostat data, Germany had the highest level of current health care expenditure among the EU Member States (2020) as expenditure was equivalent to 12.8% of the gross domestic product (GDP)[3]. The direct cost of mental illness to the health care system is approximately 44.4 billion euros per year (17). In 2015 (latest available year), 13.1% of total health expenditure was spent on mental health care (17a).

[2] In most German states the "social-psychiatric services" are part of the municipal administration responsible for public health. In the states of Bavaria and Baden-Württemberg they are primarily run by non-statutory welfare organisations. See: https://www.psychiatrie.de/kommunale-psychiatrie/sozialpsychiatrische-dienste.html

[3] See https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics

The main forms of government social support available for persons with severe MH conditions are income support, housing support, employment support, education support, social care support and legal support.

Available MH facilities and services

In Germany, primary health care doctors do not have a classical gatekeeping function, eventhough they are usually the first point of contact in the health system and their coordinating role was reinforced through GP-centred models of care proposed by health insurance funds, based on voluntary enrollment of users.

Outpatient care for adults and children/adolescents is usually provided by practice-based psychiatrists, neurologists and psychotherapists, whereby ambulatory psychiatric and psychotherapeutic care is also offered by ambulatory clinics of hospitals (*Psychiatrische Institutsambulanzen – PIA)* for patients who require hospital-based services due to the nature, severity or duration of their illness.

Capacities (facilities and beds) for inpatient MH care in specialised mental hospitals and psychiatric wards of general hospitals have been rising since 2000 after several decades of deinstitutionalisation (8). Compared to other European countries, Germany is one of the countries with the highest number of psychiatric beds (8a). At the same time capacities in community-based institutions (in particular supervised residential arrangements), ambulatory crisis intervention centres and centres for psychosocial counselling and social support also increased (8).

The following tables (Table 3-9) provide an overview of inpatient structures, MH community residential facilities and outpatient services in Germany, each subdivided into adults and children & adolescents:

Table 3 - Inpatient structures for Adult MH (>18 years) / Rates per 100.000 of adult population

		Year	Number	Rate	Source	Comments
Mental hospitals	Mental hospitals (facilities)	2020	282*	0.41	(18)	
	Beds in mental hospitals	2020	45,965	66.2		
	Annual admissions in mental hospitals	2021	665,372	958.6	(19)	PEPP-statistics: 665,372 admissions in general psychiatry and 72,818 in psychosomatic medicine; including uncategorized admissions in PEPP-statistics admissions sum up to: 803,979 (adult population)
General hospitals	Psychiatric wards/units in general hospitals (facilities)	2020	398	0.6	(18)	+ 278 wards for psychotherapy and psychosomatic medicine
	Beds in psychiatric wards/units of general hospitals	2020	56,557	81.5		+ 12.773 beds in psychotherapy/psychosomatic medicine
	Annual admissions to psychiatric wards/units of general hospitals	2020	691,118	995.7		+ 77481 admissions in psychotherapeutic/psychosomatic medicine

**Hospitals with only psychiatric, psychotherapeutic and neurological and/or geriatric beds. Unfortunately, there is no data about how many of these hospitals have exclusively neurological and/or geriatric beds (these would not be relevant for SANA). In GMK-Psychiatriebericht from 2017 the number of 216 was named.*

Table 4 - Inpatient structures for Children and Adolescent MH (under 18 years) / Rates per 100.000 of minor population

	Year	Number	Rate	Source
Mental health inpatient facilities (mental hospitals and/or psychiatric wards/units in general hospitals)	2020	143	1.0	(18)
Beds in mental health inpatient facilities (mental hospitals and/or psychiatric units in general hospitals)	2020	6,699	48.7	(18)
Total annual admissions to mental health inpatient facilities specifically for children and adolescents (mental hospitals and/or psychiatric units in general hospitals)	2021	60,044	436.9	(19)

Table 5 - Mental health community residential facilities for Adults / Rates per 100.000 of adult population (18 years and over)

	Year	Number	Rate	Source
Mental health community residential facilities	-	-	-	-
Beds in mental health community residential facilities	2015	90,442	130.3	(20)
Annual admissions to mental health community residential facilities	-	-	-	-

Table 6 - Mental Health community residential facilities specifically for children and adolescents / Rates per 100.000 of minor population (under 18 years)

	Year	Number	Rate	Source
Mental health community residential facilities	-	-	-	-
Beds in mental health community residential facilities	2015	12,325	89.7	(20)
Annual admissions to mental health community residential facilities	-	-	-	-

Table 7 - Outpatient services for adults (18)

	Hospital-based		Community-based		Other	
	Total number	*Ratio per 100.000 population*	*Total number*	*Ratio per 100.000 population*	*Total number*	*Ratio per 100.000 population*
Facilities/services	410	0.59	0	0.00	1,259	1.81
Visits in the last year by male	0	0.00	0	0.00	0	0.00
Visits in the last year by female	0	0.00	0	0.00	0	0.00
Total visits in the last year	2,613,378	0.00	0	0.00	0	0.00

Table 8 - Outpatient services for children and adolescents (21)

	Hospital-based		Community-based		School-based		Others	
	Total number	*Ratio per 100.000 population*	*Total number*	*Ratio per 100.000 population*	*Total number*	*Ratio per 100.000 population*	*Total number*	*Ratio per 100.000 population*
Facilities/services	181	1.32	153	1.11	0	0.00	0	0.00
Visits in the last year	192,194	1,398.39	345,000	2,510.20	0	0.00	0	0.00

Table 9 - Mental health workforce (20) (22)

	In MH service (all)		In child & adolescent MH services (totals of government and non-government services)	
	Total number	**Rate**	**Total number**	**Rate**
Psychiatrists	11,874	14.3	---	---
Child psychiatrists	---	---	2,688	19.6
Mental health nurses	1,000	1.2	0	0.0
Psychologists	46,000	55.3	0	0.0
Social workers	56,000	67.3	0	0.0
Speech therapists	5,000	6.0	0	0.0
Occupational therapists	64,000	77.0	0	0.0
Others	3,000	3.6	0	0.0
Total	**186,874**	**224.7**	**0**	**0.0**

Germany has a high number of health workers, but distribution of health workers across the German states and between urban and rural areas varies considerably, especially for GPs and psychotherapists (8). The number of psychotherapists in outpatient care increased in past years but the aforesaid imbalances and rising needs generate shortages in the offer of psychotherapeutic care. The number of GPs is also decreasing despite rising demand. Germany is confronted with a growing shortage of health care specialists/professionals which affects all areas of MH care (9).

Involuntary admissions to mental hospitals in Germany

A nationwide register for coercive measures, compulsory treatment and involuntary detention does not exist in Germany eventhough it has been demanded by stakeholders for a long time. A major obstacle to the set-up of such a register is the complexity of the German legislation which separates the responsibility between the German states and the Federal State (23). A distinction is made between three types of placement each regulated by different laws: public-law placements according to the Mental Health or Placement Acts of the states (*PsychKG*), civil law placements according to the federal Guardianship Law and criminal law placements under the Criminal Code (*StGB*).

Reporting registers and compulsory documentation of forced placements are legally anchored in the aforementioned respective laws of 10 out of 16 federal states[4], however, regular psychiatric reports are only available from a few of these states[5]. Some other federal states do not have any psychiatric reporting or do not seem to have implemented it yet, as the legal changes mostly came into force around the year 2020. Extensive data is available from only one state register for coercive measures that has been existing since 2015. There is also state-wide data collection in other German states, but these state registers usually do not cover measures under (federal) guardianship law. Further, data registers differ from each other as regards recording modalities and selected indicators (23).

Table 10 - Involuntary admissions

	Total number	Year	Source
Number of admissions to mental health hospitals and psychiatric wards in general hospitals, covers adults as well as children and adolescents	665,372	2020	(19)
Number of involuntary admissions	240,560	2015	(20)
Public law placements (according to state laws Psych-KG)	83418	2015	(24)
Civil law placements (according to federal Guardianship law)	56.048	2016	(25)
Criminal law placements (StGB)	12.343	2019	(26)

Mental Health Information System (MHIS)

Germany has no stand-alone Mental Health Information System (MHIS) at national level but data collection on MH is included in a general health information system. Although there are partly large amounts of data available, the sources of data are multiple, including the nationwide health monitoring studies/surveys of the RKI as well as relevant secondary data such as administrative routine data (on mental illnesses, financing, workforce capacity, utilization, service availability) from health care insurers and providers. These are complemented by data stemming from specific studies conducted at federal state level or by various health care providers and research institutions. The diversity of the data content in terms of definitions, periodicity of collection, (lacking) interlinkages, collection purposes as well study/survey designs and modes results in an heterogeneous and fragmented situation of data collection, analysis and reporting, which means that there is a lack of systematically selected and continuously available data for MH in Germany (27).

There is no specific MHIS about children and adolescents at national level in Germany, i.e. separated from MHIS about adults, and as for adult MH, data on MH of children/adolescents is integrated into the general health information system. Mental health of children and adolescents is part of the health monitoring (KiGGS surveys) of the RKI (28). Routine data of the healthcare system differentiate data for children and adolescents.

A special issue of the Journal of Health Monitoring in 2021, an online publication series of the Federal Health Monitoring (*GBE*) at the Robert Koch-Institute (RKI), which provides scientific data and analyses on health topics, was dedicated to MH in Germany (JHM Mental Health) (29). A MH surveillance system has been set up by the RKI since 2019 (30). In the frame of a consensus-building process involving

[4] Namely the states of Baden-Württemberg, Bavaria, Bremen, Hamburg, Hessen, Lower Saxony, North Rhine-Westphalia, Saarland, Saxony-Anhalt, Schleswig-Holstein.
[5] Bavaria, Hamburg, Hessen, Lower Saxony, North Rhine-Westphalia.

relevant stakeholders at national level, a set of 60 indicators for adult MH across four thematic fields[6] was worked out that would need to be operationalised for data collection.[7]

1.3 Population profile in pilot area

Delmenhorst is a city located in Lower Saxony, in North-Western Germany. It is one of eight independent cities and one of the ten largest cities in the state of Lower Saxony.

Table 11 - Population structure of Delmenhorst in 2021 expressed as number of persons, by age and sex (31)

Age group	Male	Female	Total
<18	7,891	6,259	14,150
>18	33,199	34,255	67,454
Total	**40,514**	**41,090**	**81,604**

The socio-economic profile of the population in Delmenhorst is below average, since in Delmenhorst there is a higher rate of unemployment, poverty and social exclusion.

The German Index of Socioeconomic Deprivation (GISD) of the RKI measures the extent of socio-economic deprivation using information on the education, employment and income situation in districts and municipalities from the INKAR (Indicators and maps on spatial and urban development) database (32). In a nationwide comparison, the city of Delmenhorst has a population that is considered socially disadvantaged when taking into account the indicators of education, occupation and income, and is therefore in the fifth quintile of the GISD.

Table 12 - Unemployment, life expectancy, risk of poverty, low income population & proportion of children living on social support

	Delmenhorst	Year	Germany	Year	Source
Unemployment rate	9.6%	2022	5.3 % (LS*: 5.3 %)	2022	(33) (34)
Life expectancy	82.9 y /women, 78.1 y / men (LS)*	2020-2022	83.4 y / women, 78.6 y / men	2020-2022	(35) (3)
Share of people at risk of poverty	17.2 %**	2022	16.7 % (LS*: 17.9 %)	2022	(36)
Share of low income population	46.1 %	2021	42.9 %	2021	(37)
Proportion of children living on social support (SGBII/Hartz IV)	29.7 % (children/youth under 18)	2019	13.8 % (LS*: 14.3 %)	2019	(38)

*LS = State of Lower Saxony / **The rate is for the statistical region of Oldenburg which comprises the district town of Delmenhorst and four other district areas/towns. Thus, it does not reflect the situation in the district town of Delmenhorst alone.

The unemployment rate in Delmenhorst (9.6% in 2022) is one of the two highest rates state-wide and it lies far above the rate for the state of Lower Saxony and Germany (both 5.3%).

[6] 1) Social determinants of MH, 2) MH status, 3) MH service availability, utilisation and costs, 4) Burden of disease and participation. Development of indicators for a fifth field of action on prevention and health promotion is under construction.

[7] However, at the date of finalisation of this Country Profile, this process seems to have stopped, it can thus be assumed that no MHIS will be available in the foreseeable future.

The Gini Coefficient of Lower Saxony is equal to the German-wide average. There are no valid statistics for the Gini coefficient regarding Delmenhorst itself. Above all, the proportion of the population with low income (46.1% in 2021) is particularly high, above the German average of 42.9%. According to the Federal Employment Agency (as of July 2019), the proportion of children living on social benefits (SGBII "*Hartz IV*") in Delmenhorst is 29.7% of children and young people under the age of 18, compared to only 14.3% in Lower Saxony and 13.8% in Germany.

1.4 Community-based mental health care in Delmenhorst

Key developments and policies

Based on the findings from the 2016 report on the status of psychatric care in the federal state of Lower Saxony, the state authorities adopted a 10-years strategic plan for the planning and development of mental care, which therefore also applies to the city of Delmenhorst. The plan recommends the establishment of „community psychiatric centres" (*Gemeindepsychiatrische Zentren - GPZ*) as a support structure for people with complex MH care needs that offers ambulatory and mobile care provided by multiprofessional teams in the patient's living environment. Following the piloting of model projects in selected municipalities of Lower Saxony, standards for the set-up of community psychatric centres by municipalities were issued in 2022. A municipal social-psychiatric plan for the area of Delmenhorst which contains an inventory of all available support structures and offers as well as an analysis of existing needs is available for the year 2014, but has only been updated unsystematically since then.

An overview of existing MH strategies/plans, reports and available structures and services in the state of Lower Saxony and the city of Delmenhorst (incl. those targeting children/adolescents with parents affected by mental illnesses and/or addictions) is provided in the tables below.

Overview of activities in Lower Saxony and in Delmenhorst

Table 13 - Care for mentally ill people

Stakeholder/ *Title*	**Background/ Goals**
Ministry for Social Affairs, Labour, Health and Equality in Lower Saxony ***State Psychiatry Plan of Lower Saxony (2016-2026) and Report on the State Psychiatry Plan of Lower Saxony (2016)***	• Definition of development fields in care that are priorities for the care of mentally ill people • Implementation of integrative, cross-sectoral and recovery-oriented care • Duration: 10 years
<u>Principles for state psychiatric planning and development of strategies for care design:</u> The psychiatric care system is an integral part of the infrastructure. Assistance, interventions, measures and the promotion of self-reliance are provided according to need, close to the place of residence, functionally graded and (further) developed cooperatively. • Interdisciplinary approach and working methods • Target group-related, low-threshold access to the support system • Resource-oriented, culture-, gender-, age-, diversity- and life situation-sensitive interventions • Respect for human rights (crisis intervention, coercive measures, suicide prevention) • Self-determination, human dignity, participation, self-help and equal cooperation • Dialogue between those involved in the social space, in networks and acceptance of mental illness among citizens, participation and voluntary work as well as self-help commitment among those affected and their relatives.	

- Rights of patients: Respect fundamental rights according to the UN Convention on the Rights of Persons with Disabilities, the UN Convention on the Rights of the Child and the Charter of Fundamental Rights of the EU (Art. 35); principle of equality of mentally ill people with somatically ill people.
- Person-centred, integrative and participative care
- Functional orientation (gradation) of access to support: coordinated, functional approach tailored to the individual case
- Ensuring quality assurance, human resources and professionalism
- Multidimensional approaches to action at different levels -> planning and control at individual and community level
- Care for refugees

Priority development fields and steps

1. Promote the participation of mentally ill people and their relatives as well as self-help (trial commission for the development of standards for outpatient and inpatient care; independent complaints offices; promotion of opportunities for self-representation; compensation for work in committees).
2. Integrative planning and optimised interdepartmental control
3. Community psychiatric centres with multiprofessional, outreach teams with crisis support (pilot project to test different models and concepts)
4. Reducing coercive measures (register, monitoring, testing innovative approaches)
5. Care for children and adolescents (improve cooperation between child and youth psychiatry and youth welfare, promote training, close gaps in care)
6. Strengthening early detection - early intervention (reducing waiting times, qualifying family doctors/ paediatricians, measures in occupational health management)
7. Care for the elderly
8. Treatment of patients in a correctional facility

Source: Ministry for Social Affairs, Labour, Health and Equal Opportunities Lower Saxony (2016) (39)

Stakeholder/ Title	Background/ Goals
Ministry for Social Affairs, Health and Equality in Lower Saxony, State Office for Psychiatry Reporting Lower Saxony (2021) ***Report on the care of people with mental illness in Lower Saxony 2020***	• Transparency about structures and utilisation of care • Data from 36 of the 44 municipal social-psychiatric services in Lower Saxony (services, tasks, staffing, utilisation) • Data from the 27 clinics and departments of adult psychiatry and psychotherapy authorised under the Lower Saxony Act on Assistance and Protective Measures for the Mentally Ill (*NPsychKG*) (number of discharged treatment cases after compulsory placement, number of security measures carried out).

Source: Ministry for Social Affairs, Labour, Health and Equal Opportunities Lower Saxony (2021) (40)

Stakeholder/ Title	Background/ Goals
Ministry for Social Affairs, Health and Equality in Lower Saxony (n.d.) ***A standard for community psychiatric centres - definition, checklist and***	Following the state psychiatry plan, community psychiatric centres were established as models in three regions (district of Cuxhaven, Heidekreis, city of Braunschweig). The Institute for Social Psychiatry of the State of Mecklenburg-Western Pomerania was commissioned by the State of Lower Saxony to develop standards for municipalities to set up community psychiatric centres. Target group: people with severe mental illness (SMI)[8].

[8] Persons "with any psychiatric diagnosis who have had symptoms of the illness or are undergoing treatment for a longer period of time, i.e. for at least two years, which are associated with significant effects on the activities of daily living and the level of social functioning and are often associated with intensive use of the treatment and psychosocial support system" (DGPPN, p.7) (50). The focus is therefore not on

model fidelity scale (MTS-GPZ)	Model fidelity scale assesses the extent to which implementation in practice meets the standards of the evidence-based model; gradual mapping of indicators. Goal: Guidelines for action for municipalities

- Evidence base on Home Treatment (HT), ACT, Flexible Assertive Community Treatment (FACT) (NL)
- Definition: Community Psychiatric Centres in Lower Saxony combine the resources of regionally existing providers and functions to ensure outpatient, team-based, multi-professional and mobile outreach psychiatric care. The target group is adults with severe mental illness ("Severe Mental Illness"/SMI according to the S3 guideline "Psychosocial Therapies for Severe Mental Illness") and high and complex support needs who are temporarily or permanently unable to obtain and coordinate the necessary services themselves.
- Participants: service providers (specialist medical and psychotherapeutic practices or medical care centres psychiatric hospitals with outpatient clinics, social-psychiatric services, socio- and occupational therapists, providers of home psychiatric care, of integration assistance, of psychiatric rehabilitation, day-structuring services, of work and employment opportunities, counselling centres, crisis services and self-help organisations) as well as qualified experts by lived experience.
- Multi-professional teams
- Fixed catchment area of 80,000-150,000 inhabitants.
- Focus:
  - Core tasks / basic functions: Counselling/information, assessment/diagnosis, case management, recovery, rehabilitation and participation planning, multi-professional and mobile treatment, crisis intervention, psychotherapy.
  - Organisation: multi-professional teams (psychiatrist, nurse, social worker, psychologist, expert by experience); defined framework conditions; staffing ratios; support key; advisory council
  - Admissions/discharges: defined rules; duration between referral and initial contact; duration between initial contact and assessment; duration until home visit; duration until integrated treatment plan; client participation; aftercare measures
  - Dealing with crises: individual crisis plans; outpatient crisis preparedness; use of digital media to monitor clients in acute crises
  - Cooperation with clinics: Participation in admissions; maintaining contact during inpatient stays; contact with clinic staff; cooperation agreements with clinics.
  - Qualification: Teams have evidence-based, disorder-specific psychotherapeutic procedures; teams are qualified for basic interventions (e.g. motivational interviewing, de-escalation, recovery); staff with specific competence and experience in e.g. addiction therapy, vocational rehabilitation etc.; regular case supervision; staff-related qualification planning.
  - Cooperation / coordination: cooperation agreements with providers from other sectors (e.g. disability support, homeless support); inclusion of reference persons at these providers in case conferences; cooperation with and support of the client's personal support system; use at the system level for the further development of care for SMI.
  - Documentation: Documentation of informing clients about their rights; IT-supported information and documentation system.

Source: Ministry for Social Affairs, Labour, Health and Equal Opportunities Lower Saxony (n.d.) (41)

diagnoses, but on the duration of the disease, the associated functional impairments and the intensity of the use of the care system. Concerns approx. 1-2% of the adult population.

Stakeholder/ Title	Background/ Goals
Social psychiatric association of the city of Delmenhorst	• Based on the requirements of the Lower Saxony Act on Assistance and Protective Measures for the Mentally Ill (*NPsychKG*) • Inventory of all help offers and analysis of still existing needs • Coordinated system of help close to home to improve the living situation of mentally ill people; development of new offers • Destigmatisation through public relations work and education
• Overview of available support in general psychiatry, addiction, gerontological psychiatry, child and adolescent psychiatry, other services. • Population-related data on Delmenhorst (districts and social areas) (population structure, countries of origin of foreign residents) • Overview of regional offers for psychiatric care • Overview of support offered by regional facilities • Excerpt from the coalition agreement for the 17th legislative period of the Lower Saxony state parliament • Addresses / signposts to psychiatric and psychosocial support • Reflections on future challenges / needs	
Source: Stadt Delmenhorst (2023) (42)	

Table 14 - Children of mentally ill and addicted parents

Stakeholder	Background/ Goals
State Office for the Coordination of Psychiatry in Lower Saxony (LSPK)	Project database since 2023 → make innovative and conceptually sound projects transparent, promote transfer to other municipalities; Project goals: Prevention, alleviation of symptoms, strengthening of personal resources in dealing with mental illness, education/ sensitisation/ destigmatisation.
Projects for children of mentally ill parents: • **Sponsorships** for children of mentally ill parents (Hildesheim, ongoing since 2008); sponsor families for primary school children, cooperation with social-psychiatric service	
• **Network HiKip** - Hildesheim, since April 2019 - Municipal and cross-jurisdictional network - Goals: Improve structures, offer services for children, enable low-threshold access. Source: Landkreis Hildesheim (2023) (43)	
• **„Schatzsuche“ (“Treasure Hunt”) – Promoting children's mental well-being in the day care centre** - Parent-child programme, funded by “Techniker Health Insurance” since 2017; in 11 federal states - Goals: Sensitisation of parents and professionals to children's needs, their strengths and protective factors (resilience). Source: Hamburgische Arbeitsgemeinschaft für Gesundheitsförderung (2022) (44)	
• **„Kleine Angehörige“ ("Little relatives")** - City of Wolfsburg, Health Division; ongoing - Civic engagement; sponsorships for children from families with a mentally ill parent - Goals: trusting and reliable care outside the family Source: Stadt Wolfsburg (2021) (45)	
• **Kidstime-Workshop** - 17 locations across Lower Saxony, ongoing - Goals: resilience-promoting improvement of communication about mental illness in families and between affected families; focus on the needs of children/adolescents; increased resilience for families, especially children (multifamily approach); destigmatisation. Source: Kidstime- Netzwerk (2022) (46), Landesstelle Psychiatriekoordination Niedersachsen (2023) (47)	

Stakeholder/ *Title*	Background/ Goals
Delmenhorst: **Project group "Children of mentally ill parents" of the social-psychiatric association (SpVb)**	**DelKip** (Delmenhorst children of mentally ill parents) • Information for children and young people on mental illness • Counselling for mentally-ill parents and relatives on how to talk to their child/children about the mental illness • Destigmatisation of families with mentally ill persons • Cooperation with persons and institutions that advocate for the interests of affected children **Delmenhorst sponsorship model for children of mentally ill parents** • Goals: reliable relationships outside the family; emotional, social and practical support; relationship between parents and godparents; promoting children's MH • Volunteer sponsors • Offers for sponsors: Support for the sponsorship relationship, qualified contact persons, networking, specialist information on the subject, flat-rate allowance for expenses.
Source: Stadt Delmenhorst (2014) (48)	

Stakeholder environment

In Delmenhorst, following stakeholders are involved in the provision of MH services to the population: one general hospital, about 100 GPs and specialists, six paediatricians (in 3 practices), the local public health authorities (five physicians, no psychiatrist), youth welfare office and many different services for families and children and psychosocial services. There is ongoing collaboration between the social-psychiatric services and other non-health authorities, services (incl. NGOs/CSOs) and stakeholders that are relevant for children and adolescents care and are organised in the social-psychiatric plan.

Inpatient structures and outpatient services for AMH and/or CAMH

There is only one psychiatric hospital for adults in the pilot area which offers seven beds (2022), i.e. 0.1 bed per 10,000 adult population. The number of admissions in 2022 amounted to 587 which corresponds to a rate of 87 admissions per 10,000 of adult population. There is no general hospital with a psychatric ward for adults in the pilot area.

Several residential facilities for adults that are rarely related to the target group of the pilot project exist. There are six different residential facilities for children and adolescents. Five of them (from the faith-based association „Wichernstift“) are targeted to different sub-groups of children/adolescents from age 8 to 18 and one is for males only. The other facility is managed by the Wichernstift as well.

One hospital-based outpatient facility for adults is available at the regional registered hospital (*Karl-Jaspers-Klinik*) that drives an outpatient service with 16 treatment places for acute cases as day hospital. The hospital also provides an ambulatory clinic for those patients who require hospital-based services due to the nature, severity or duration of their illness. In addition there are several therapists for adults organised in private practices in the city of Delmenhorst and its neighbourhood.

There is one hospital-based MH outpatient service specifically for children and adolescents in Delmenhorst located at the highly frequented day clinic of the regional hospital of the Wichernstift. Two community-based counselling facilities provide psychological consultations in the case of sexual abuse (non-therapeutic). In terms of school-based counseling, there are two psychologists available for a region with a population of 200,000 inhabitants.

Existing crisis helplines in Delmenhorst are the children telephone hotline, the number against sorrow, the number for pastoral care and the children emergency service number.

Public social support services and schemes available to persons with MH problems and/or pyschosocial disabilities are identical to nationwide services and schemes with different modules, e.g. the Jobcenter for unemployed people, housing subsidies, reintegration and rehabilitation during and after treatment. Social support services are regulated and organised within strictly separated legislation and systems which generates huge challenges in terms of coordination because of lacking case-management.

Challenges in terms of availability of structures and services remain:

- There are no adequate procedures for a smooth transition between child/adolescent to adult MH services in Delmenhorst, like in many other parts in Germany;
- According to own estimations of the pilot coordination team based on stakeholder interviews, 25% or less of discharged inpatients with MH conditions received a follow-up outpatient visit within one month in 2022;
- The service situation for MH problems is very tense in Delmenhorst. Growing needs on one side are facing a lack of professionals on the other side. For instance, the position of the head of the social-psychiatric department of the municipal administration, who established and coordinated the social-psychiatric network of local stakeholders (2014) was vacant during five years.

Workforce in MH:

Table 15 - Total number of MH workers in the municipality of Delmenhors*

	In MH services (all)		In child & adolescent MH services	
	Total number	**Rate**	**Total number**	**Rate**
Psychiatrists	6	0.7	----	----
Child psychiatrists	---	---	4**	2.8
Mental health nurse	0	0.0	0	0.0
Psychologists	27	3.3	11	7.8
Social workers	0	0.0	0	0.0
Speech therapists	6	0.7	0	0.0
Occupational therapists	10	1.2	0	0.0
Others	5	0.6	0	0.0
Total	**54**	**6.6**	**0**	**0.0**

**Numbers are the results of own research conducted by the pilot coordination team at the DIG, based on interviews of local stakeholders.*
***The four child psychiatrists are working in the Wichernstift and are responsible for a region of 400,000 people. In Delmenhorst there are no child psychiatrists in private practices.*

Other available and used (CB)MH services:

There are many health promotional and preventive activities organised by the municipal authorities, for example a multiprofessional prevention group (*Kommunaler Präventions-Rat – KPR*) and the activities dealing with unintentional and intentional injuries on a high level (within the Safe Communities' movement of the WHO). Following the adoption of the federal Child Protection Law in 2012 some improvements in child protection were achieved. During the Covid pandemic, the municipal public health administration was further developed, enabling self-help-groups to be reestablished.

A multitude of self-help-groups exist in Delmenhorst (18 out of 48 are for MH conditions/addiction). The drug advice center (DROB) is a very active initiative in the prevention of legal and illegal drug/substance abuse and the danger of non-substance related dependency like pathological gambling. In the last years, the DROB developed its programme of services that includes the needs of

children and is very active in school-based-research. Moreover, there are several streetworkers in the city of Delmenhorst with a focus on violence-prevention and integration.

Available MH care at primary care level:

Pharmacological interventions for MH conditions are available and provided by GPs and specialists and covered by health insurance. Psychosocial interventions for MH conditions are also available and provided. Besides many different self-help-groups there is also a specialised psychiatric care service available (at the AWO association), coordinated by the social-psychiatric network. In general, health workers are trained on the management of MH conditions, however physicians/medical doctors/paediatricians only during their specialisation (internship) by choice, if interested. A minority of paediatricians voluntarily attends training in so-called "psychosomatic primary care (*psychosomatische Grundversorgung*). With regard to the collaboration between primary and specialised care levels, there is often an unstructured collaboration, depending on individual contacts.

Mental Health Information System (MHIS):

At the level of Delmenhorst, there is neither a stand alone and specific MHIS for adult MH, nor for children/adolescent MH, but items related to MH of both adults and children/adolescents are included in a general information system based on the „hospital discharge database“ system at the level of the municipality. Data about inpatient and outpatient services are transmitted from the municipal level to the state-level health information system in a half-year period in the frame of the reporting about the State Psychiatric Plan (last update in 2020), but data collection remains fragmentary and irregular.

2 Needs Assessment (NA)

The SWOT analysis has been prepared by the Delmenhorst Insitute for Health Promotion (*DIG - Delmenhorster Institut für Gesundheitsförderung*) as part of the preparation of the pilot action implementation. The pilot action focuses on children of mentally ill and/or addicted parents as final target group. Semi-structured, guideline-based expert interviews were conducted with 39 persons/stakeholders in different functions, some of them in multiple functions (e.g. both psychotherapist in own practice and psychotherapist in a child and youth psychiatry responsible for the district). In order to obtain a comprehensive picture, it was first analysed which professionals/ stakeholders would be relevant in the context of the planned pilot action, with the aim to interview as many stakeholders from different areas as possible. Among the persons interviewed there were psychotherapists, psychiatrists, physicians, social workers, public service officers (police and fire/rescue department) and a midwife. The interviews lasted about 35 minutes on average; 39 interviews were conducted, three of them with two persons each. The shortest interview lasted about 15 minutes and the longest (double interview) about 90 minutes. Only very few interviews had a duration of less than 30 minutes. All the interviewed persons were very willing and motivated to share information. The interviews also had an activating function, in the sense that they prompted the interviewed experts/professsionals to join and contribute to the planned pilot action. At the moment of finalisation of this Country Profile, the interview analysis phase is still ongoing at the institute, but first results of the SWOT analysis were outlined based on the impressions and initial stakeholder analysis:

Table 16 - SWOT Analysis

Strength	Weaknesses
• Complex network… • … with numerous members from different sectors • Preexisting network, working in practice (but disrupted by Covid-19) • Municipality dimension (not too big) • Transparency and good overview about situation due to a lot of interviews/contacts	• Self-centeredness and competition between different networks and within subgroups (esp. private medical sector) • Sector fragmentation/borders (especially between health care and social services) • Fragmented "work culture and thinking" • Different subgroups with own networks (dependent on "caring persons") • Problems during (growing) closing hours / crisis interventions • Lack of (qualified) personnel/resources • Fluctuation of employees (mainly in social work) • Mistrust in administration (specially youth welfare center) • Deficits in (early) prevention • Educational sector (Kindergartens & schools) not integrated • Networking work not rewarded/paid • Individualistic "therapeutic centered" view in adult MH • Lack of group activities • Social sector (work place/ unemployment office) not included systematically • Missing transition structures transition between residential psychiatric and follow-up psychotherapeutic treatment • Missing structures for participation of families and young patients • Very long waiting times
Opportunities	**Threats**
• Growing needs and wishes for collaboration by many stakeholders for strengthening the network • Growing attention for personal communication measures and MH after Covid-19 • Pilot leading organisation as "neutral" private organisation without own egoism in the field • Independence from administration • Existing needs for "centralized case manager" esp. in crisis situation are accepted • Reactivation of existing networks • Potential for activities of awareness raising (starting in schools) destigmatisation and prevention	• Establishment of (new) parallel structures • No sustainable structures established which leads to frustration after commitment • Mental health care might be neglected because of other priorities • Already overloaded help system threatens to collapse

Strengths: Delmenhorst offers a complex network of different support systems and stakeholders, some of which were still in regular exchange with each other until before the Covid-19 pandemic. There are many committed helpers/stakeholders from different sectors who were willing to hold intensive discussions with the coordinator of the planned pilot action. The local coordination team responsible for implementing the pilot action was able to get a good overview of the situation in the pilot area thanks to the detailed interviews and discussions.

Weaknesses: The complexity and diversity of the support systems is equally a weakness, as these are not transparent to each other and to outsiders, parallel structures exist and self-serving interests prevail among stakeholders. In particular, internal structures of the municipal administration, including the youth welfare office and the social-psychiatric services, are not transparent for stakeholders outside the administration, in particular for professionals from the health sector, and are in need of

constant improvement. The health and social service system(s) face sectoral boundaries linked to different legislation and organisation forms that make collaboration difficult. Mental health is not sufficiently integrated into the structures of the health system, where a „culture" dominated by physical health (diagnoses) still prevails. Several (too many) existing networks dominated by single key stakeholders make sustainable cross-sectoral collaboration difficult. The lack of qualified staff and resources is a major weakness in many areas, as sufficiently good care cannot always be ensured. Stigma runs deep and stigma associated to the role of the youth welfare office in particular has contributed to creating a bad reputation of the office, which prevents many people in need from seeking help from its services. Educational settings such as kindergartens and schools are hardly integrated within existing networks. The payment system does not provide for remuneration of networking activities. Psychotherapeutic care for adults is exclusively single-centred and individual, so that the „family" as a system is often not perceived as such. Waiting times for psychotherapy are very long (at least six months) and there is a lack of group support offers. A lack of structures and procedures for transition from residential psychiatric care to (ambulatory) psychotherapeutic services leads to uncertainty and discontinuity of care. The diversity and specificities of the living environments of specific population groups (e.g. unemployed people, refugees, children in isolated families, etc.) need to be better considered for the provision of care and the transition from children and adolescent to adult care is still a general problem in the whole German (mental) health system.

Opportunities: There is a great interest from the stakeholders within the diverse support systems to work on and within sustainable networks and partnerships. Awareness of (the importance of) MH has increased in the time of COVID-19. The importance of the planned pilot action and the need for improvement of MH care structures are seen, accepted and desired by stakeholders. The local coordinating institute (DIG) of the pilot action is a neutral and independent organisation, which facilitates networking in many ways. Some networks and structures that collapsed during the pandemic can be reactivated with its support. Raising awareness and networking create better opportunities for destigmatisation and early prevention, which starts at birth and extends through all settings (kindergartens, elementary schools, etc.) within a life-course approach.

Threats: There is a risk of creation of new parallel structures. Frustration among engaged stakeholders might rise if sustainable improvement of care structures is not seen, enabled and reached. Due to other global disasters, there is a risk that the topic of MH will lose importance again and will not be given enough consideration. The support system(s) are already overstretched due to a lack of personnel and other difficult factors inherent to the social support systems for aforementioned specific vulnerable population groups. An additional concern is the (increasing) social burden caused by mental stress experienced by parents at the workplace which needs to be addressed as well.

3 Reflection on SANA results

Overall, the data situation and the documentation of services and facilities on the topic of CBMH care is poor. This is the case on a national level as well as at the level of the pilot region. There is sufficient funding for MH services within growing resources of health care budget in the pilot area and for the specific target group. However, the funding distribution among various sectors is disproportionately skewed, to the detriment of MH care.

There is a strong fragmentation of services within the health sector and between the health and other sectors for the reasons indicated above and coordination of (needed) support and care between sectors and services is missing. The collaboration between primary and specialised (health) care is

often unstructured, rather depending on individual contacts than on existing collaborative structures and procedures. Due to a growing lack of MH professionals in the pilot area and resources there are inacceptably long waiting times (from four up to 18 months) for access to services for the specific target group. In particular, there are not enough therapists, integration of MH care into care for other (physical) health problems and diseases is missing and interdisciplinarity among health professionals is lacking. The situation in the pilot area is exacerbated by the fact that the position of head of the

Box 1. Prioritised measures for pilot implementation

- **(Sub-)Strategic Area 1.2:** *Building (consolidating or extending) and sustaining networks based on intersectoral, multidisciplinary and recovery-oriented approach (at pilot site)*

  ➔ **Engagement of relevant stakeholders into intersectoral collaboration, so that they work together and bundle their activities in a systematic way**

  The many parallel and opaque stakeholder **network structures in the city of Delmenhorst are in need for coordination**. Due to the COVID-19 pandemic, many of them have fallen into disuse, and therefore require reactivation. The first priority is to **reinforce and potentially expand the intersectoral multidisciplinary mental health network** and **ensure that the municipal social-psychiatric services are connected and informed.**

- **Strategic Area 3:** *Extensive global training programme of stakeholders (in support of the reform & cultural change in service provision)*

  ➔ **Training activities & capacity building for relevant and interested stakeholders (incl. training sessions, workshops, conferences, reflection days, seminars, thematic meetings, briefing, on-the-job training, internships abroad and coaching)**

  To provide evidence-based training regarding community coalition and sensibilization to the staff, training sessions will be offered under the guidance of the institute Mario Negri during the period December´23 to February ´24

- **Strategic Area 4:** *Intensive continuous communication, information and awareness raising among/towards stakeholders and users (in support of the reform and a culture of change)*

  ➔ **Promotion of awareness of MH issues, destigmatisation and social inclusion through information and communication**

  A further priority of the activities in Delmenhorst is **destigmatisation by raising awareness** as early as possible, i.e. kindergartens and schools, up to all social settings. Stakeholders in all relevant **sectors** should be **informed on principles of recovery and social inclusion** of people with MH issues and **families** should have **more information about available services and access to them**. The aim is also to ensure that **media covers topics / discussions** related to mental health **in a non stigmatising way.**

- **Strategic Area 5:** *Data collection, monitoring & evaluation*

  ➔ **Increase of data collection and usage**

  In order to achieve increased data collection and use, an **agreement** between the local level (city/district of Delmenhorst) and the **federal state level on (a minimal set of) MH data needed at local level** should be achieved. In addition, a **concept for a dashboard of (mental) health indicators at local level** should be developed and agreed in cooperation with relevant local stakeholders.

municipal social-psychiatric services has been vacant for 5 years. Stigmatisation, shame, lack of trust in administration (especially in the youth welfare office), lack of psychoeducation and awareness in settings for children and adolescents are mentioned by stakeholders as further attitudinal barriers to the use of services. Missing knowledge of existing services among the population and concerned families, due to a lack of transparency about responsibilies and feasibility of interdisciplinary approaches are mentioned as barriers to accessibility and/or to continuity of MH services. Group therapies are lacking that could help meet the increasing needs, but they appear to be less attractive to therapists in training.

4 Priorities & Next steps

Based on the findings of the sitatuation analysis and needs assessement the following priority activities and next steps for pilot implementation have been identified:

- Identification of key persons/stakeholders (also from outside the health sector);
- Interviews of stakeholders to gauge commitment and motivation;
- Increase collaboration with relevant stakeholders (including persons with lived experience);
- Ensure that qualified personnel at the municipal social-psychiatric services are available, informed and connected;
- Engage into communication and information exchange activities in order to sensitise relevant stakeholders in all sectors to overcome sector borders, raise awareness of concerned families and empower them to seek support, and collaborate with media to increase awareness and improve media coverage about MH at local level in a non-stigmatising way;
- Engage into a dialogue with local stakeholders and state level authorities about data collection and use with a view to agree on a minimum set of needed data at local level and develop a concept for dashboard development.

5 References

(1) Eurostat (2021). Population on 1 January by age and sex. Retrieved from: https://ec.europa.eu/eurostat/data-browser/view/DEMO_PJAN__custom_7141591/default/table?lang=en [15.11.2022]

(2) Statista (2023). Durchschnittliche Lebenserwartung in Europa bei der Geburt im Jahr 2022 nach Region (in Jahren). Retrieved from: https://de.statista.com/statistik/daten/studie/199596/umfrage/lebenserwartung-in-europa-nach-geschlecht-und-region/ [30.06.2023]

(3) Destatis (2023). Entwicklung der Lebenserwartung in Deutschland. Retrieved from: https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Bevoelkerung/Sterbefaelle-Lebenserwartung/sterbetafel.html [15.01.2023]

(4) Eurostat (2023). People at risk of poverty or social exclusion. Retrieved from: https://ec.europa.eu/eurostat/data-browser/view/sdg_01_10/default/table?lang=en [25.07.2023]

(5) Eurostat (2023). Gini coefficient of equivalised disposable income - EU-SILC survey. Retrieved from: https://ec.europa.eu/eurostat/databrowser/view/ilc_di12/default/table?lang=en [25.07.2023]

(6) Eurostat (2023). Total health care expenditure. Retrieved from: https://ec.europa.eu/eurostat/data-browser/view/tps00207/default/table?lang=en [25.07.2023]

(7) Institute for Health Metrics and Evaluation (2019). Global Burden of Disease study (2019). Retrieved from: https://vizhub.healthdata.org/gbd-results/ [18.09.2023]

(8) Blümel M, Spranger A, Achstetter K, Maresso A, Litvinova Y, Busse R (2022). Germany: Health system summary, 2022. https://apps.who.int/iris/rest/bitstreams/1491793/retrieve

(8a) Eurostat (2017). Mental health care – psychiatric hospital beds. Retrieved from: https://ec.europa.eu/eurostat/de/web/products-eurostat-news/-/edn-20201009-1 [16.09.2023]

(9) Bramesfeld, A. (2023). Die Versorgung von Menschen mit psychischen Erkrankungen in Deutschland aus Perspektive des Gesundheits- und Sozialsystems: Aktuelle Entwicklungsbedarfe. Bundesgesundheitsblatt-Gesundheitsforschung-Gesundheitsschutz, 66(4), 363-370.

(10) Greve, N., Bomke, P., Kurzewitsch, E., & Becker, T. (2021). Versorgungsnetze für Menschen mit psychischen Störungen. Krankenhaus-Report 2021: Versorgungsketten–Der Patient im Mittelpunkt, 149-171.

(11) Bundesministerium für Gesundheit (BMG) (2023). Innovationsfonds. Retrieved from: https://www.bundesgesundheitsministerium.de/service/begriffe-von-a-z/i/innovationsfonds.html [02.08.2023].

(12) Kassenärztliche Bundesvereinigung (KBV) (2023). Ambulante Komplexversorgung: Ein neues Versorgungsangebot für Menschen mit psychischen Erkrankungen. PraxisInfoSpezial. https://www.kbv.de/media/sp/PraxisInfoSpezial_Komplexversorgung.pdf

(13) Stahmeyer JT, Märtens C, Eidt-Koch D et al (2022) The state of care for persons with a diagnosis of depression. Dtsch Arztebl Int. https://doi.org/10.3238/arztebl.m2022.0204

(14) Bundespsychotherapeutenkammer (2018) Ein Jahr nach der Reform der Psychotherapie-Richtlinie: Wartezeiten 2018. Retrieved from: https://api.bptk.de/uploads/20180411_bptk_studie_wartezeiten_2018_c0ab16b390.pdf [20.06.2023]

(15) Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (2018) Bedarfsgerechte Steuerung der Gesundheitsversorgung. Retrieved from: https://www.svr-gesundheit.de/fileadmin/Gutachten/Gutachten_2018/Gutachten_2018.pdf [20.07.2023]

(16) Kassenärztliche Bundesvereinigung (2022) Tätigkeit der Terminservicestellen: Evaluationsbericht 2021 gem. § 75 Abs. 1a Satz 19 SGB V. https://www.kbv.de/media/sp/22-0624_Evaluationsbericht_2021_TSS.pdf [16.07.2023]

(17) Statistisches Bundesamt (2019). Statistisches Jahrbuch 2019: Kapitel 4 Gesundheit. [24.05.2023]

(17a) Statistisches Bundesamt (2015). Krankheitskostenstatistik according to diagnoses based on ICD.

(18) Destatis (2021) Grunddaten der Krankenhäuser. Retrieved from: https://www.destatis.de/DE/Themen/GesellschaftUmwelt/Gesundheit/Krankenhaeuser/Publikationen/_publikationen-innen-grunddaten-krankenhaus.html [10.10.2022]

(19) GBE-Bund (2021) Aus dem Krankenhaus entlassene vollstationäre Patientinnen und Patienten (einschließlich Sterbe- und Stundenfälle) nach pauschalierenden Entgelten für Psychiatrie und Psychosomatik (PEPP) (Anzahl und je 100.000 Einwohner). Retrieved from: https://www.gbe-bund.de/gbe/pkg_isgbe5.prc_menu_olap?p_uid=gast&p_aid=11445444&p_sprache=D&p_help=3&p_indnr=119&p_indsp=&p_ityp=H&p_fid [08.10.2022]

(20) WHO (2021) Mental Health ATLAS 2020. Retrieved from: https://www.who.int/publications/i/item/9789240036703 [03.01.2023]

(21) WHO (2015) Mental health atlas 2014. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/178879/9789241565011_eng.pdf?sequence=1&isAllowed=y [20.02.2023]

(22) Bundesärztekammer (2021) Ärztestatistik zum 31. Dezember 2021. Retrieved from: https://www.bundesaerztekammer.de/fileadmin/user_upload/BAEK/Ueber_uns/Statistik/2021/2021_Statistik.pdf [16.06.2023]

(23) Steinert, T., Hirsch, S. & Flammer, E. (2022). Monitoring von Zwangsmaßnahmen und Zwangsbehandlungen in Deutschland. In: Nervenarzt 2022 · 93:1105–1111 https://doi.org/10.1007/s00115-022-01349-4

(24) Federal justice office (2021) Zusammenstellung der Geschäftsübersichten der Amtsgerichte für die Jahre 1995 bis 2021. Retrieved from: https://www.bundesjustizamt.de/SharedDocs/Downloads/DE/Justizstatistiken/Geschaeftsentwicklung_Amtsgerichte.pdf?__blob=publicationFile&v=5 [22.10.2023]

(25) Federal justice office (2018) Betreuungsverfahren. Retrieved from: https://www.bundesjustizamt.de/SharedDocs/Downloads/DE/Justizstatistiken/Betreuungsverfahren_1992-2017.pdf?__blob=publicationFile&v=2

(26) German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology (2023) Basisdaten Psychische Erkrankungen. Stand Januar 2023. Retrieved from: https://www.dgppn.de/_Resources/Persistent/93a818859031c45661aa7f6d298d6fecc6de45e9/20230104_Factsheet_Kennzahlen.pdf [19.11.2023]

(27) Thom, J., Mauz, E., Peitz, D., Kersjes, C., Aichberger, M., Baumeister, H., Bramesfeld, A., Daszkowski, J., Eichhorn, T., Gaebel, W., Härter, M., Jacobi, F., Kuhn, J., Lindert, J., Margraf, J., Melchior, H., Meyer-Lindenberg, A., Nebe, A., Orpana, H., Peth, J., Reininghaus, U., Riedel-Heller, S., Rose, U., Schomerus, G., Schuler, D., von Rüden, U., Hölling, H. (2021): Aufbau einer Mental Health Surveillance in Deutschland: Entwicklung von Rahmenkonzept und Indikatorenset. J. Health Monitoring 6 (4): 36–68. doi: 10.25646/8860.

(28) KIGGS-Studie (2018) KIGGS-Ergebnisse. Retrieved from https://www.kiggs-studie.de/ergebnisse.html [10.08.2023]

(29) Robert-Koch-Institut (2021). Psychische Gesundheit - Journal of Health Monitoring 4/2021. Retrieved from https://www.rki.de/DE/Content/Gesundheitsmonitoring/Gesundheitsberichterstattung/GBEDownloadsJ/JoHM_04_2021_Psychische_Gesundheit.html [05.08.2023]

(30) Robert-Koch-Institut (2023). Aufbau einer nationalen Mental Health Surveillance am Robert Koch-Institut (MHS). Retrieved from https://www.rki.de/DE/Content/Gesundheitsmonitoring/Studien/MHS/mhs_node.html [03.08.2023]

(31) Stadt Delmenhorst (2022). Bevölkerung. Retrieved from: https://www.delmenhorst.de/leben/stadt/statistiken/bevoelkerung.php [13.09.2022]

(32) Michalski, N., Reis, M., Tetzlaff, F., Herber, M., Kroll, L. E., Hövener, C., Nowossadeck, E., & Hoebel, J. (2022). German Index of Socioeconomic Deprivation (GISD): Revision, update and applications. Journal of health monitoring, 7(Suppl 5), 2–23. https://doi.org/10.25646/10641

(33) Bundesagentur für Arbeit (2023) Arbeitslose und Arbeitslosenquoten - Deutschland, Länder, Kreise und Gemeinden (Zeitreihe Monats- und Jahreszahlen). Retrieved from: https://statistik.arbeitsagentur.de/SiteGlobals/Forms/Suche/Einzelheftsuche_Formular.html?topic_f=gemeinde-arbeitslose-quoten&r_f=bl_Niedersachsen [20.09.2023]

(34) Bundeszentrale für politische Bildung (2023) Arbeitslose und Arbeitslosenquote. Retrieved from: https://www.bpb.de/kurz-knapp/zahlen-und-fakten/soziale-situation-in-deutschland/61718/arbeitslose-und-arbeitslosenquote/ [21.04.2023]

(35) Destatis (2021) Lebenserwartung in Deutschland nahezu unverändert. Retrieved from: https://www.destatis.de/DE/Presse/Pressemitteilungen/2021/07/PD21_331_12621.html [03.06.2023]

(36) Statistikportal (2023). A.5 Armutsgefährdungsquoten, Raumordnungsregionen (Bundesmedian, Landesmedian, regionaler Median). Retrieved from: https://www.statistikportal.de/de/sbe/ergebnisse/einkommen-armutsgefaehrdung-und-soziale-lebensbedingungen/armutsgefaehrdung-und-7 [11.06.2023]

(37) Wegweiser Kommune (2023). Haushalte mit niedrigem Einkommen (%). Retrieved from: https://www.wegweiser-kommune.de/daten/haushalte-mit-niedrigem-einkommen+delmenhorst+deutschland+2021+tabelle [21.09.2023]

(38) Bertelsmann Stiftung. (2020). Factsheet Kinderarmut in Deutschland, p. 10. Retrieved from: https://www.bertelsmann-stiftung.de/fileadmin/files/BSt/Publikationen/GrauePublikationen/291_2020_BST_Facsheet_Kinderarmut_SGB-II_Daten__ID967.pdf [20.09.2023]

(39) Ministry for Social Affairs, Labour, Health and Equal Opportunities Lower Saxony (2016) Landespsychiatrieplan Niedersachsen. Retrieved from: https://www.ms.niedersachsen.de/startseite/gesundheit_pflege/gesundheit/psychiatrie_und_psychologische_hilfen/landespsychiatrieplan-niedersachsen-162374.html [11.07.2023]
Niedersächsisches Ministerium für

(40) Soziales, Gesundheit und Gleichstellung (2021) Bericht zur Versorgung von Menschen mit psychischen Erkrankungen in Niedersachsen 2020. Retrieved from: https://www.ms.niedersachsen.de/download/178132/Bericht_zur_Versorgung_von_Menschen_mit_psychischen_Erkrankungen_in_Niedersachsen_2020.pdf [13.08.2023]

(41) Niedersächsisches Ministerium für Soziales, Gesundheit und Gleichstellung (n.d.) Ein Standard für Gemeindepsychiatrische Zentren –Definition, Checkliste und Modelltreue-Skala (MTS-GPZ). Retrieved from: https://www.ms.niedersachsen.de/download/180497/Ein_Standard_fuer_Gemeindepsychiatrische_Zentren_Definition_Checkliste_und_Modelltreue-Skala_MTS-GPZ_.pdf [14.07.2023]

(42) Stadt Delmenhorst (2023), Sozialpsychiatrischer Verbund (SpVb). Retrieved from: https://www.delmenhorst.de/vv/produkte/20/144010100000013434.php#tab-infos [13.07.2023]

(43) Landkreis Hildesheim (2023) Netzwerk HiKip. Retrieved from: https://www.landkreishildesheim.de/B%C3%BCrgerservice/B%C3%BCrgerservice/Familie-Kinder/Netzwerk-HiKip-/ [10.07.2023]

(44) Hamburgische Arbeitsgemeinschaft für Gesundheitsförderung (2022) Schatzsuche. Retrieved from: https://www.schatzsuche-kita.de/qualitaetsentwicklung/qualitaetssicherung/ [19.07.2023]

(45) Stadt Wolfsburg (2021) Stadt Wolfsburg Geschäftsbereich Gesundheit – Kleine Angehörige. Retrieved from: https://mein.wolfsburg.de/organisationen/stadt-wolfsburg-geschaeftsbereich-gesundheit-kleine-angehoerige/ [12.07.2023]
(46) Kidstime Netzwerk (2022) Kidstime Netzwerk. Retrieved from: https://kidstime-netzwerk.de/ [05.07.2023]
(47) Landesstelle Psychiatriekoordination Niedersachsen (2023) Projektdatenbank. Retrieved from: https://www.psychiatrieko-ordination-nds.de/projektdatenbank [29.06.2023]
(48) Stadt Delmenhorst (2014) Sozialpsychiatrischer Plan 2014. Dritte Fortschreibung. Retrieved from: https://www.delmen-horst.de/medien/publikationen/SpPLAN_2014.pdf [01.07.2023]
(49) Ministry for Social Affairs, Labour, Health and Equal Opportunities Lower Saxony (2022) Krankenhäuser in Niedersach-sen. Retrieved from: https://www.ms.niedersachsen.de/krankenhaeuser/krankenhaeuser-in-niedersachen-14126.html [11.08.2023]
(50) DGPPN (2018) S3-Leitlinie Psychosoziale Therapien bei schweren psychischen Erkrankungen. Retrieved from: https://register.awmf.org/assets/guidelines/038-020l_S3_Psychosoziale_Thera-pien_bei_schweren_psychischen_Erkrankungen_2019-07.pdf [19.09.2023]

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