Care for people with mental illness: What's going wrong?

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Mental illnesses have reached the top of the list in terms of days lost due to incapacity for work. The relevant figures have risen by approximately 250% over the last two decades and continue to rise. There is no end in sight to this trend. Many factors may be responsible for such a development, yet it is nevertheless astonishing that, in parallel with this trend, treatment costs have more than doubled, both for treatment with psychotropic drugs and for treatment with psychotherapy. According to the World Health Organisation (WHO), depression will rank second in terms of disability-adjusted life years (DALYs) in the future. Days of incapacity for work represent only one aspect of the societal burden caused by mental illness. The loss of productivity in businesses or public authorities due to people with mental illness is of great economic significance. Of course, the personal suffering of those affected must also be taken into account, as must that of their families and the wider social environment. Mental illnesses are often passed on to children not only through genetic factors but also through family history. If one in three people will be affected by a mental illness at some point in their lives and a society is unable to deal effectively with mental illness, it faces a fundamental problem.

>> Yet for most mental illnesses, there are sound treatment guidelines available that are based on scientific evidence and suggest successful treatments. A noteworthy change in treatment guidelines has occurred over the last 30 years due to the increasing emphasis on psychotherapeutic treatments, which are now considered ‘first-line treatments’ for almost all mental illnesses, sometimes even taking precedence over pharmacological treatment options (e.g. in the areas of obsessive-compulsive disorder, post-traumatic stress disorder and insomnia). Following decades of relative stagnation in the field of psychopharmacology, new hopes are now being pinned on treatment approaches such as those involving psychedelics. Despite these reports of success, the current scientific assessment also highlights clear downsides to these treatment approaches. In the field of psychopharmacotherapy, a response rate of under 50% is assumed; new meta-analyses involving over 50,000 patients confirm that 80% of the response rates for antidepressants are already found in the placebo group, and thespecificity of the effect is therefore questionable (Meyerson, Pieper, & Hoyle, 2023).

Summary

Introduction: The provision of care for mental health conditions is caught in a downward spiral: on the one hand, the demand for care is rising continuously, as are the resources allocated (more pharmacotherapy and more psychotherapy); on the other hand, the quality of care is not improving significantly. Certain aspects of care contribute specifically to this: for both pharmacological and psychotherapeutic treatments of mental illness, we must assume that

more than half of the patients treated do not achieve a sufficiently satisfactory outcome; in routine care, these figures are likely to be significantly worse.

Methods: An analysis of the current care situation is conducted, insights from an international care project in England are reported, and recommendations for improving care for people with mental illness in Germany are derived from these.

Results: There is too much inpatient treatment, and Germany ranks among the highest globally. Many proposals for innovation are based more on the principle of 'more of the same' than on being truly innovative. From this, the following four aspects of a necessary, more radical innovation are derived: (1) stepped-care models (also taking into account digital care options and AI-supported new developments), (2) a shift away from inpatient (often far from home) care and towards new, interdisciplinary care centres in the outpatient sector, (3) the establishment of 'self-learning healthcare models' with continuous improvement in the hands of the relevant professions, and (4) a focus on more problem-oriented and life-world-oriented treatments. Existing obstacles are listed.

Discussion: Legislators, the Innovation Fund, and all providers and funders of healthcare services are called upon to break down existing barriers and to demand and promote innovative care concepts.

Keywords

Mental health, healthcare systems, self-learning system, tiered care

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Even among people with severe depression, such high response rates are found in the placebo group, indicating that we are still a long way from treatments with specific efficacy. With the 'new' psychotropic drugs, distinguishing them from pure placebo effects appears particularly difficult (Lii et al., 2023). But the situation is only marginally better in the field of psychotherapy: here too, new, more realistic meta-analyses report success rates of under 50% in scientific studies, whilst in clinical practice, even lower success rates are assumed (Cuijpers et al., 2020). Psychotherapeutic approaches appear to have at least somewhat longer-lasting effects: after the end of treatment, relapses are frequently observed in patients treated with medication alone (Voderholzer et al., 2024).

It is striking in many clinical studies that areas such as work capacity or general impairment due to illness are often not given sufficient attention, with studies focusing purely on primary clinical outcomes. Additional problems arise in clinical practice: the number of psychotropic drugs that patients discontinue relatively soon is high. For psychotropic drugs prescribed by GPs, at least one third of patients discontinue the medication within the first few months (Garcia-Marin et al., 2023). Although psychotherapeutic care in Germany ranksamong the best internationally in terms of fundedservices, there are still long waiting times for a treatment place and treatment durations are exorbitantly long by international standards (Gallas, Puschner, Kühn, & Kordy, 2010). Patients' preference for

psychotherapy over psychopharmacotherapy in cases of doubt cannot normally be accommodated, even if this would be the best course of action according to guideline recommendations (McHugh, Whitton, Peckham, Welge, & Otto, 2013).

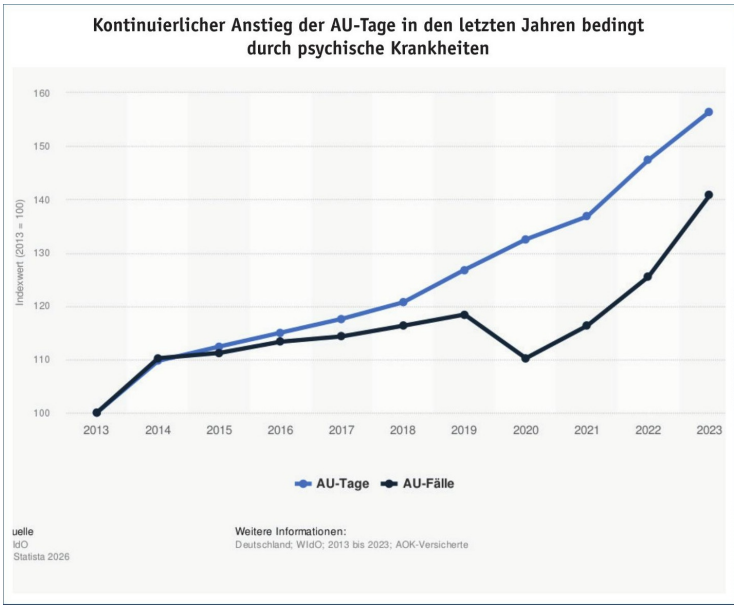


Fig. 1: **Continuous rise in sick leave days in recent years due to mental illness. Statista 2025.**

A distinctive feature of mental health care in Germany is its leading position worldwide in the field of inpatient care. In no other country on earth are people with mental health conditions admitted to inpatient facilities for treatment as frequently (often far from their homes) as in Germany (Papanicolas, Woskie, & Jha, 2018). However, inpatient treatment far from home does not automatically offer the advantage of higher-quality and more complex care: in an earlier review of inpatient psychosomatic rehabilitation treatments, whilst some showed excellent short-term treatment outcomes, others failed to achieve even short-term demonstrable improvements in the samples examined (at least 40 people per clinic; (Schulz, Barghaan, Harfst, & Koch, 2008; Watzke et al., 2008)). Although the author believes that there will continue to be a long-term need for inpatient treatment in the field of mental illness, it is nevertheless quite clear that too many patients in Germany are receiving expensive inpatient treatment, with all the disadvantages that such treatment entails: being far from family and work, but often also far from the solutions to the real-life conflicts in their personal circumstances.

As a member of the Innovation Fund's expert group, one can also observe that many initiatives have been launched to improve the care situation. Scientifically supported trials to increase compliance, monitoring of psychopharmaceuticals, mandatory acute consultations in psychotherapy, as well as further policy initiatives such as 'complex treatments' or improved outpatient services linked to inpatient facilities can be cited. And yet: nothing has changed in the problem situation outlined at the outset. The problem with the innovations of recent years and decades has been their tendency to be 'more of the same'. Clearly, however, the issue is not about minor changes to the existing system: radical innovation

is what is needed. If one looks for truly innovative projects, for example within the G-BA's Innovation Fund, it is hard to find much cause for enthusiasm there. Many project proposals tend to stem from an internal perspective rather than advancing radically new approaches. Psychiatrists propose improvements to medication compliance and to increasing medication consumption; psychotherapists call for more NHS-funded positions and would like to see certain psychotherapeutic approaches represented more frequently within the healthcare system; and finally, there are also attempts to offer existing services more cost-effectively through digital adaptations, which logically does not go hand in hand with greater effectiveness. Thinking and acting from within the existing system, often further complicated by conflicts relating to professional politics or specific psychotherapy schools, seems to hinder rather than promote innovation.

A digression on the English care model

Given the scale and ongoing analysis of issues within the English 'Talking Therapies' model – which emerged from the 'Improving Access to Psychological Treatments' (IAPT) and in which 500,000 to 1 million patients are currently treated annually, some insights should be drawn before recommendations are made for changes to the healthcare system in German-speaking countries. A distinctive feature of the English system is that feedback data on treatments is available from over 99% of participating patients within a tiered care model. This data is continuously used to drive initiatives to change the care model; in other words, continuous cycles for quality improvement have been implemented. The programme began in 2008 with the establishment of a tiered care model and a focus on evidence-based measures. Although this was already an incredible feat, the initial results were rather disappointing, with response rates of around 20% (though we cannot expect to achieve higher success rates in routine care in Germany either). It was only through systematic improvement via feedback loops in the following years that success rates in routine care could be increased to over 50% – rates we would otherwise achieve at best in controlled trials. It can therefore be concluded that the establishment of well-conceived, evidence-based measures alone is not sufficient to achieve substantial success; rather, implementation must take place in the spirit of a learning system that continuously evolves through ongoing feedback processes. Secondly, it became clear that as waiting times for treatment places increase, the prognosis for treatment deteriorates substantially. If the wait for a psychotherapy place exceeds 4–6 weeks (which is the norm in Germany), the prospects of success drop substantially. A further finding was that even in stepped-care models, mechanisms must be put in place to ensure that in urgent cases, more intensive care is initiated from the outset, rather than necessarily proceeding step by step. Finally, the study also examined the extent to which a gatekeeper function among GPs led to better allocation. This was not the case; on the contrary, pre-selection by GPs led to greater social injustice in the sense of more intensive psychological care being provided to people from higher social classes.

Over the last 10 years, based on feedback, this programme has increasingly identified problem groups where there are evident gaps in care. It was thus found that people with a migrant background benefit significantly less from the services than patients with roots in the country itself. Building

on this, various changes were made to the programme to establish more culturally sensitive treatment options and care structures. This ultimately led to comparable success rates being achieved among people with a migrant background, people of colour, etc.

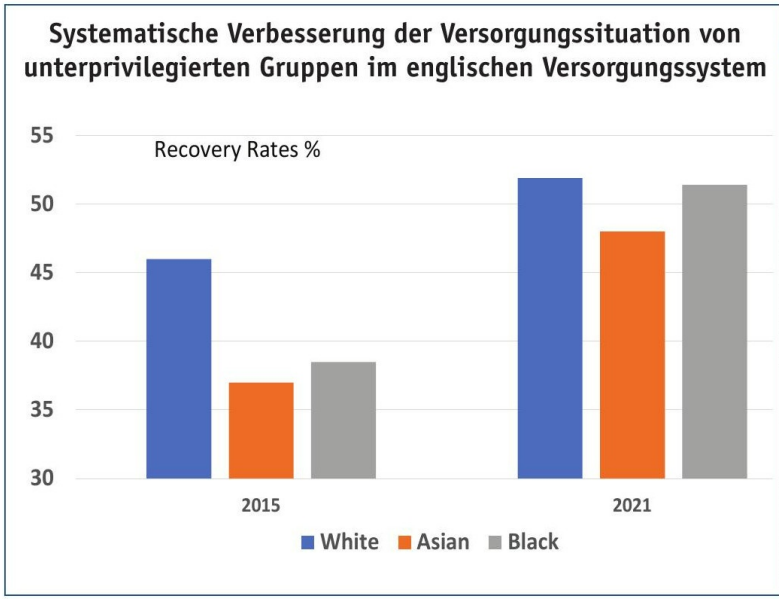


Fig. 2: **Systematic improvement in the care situation for underprivileged groups within the English healthcare system. Own illustration.**

This small selection of results from the continuously evolving process is intended to illustrate that, for a good healthcare system, it is not enough to have a few good ideas and then implement them across the board (which is difficult enough in itself); rather, healthcare systems only become successful when continuous feedback loops are established, problem areas are identified and these are then systematically addressed until they have led to a substantial improvement in the sense of a quality management process (‘learning healthcare systems’). Further information on the English programme can be found in the literature (Clark, 2018).

Possible solutions to the current gaps in care for people with mental health conditions in Germany

Certainly, some improvements can be achieved if we attempt to provide better care by adapting existing treatment options. More evidence-based treatments, better compliance on the part of both practitioners and patients, more targeted resource allocation, and complex outpatient treatments are examples of how this is being proposed or attempted in some cases. Nevertheless, for a fundamental improvement, it will likely be necessary to move beyond existing ways of thinking and establish completely new approaches.

Stepped-care models

Ultimately, stepped-care models are an obvious necessity. There will always be a subgroup of people with mental health conditions who require very intensive treatment, where their resilience is acutely and permanently compromised and there is a risk of disability. On the other hand, not every student suffering from exam anxiety or self-esteem issues, even if their

subjective distress is high, needs to receive years of psychotherapeutic treatment straight away. The criteria for inpatient treatment must be drastically scaled back in favour of better, yet more cost-effective, outpatient care. Such considerations give rise to stepped-care systems, which also take into account the possibilities of digital treatments and new AI-driven systems, particularly as they offer the additional option of language adaptations for people with difficulties with the German language. A lesson to be learned from the English system is that experts must have the option, from the outset following a decision on the indication, to refer patients to higher levels of the stepped-care model in order to avoid prolonged preliminary treatment if this is unlikely to be successful. At the same time, the potential of low-threshold treatments must be utilised and evaluated more consistently.

Outpatient care networks as alternatives to inpatient treatment

Cross-sectoral shifts in treatment provision have so far been virtually impossible in Germany, as various forces of inertia (particularly financial considerations) work against this. Nevertheless, the legislature must also take action here: the high rate of inpatient treatment for people with mental health conditions in Germany is unacceptable, unprecedented internationally, and calls for radical change. Outpatient care networks are a good idea in this regard, even if previous proposals for their implementation have been too cumbersome and are therefore not utilised sufficiently. Interestingly, in the new Psychotherapy Act, the legislator has provided for interdisciplinary treatment centres, which can, for example, place a stronger focus on restoring resilience (in work or school) than previous treatment options. In addition to a psychotherapeutic focus and medical co-management, social workers (e.g. for vocational reintegration) and physiotherapists (to increase physical resilience) can play central roles in interdisciplinary treatment centres. Not only here, but also here, we must move away from the old notion that such care networks or treatment centres can only ever be medically led: it does not work if, given the shortage of outpatient psychiatrists, they are then also tasked with setting up and managing outpatient treatment centres. A professional opening up of roles, including at management level, accompanied by continuous quality evaluation – as recently seen with the DMPs for depression – is sensible and effective.

“Learning healthcare systems”: establishing systematic feedback systems

Even though we in Germany are still lagging far behind in terms of digitalisation, this is nevertheless the way forward: after every hotel stay, guests are asked to provide feedback; why should this not also work for every interaction with the healthcare system and be able to fulfil an important steering function? This could be fed into databases that are supervised and analysed by specialist scientists and professional bodies – in other words, by experts – to avoid any potential criticism that the health system’s funders are merely using this channel to drive down costs. Such a feedback system must be linked to analyses carried out at least annually to identify, for which clinical groups, which problem constellations and in which regions, structural care deficits as well as deficits in the quality of outcomes exist, on the basis of which intervention programmes can then be planned

and implemented.

Problem-oriented and life-world-oriented treatments

Treatment guidelines, and consequently many treatment decisions, are based on diagnoses; however, it has rightly been established that these are poorly suited as a basis for deciding on treatment indications (Rief et al., 2023) (see also the American development of the RDoC system; nimh.nih.gov/health). At the very least, in addition to clinical variables, the real-life problem constellations and living environments that contribute to the need for treatment (e.g. inability to work, family conflicts, individual problem constellations beyond the clinical issue) must also be incorporated into treatment planning. Mental illnesses are biopsychosocial disorders, meaning that purely biological treatments (e.g. pharmacotherapy) are just as inadequate from the outset as protracted psychotherapeutic treatments that pay too little attention to patients' real-life circumstances and fail to take sufficient account of aspects such as resilience, ability to work or other real-world environmental problems. Psychotherapeutic treatment approaches must move away from their 'procedure-specific self-hypnosis' and address real-world problems, particularly those affecting underserved groups. Examples of underserved groups include older people, very young children, people from migrant backgrounds, people with disabilities, people with physical ailments requiring psychotherapeutic treatment, and others. Psychotherapeutic approaches must leave the ivory tower of their theoretical schools and work together to develop solutions for these real-world problems. To this end, the approval of psychotherapeutic methods should also be critically reviewed. Currently, a Scientific Advisory Board on Psychotherapy decides whether a psychotherapeutic treatment approach is approved across the board for all conditions or whether it becomes part of statutory health care; Rules regarding indications or effectiveness in relation to specific real-world problems beyond clinical symptoms play a secondary role. An alternative approach here would be to decide, on a problem- and indication-specific basis, which treatment approach would be most scientifically recommended to what extent for which problem and under which contextual conditions.

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Conclusion

The care of mental illnesses is caught in a downward spiral of continuously rising demand and an expanding range of treatments, without any significant improvement in the quality of care or an increase in treatment success rates. For both psychopharmacological and psychotherapeutic treatments of mental illnesses, we must assume that more than half of the patients treated do not achieve a sufficiently satisfactory outcome; in routine care, these figures are likely to be significantly worse. A radical rethink is therefore necessary; however, an 'inside-out' approach, actions motivated by professional politics, or approaches specific to particular schools of psychotherapy are more of a hindrance than a help. Legislators, the Innovation Fund, and all providers and funders of healthcare services are called upon to break down existing barriers and to demand and promote innovative care concepts, particularly where these enable continuous improvement and further development through feedback loops. <<

The care of mentally ill patients: What's going wrong?

Introduction: The treatment of mental illness is caught in a downward spiral: on the one hand, the demand for care is constantly increasing, as are the resources allocated (more pharmacotherapy and more psychotherapy), whilst on the other hand, the quality of care is not improving significantly. Certain aspects of care contribute specifically to this: in both psychopharmacological and psychotherapeutic treatments for mental illness, meta-analyses indicate that more than half of the patients treated do not achieve a sufficiently satisfactory response; in routine care, these figures are likely to be even worse.

Methods: The state of mental health care in Germany is analysed, and some insights from an international mental health care programme are reported. This provides the basis for outlining some recommendations for reforming the German healthcare system.

Results: Too much treatment is provided on an inpatient basis, and Germany ranks highest in the world in this regard. Many proposals for innovation are based on the principle of 'more of the same' rather than on being truly innovative. The article outlines the following four aspects of a necessary, more radical innovation: (1) Stepped care models (also taking into account digital care options and AI-supported new developments), (2) a shift away from inpatient care (often far from home) and towards new, interdisciplinary care centres in the outpatient sector, (3) the establishment of "self-learning healthcare models" with continuous improvement in the hands of the relevant professions, and (4) a focus on more problem-oriented and life-world-oriented treatments. Previous obstacles are listed.

Discussion: Legislators, the innovation fund, all healthcare service providers and funders are called upon to break down existing barriers and to demand and promote innovative mental health care concepts.

Keywords

Mental Health, Healthcare Systems, Self-learning system, Stepped care

Author's declaration

The author declares that there are no conflicts of interest.

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