Depression scorecard: Germany

This report was produced by The Health Policy Partnership as part of the Words to Actions initiative. Words to Actions began in 2018 with a report from nine mental health organisations from across Europe. The idea for the depression scorecard came from collaborative discussions between The Health Policy Partnership and Janssen Pharmaceutica NV, and the scorecards were developed as a follow-on but separate activity. The authors had full editorial control over the content of this report. All Words to Actions materials are initiated and funded by Janssen Pharmaceutica NV. For full details, please see wordstoaction.eu/about. No experts involved in the original depression scorecard work, other than The Health Policy Partnership, were paid for their time.

The
Health Policy
Partnership

About this scorecard

The depression scorecard is a tool that aims to support the assessment of national-level performance in key aspects of policy, delivery and care for people with depression. The framework that underpins the scorecard was developed based on an international literature review and consultation with an expert advisory group.

The scorecard framework was applied initially by The Health Policy Partnership, in collaboration with experts, to four countries: Belgium, France, Italy and Romania, with national-level findings summarised in individual scorecard reports. In the next phase of work, reports were developed for Finland and Germany, and the assessment framework was made available for independent researchers to prepare scorecards for their own countries.

This scorecard focuses on Germany.

Author and contributor details

The research and drafting of this depression scorecard report were led by Stefanie Ettelt and Jody Tate of The Health Policy Partnership. We are grateful to members of the Depression Scorecard Advisory Group, who volunteered their time to provide the guidance and feedback that shaped the original assessment framework:

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About The Health Policy Partnership

The Health Policy Partnership (HPP) is an independent research organisation, working with partners across the health spectrum to drive the policy and system changes that will improve people's health.

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Contents

Depression: why it matters

Depression is the most common mental health condition affecting people today.[1] It is a distinct, diagnosable mood disorder not to be confused with normal feelings of sadness.[2] Anyone can develop depression, and if a person is also experiencing another illness, addiction, poverty, unemployment or a personal loss, risk of depression increases.[2] Depression can range in severity and persistence.[2] Best practice is to manage the condition as early as possible, while the person is still well enough to be fully engaged in their recovery and before treatment-resistant depression sets in.[3] Yet stigma associated with depression may prevent people from seeking and receiving the care they need, and exacerbate suffering.[4]

Depression has a devastating impact on the lives of those affected, their families and carers, and societies and economies more broadly.

10%

of people in Germany have symptoms of depression[12]*

18 psychiatrists

per 100,000 inhabitants, above the EU average of 17[13]‡

4.8%

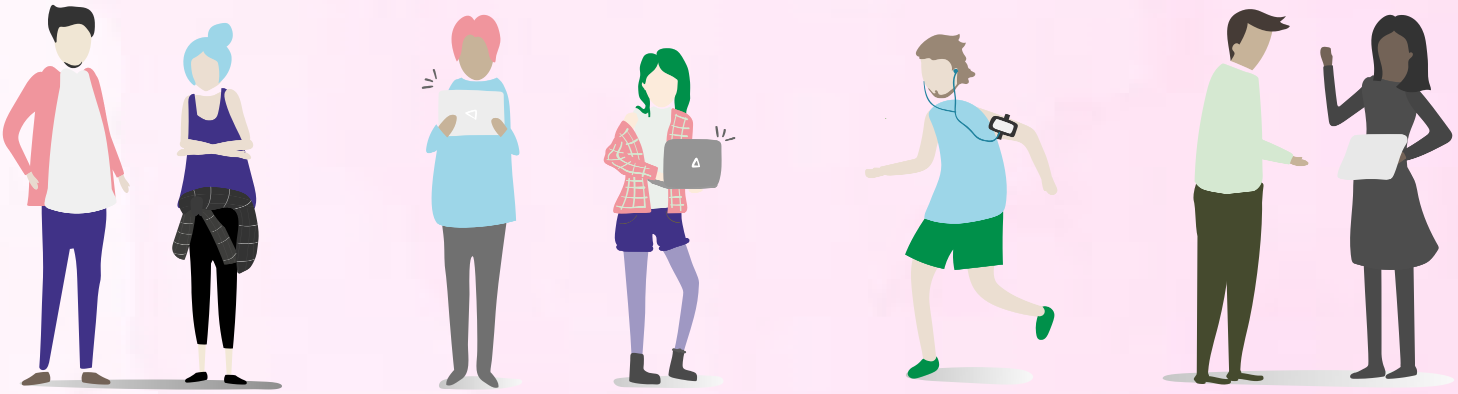
cost of mental health to Germany's GDP (direct and indirect expenditure compared with 4% in the EU overall[17]§

€7.6 billion

total healthcare costs for depression in Germany, 2.2% of all healthcare costs[14]§

€42.7 billion

total healthcare costs for mental health in Germany, 13% of all healthcare costs[15][16]§

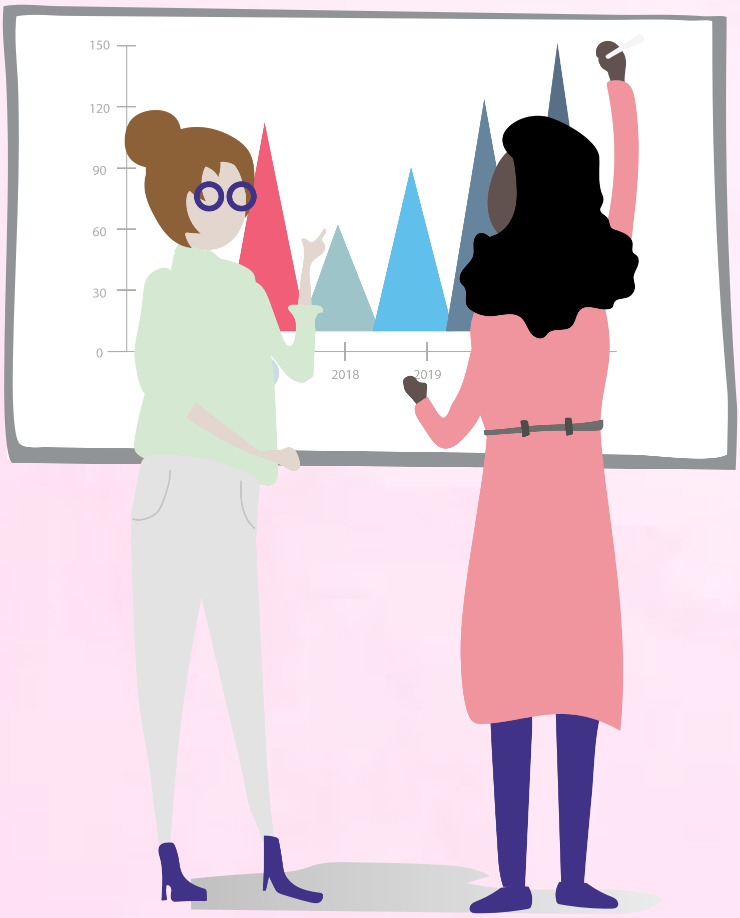


*Data from 2014–15 ‡Data from 2019 §Data from 2015

The condition is associated with numerous negative outcomes throughout a person's life, including poorer academic performance, reduced earnings, other chronic illnesses, diminished quality of life and a higher chance of premature death.[5] [6] Depression is also the leading cause of suicide[7] – as many as 15% of people with untreated depression may die by suicide.[1] Up to 60% of all deaths by suicide worldwide are associated with depression.[8]

The COVID-19 pandemic has exacerbated the already significant crisis of depression. Demand for mental health services has soared while availability of in-person care has been constrained.[9] It is estimated that the pandemic was responsible for an additional 53.2 million cases of depression in 2020.[10]

Despite a growing understanding of depression and how best to support people living with the condition, global prevalence has risen nearly every year since 1990.[11]

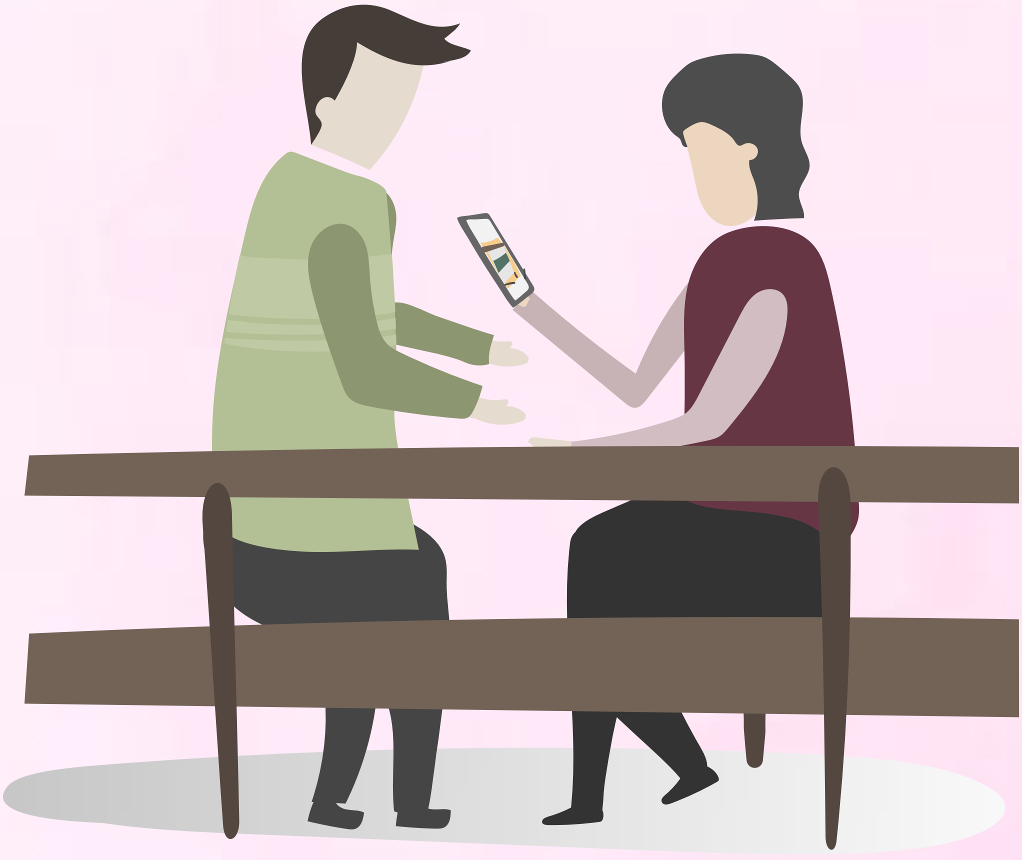


Depression scorecard for Germany

Germany has a high burden of depression. Just over 10% of people in Germany have depression or are living with depressive symptoms. This is significantly higher than the European average of 6.6%, although the difference mostly relates to mild forms of depression.[12 18] Rates of depression are particularly high among young people.[18] In 2020, more than 9,200 people died by suicide – a rate of about 25 deaths per day – with suicide rates twice as high in some federal states (Sachsen-Anhalt) than in others (North Rhine-Westphalia).[19] Globally, it is estimated that depression may contribute to up to 60% of deaths by suicide.[8]

Awareness of depression seems to be growing among healthcare providers and the wider population. While the number of people experiencing depression has been relatively constant over time, this contrasts with an increase in diagnoses in recent years.[20 21]

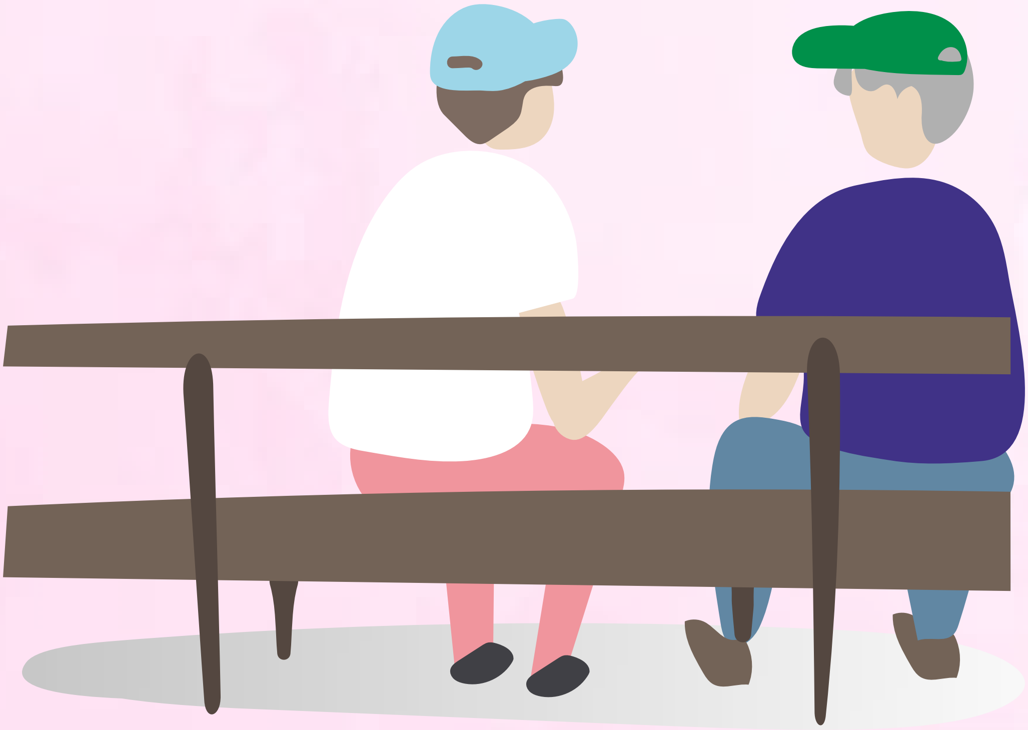
Depression is an important driver of healthcare costs. Direct excess healthcare costs for people with depression are twice as high as for those without depression (hospital and outpatient care as well as medication).[22] In addition, wider societal costs, including sick leave and early retirement, are more than twice as high among people with depression as among those without.[22] Of people receiving a state pension in compensation for their reduced ability to work in 2019, a staggering 42% did so because of mental health disorders, with a large proportion likely to be people with depression.[23]



Healthcare services for people with depression in Germany are comprehensive and delivered to a high standard. There is a range of healthcare professionals able to diagnose and treat depression. These include mental health specialists, such as psychiatrists or psychotherapists, and specialists in psychosomatic medicine in outpatient settings as well as hospital and specialist inpatient settings. In addition, depression can be diagnosed by other qualified healthcare professionals.[24] Despite this, it is estimated that about two thirds of people with symptoms of depression do not receive any psychotherapeutic or psychiatric care.[25] Many people with depression will first and foremost seek help from their general practitioner (GP).[24]

Despite some improvement in recent years, difficulties in accessing mental health services persist in some regions. People in rural areas, and in some parts of eastern Germany, are most likely to encounter difficulties in accessing specialist care for depression. While there have been efforts to support people in finding a mental health specialist, these cannot compensate for the lack of availability in some areas.[26 27]

As with many other health topics in Germany, there are no national or regional mental health plans or strategies for depression. There is also no government lead for mental health, although there are ombudsmen for nursing and long-term care, patient rights and addiction.[28 29]



Assessing depression management: the scorecard

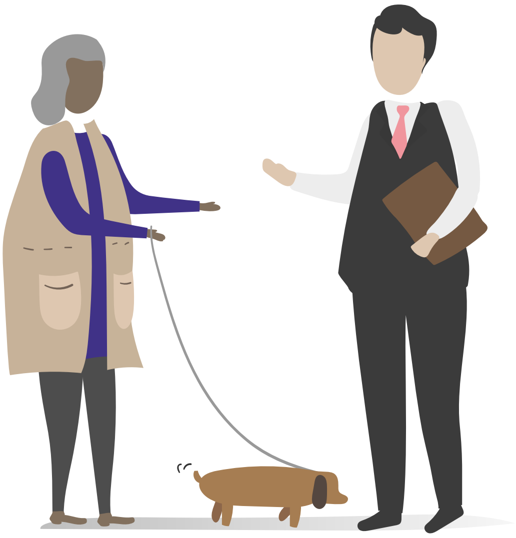
This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Germany. It is our hope that this document may galvanise policymakers to work in close partnership with all stakeholders to reverse the course of depression in Germany, taking a comprehensive and preventive approach to address it in all its complexity.

The scorecard focuses on four key areas, identified as priorities for improvement:

1

Joined-up and comprehensive depression services

Integrated care – that is, a patient-centred system that supports the person with depression throughout their lifetime and with continuity across the health system – is essential to delivering adequate support and treatment. Integrating mental health services into wider health and social care services is convenient and can increase treatment rates, improve comprehensiveness of care and reduce overall costs.[30]



2

Data to drive improvements in depression care

Collecting and analysing robust and up-to-date data on depression is essential for ensuring the right services are available for everyone who needs them. Monitoring patient outcomes helps to identify and inform good practice, and may give hope to service users that their mental health can improve.[30] Data on services can support clinicians, policymakers and people with depression to better understand what treatment options are available and accessible. More transparent data will also facilitate shared learning across all domains of depression care. New digital tools may have the potential to facilitate documentation for transparency and research purposes while retaining the anonymity of the user.[30]

3

Engaging and empowering people with depression

It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.[31] Peer support, whereby a person who has previously experienced depression offers empathy and hope to others in the same position, can assist both people with depression and their peer supporter in their recovery.[32] Social systems, patient advocacy groups and other civil society organisations with access to underserved communities are critical in ensuring mental health services reach everyone, including those who have 'slipped through the net.'[30]

4

Harnessing technology to improve access to depression care

Digital platforms such as those which facilitate remote therapy sessions and online prescription requests, as well as other depression-focused software, smartphone applications and virtual platforms, can allow greater choices of treatment for people with depression while supporting them to take more control of self-managing their condition. While virtual sessions cannot replace in-person therapy, they may be a flexible option to support people with depression between regularly scheduled visits. Health and social services may also use digital tools to facilitate data collection and monitor care.[33] [34] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[35]

Summary scorecard for Germany

Joined-up and comprehensive depression services

Is depression included in either the national health plan or a specific plan for mental health?	●──
Is there a government lead on mental health, with cross-ministerial responsibility to support a ‘mental health in all plans’ approach?	●──
Is collaboration between primary care and mental health services supported and incentivised/encouraged/facilitated?	─●─
Are there guidelines on depression care developed jointly by primary care and psychiatry?	──●
Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?	──●

Are depression services available and tailored for at-risk groups?

▪ Young people	─●─
▪ Older people	●──
▪ People in the workplace	─●─
▪ Homeless people	●──

Data to drive improvements in depression care

Are data on people with depression systematically collected by the health system?	─●─
Are data on mental health services being used for planning?	●──
Are patient-reported outcomes being measured systematically?	●──

No	●──
Somewhat	─●─
Yes	──●

Engaging and empowering people with depression

Do guidelines or care pathways for depression recognise the importance of patient empowerment?	──●
Were patient and carer representatives involved in the most recent national plan or strategy covering depression?	**N/A**
Is peer support recommended in depression care guidelines?	●──
Do guidelines on depression recognise the role of families and carers in making decisions on the planning and delivery of care?	──●
Do carers have access to financial aid to help them support their loved ones with depression?	──●
Are peer support roles reimbursed?	●──

Are there national associations advocating for the rights of:

▪ people living with depression?	──●
▪ carers of people living with depression?	──●

Harnessing technology to improve access to care for people with depression

Can patients access depression support remotely (via telephone or the internet) in addition to services delivered face-to-face?	─●─
Do professional societies or guidelines recommend the use of remote services alongside face-to-face services?	──●
Is remote support for depression reimbursed?	──●
Are people with depression able to use telephone or online platforms that allow them to renew their prescriptions from home?	─●─

Joined-up and comprehensive depression services

A wide range of services are available to people with depression in Germany, although access can vary

A wide range of fully reimbursed therapeutic options are available for people with depression. These include cognitive behavioural therapy (CBT), analytic psychotherapy, depth psychology-based therapy and systemic (family) psychotherapy, as well as pharmacological interventions and neurostimulation.[24] In principle, access to care for depression is simple, as people can visit any provider directly. Sickness funds pay for a generous number of sessions for individuals in need of psychotherapy.[36] People will need approval from their sickness fund if they enter into longer-term therapy with a psychotherapist, but this is often a formality given that permission is based on the therapist's assessment.[36]

In practice, however, access to care may be more complicated owing to regional variation and gaps in the availability of mental health specialists for specific groups. The average waiting time for a psychotherapy appointment is almost 20 weeks, although this masks substantial regional variation.[37] In 2019, approximately 40% of people diagnosed with a mental health condition waited between three and nine months to begin psychotherapy.[38] Children and young people often face particular challenges owing to growing demand and a shortage of tailored services.[26 39] The stigma and feelings of shame that are associated with a diagnosis of depression – and mental health conditions more generally – also persist, further impacting the likelihood of people seeking care.[40] In addition, there are very few services that address the needs of vulnerable groups, such as people who are homeless or refugees.[26]

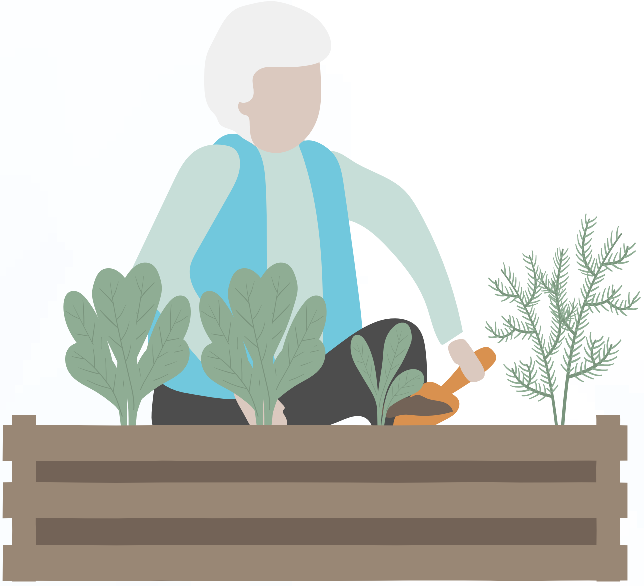
GPs play a prominent role in delivering care to people with depression, but this may not always be appropriate. Despite accounting for more than half of all diagnoses of depression, GPs are less likely than mental health specialists to diagnose specific types of depression.[41] This has important implications for people with severe depression, almost 40% of whom are treated by a GP only, without access to the specialist services they need.[24] While specialist training on diagnosing depression is available for GPs, this is part of continuing professional development and is entirely voluntary.[42 43]

Although comprehensive clinical guidelines for treating depression exist, adherence is often inconsistent. For example, only 24–40% of people with depression (depending on illness severity) receive the recommended minimum of 10 psychotherapy sessions or adequate pharmacotherapy within the first 12 months of diagnosis.[44] While people can access psychiatric care in inpatient and outpatient hospital settings directly, they may find it difficult to identify and access the most appropriate treatment options.[45]

Gaps in the coordination of care may act as a barrier for people with depression, preventing them from accessing continuous care across primary and specialist services

Coordination between GPs and specialists has improved over time, but there is still a need to strengthen cooperation between providers. Ambulatory psychiatrists often act as coordinators of care for people with chronic mental health conditions to help them avoid hospitalisation.[16] However, many people with depression do not see a psychiatrist and instead receive treatment from their GP.

In addition, care for depression has been described as being disjointed and insufficiently coordinated, undermining the delivery of quality care.[16] Both people with chronic depression and those with recurring depression often face gaps in care, if they require ambulatory care for routine management of their depression and hospital care when dealing with more severe episodes. There are barriers to transitioning between different levels of the health system, resulting in suboptimal care. A recent study found that 92% of people with severe depression and 50% of people with moderate depression who had been discharged from a psychiatric hospital had not received follow-up treatment in line with clinical guidelines, and 21% of people treated for depression in a psychiatric hospital were readmitted within less than a year.[37] Following discharge from hospital, people waited 17 weeks on average to continue care in the community, reflecting long waiting times for psychotherapy in some areas.[37] Group psychotherapy could be used to compensate for the shortage of individual psychotherapy places available, but it is less well established in Germany than in other countries.[37] Researchers aim to better understand the factors behind the increased risk of suicide in people who have been discharged from a psychiatric hospital, and whether such risk can be reduced by providing follow-up care from mental health specialists in the community.[46]

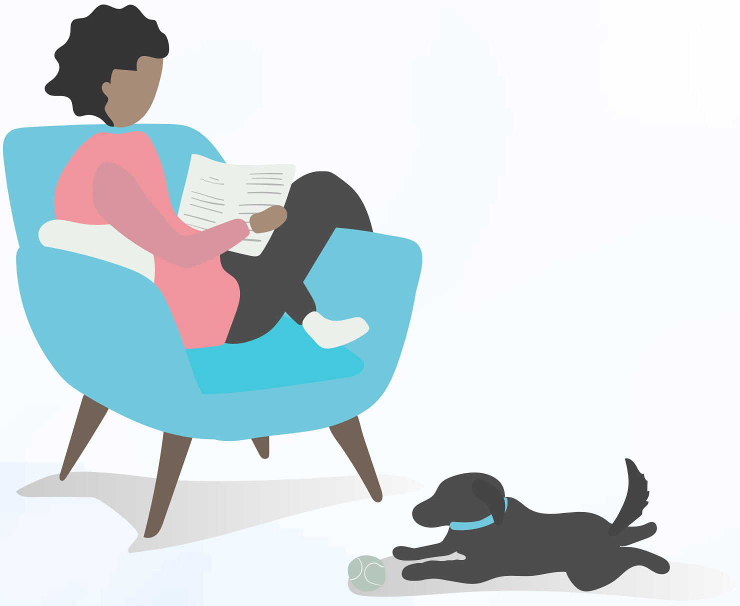


Efforts are being made to improve the coordination of care for people with depression

In 2019, a disease management programme was created for people with chronic and recurring depression (**Case study 1**). There have also been efforts to improve coordination of care and establish referral pathways for people with mental illness through contracts between individual sickness funds and providers or provider networks (selective contracting).

Case study 1. Disease management programme for severe depression[47]

In 2019, the Federal Joint Committee authorised a disease management programme (DMP) for the treatment of chronic depression or recurring depressive episodes. The details of how the programme will be implemented at the regional level are currently being agreed but, broadly, the DMP aims to provide a coordinated treatment pathway based on evidence-based guidelines, which allows for tailored care based on a detailed diagnostic assessment. The DMP sets out the responsibilities of the treating physician, which include care planning, documentation and coordination, such as organising a referral to a specialist in an inpatient or outpatient setting. The preferences of the person with depression are central to the DMP. The programme also recommends involving the person in the development of their care plan.



A number of other initiatives are also being implemented to improve continuity of care for people with depression. These include the Psychiatry-Neurology-Psychotherapy (PNP) programme introduced in the state of Baden-Württemberg for members of one (large) sickness fund, AOK. The PNP combines gatekeeping by GPs with a referral pathway to specialist inpatient and outpatient mental health care.[48] The programme is an extension of the gatekeeping-based GP contract. Studies so far have shown mixed results, with no difference in patient outcomes and satisfaction; however, there was a reduction in inpatient stays and sick pay compared with routine care.[48 49] In addition, there are a number of pilot projects and selective contracts through which individual sickness funds finance novel care models for depression.[50] These have not yet translated into improvements outside their project areas.

Recent changes in regulation aim to improve the transition between ambulatory and hospital care for people with severe mental illness, including depression. From September 2021, guidance issued by the Federal Joint Committee has enabled reimbursement of services delivered by networks of mental health care providers in both ambulatory and outpatient settings.[51] Provider networks have to meet certain criteria to qualify; for example, they need to ensure participation of at least ten psychiatrists or psychotherapists, at least one hospital with a psychiatric or psychosomatic department, one domiciliary care provider and one occupational therapist. Key aims are to ensure better care coordination, timely diagnostics and quality-assured therapy, delivered according to clinical guidelines and based on a treatment plan which integrates the social environment of the person with depression and is tailored to their preferences. In addition, networks will be able to integrate services of non-medical providers, including crisis intervention teams, self-help groups, long-term care services and providers that specialise in serving vulnerable groups such as refugees.[51]

Although cross-sectoral initiatives that address depression seem to be lacking, some efforts are being made to improve mental health in the workplace

In 2020, the Federal Ministry of Labour and Social Affairs – together with the Federal Ministry of Health and the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth – launched an initiative to improve mental health and reduce stigma associated with mental health disorders in the workplace.[52] The initiative also aims to encourage people to seek care if they feel they are unable to cope and require professional support.

Data to drive improvements in depression care

Comprehensive data on depression are not yet systematically collected or used for service planning and improvement

There are no registries in Germany that systematically collect data on the prevalence or treatment of depression. There are plans to introduce a national mental health surveillance system, but this has not yet been implemented (**Case study 2**).[53] There is a substantial amount of data collected for administrative and claims purposes.[26] The Institute for the Hospital Reimbursement System (InEK) collects data on service use through the diagnosis-related groups system in psychiatry and psychosomatic care (PEPP), used to facilitate the reimbursement of inpatient services. These data are available to medical associations, clinicians and researchers, but they are not used for regional or national service planning.[45]

The Robert Koch Institute, Germany's leading governmental institution in the field of biomedicine, has conducted several population-based studies with mental health components, including depression:

- Studie zur Gesundheit Erwachsener in Deutschland included a mental health module covering the years 2008–2011.[54]
- Gesundheit in Deutschland aktuell included items on the users of psychotherapeutic and psychiatric services as part of another study.[25]
- Studie zur Gesundheit von Kindern und Jugendlichen in Deutschland (KiGGS), a long-term cohort study, collected data on the effects of mental health disorders on the lives of young people. Beginning in 2003, data were collected in three waves, most recently from 2014 to 2017.[55]

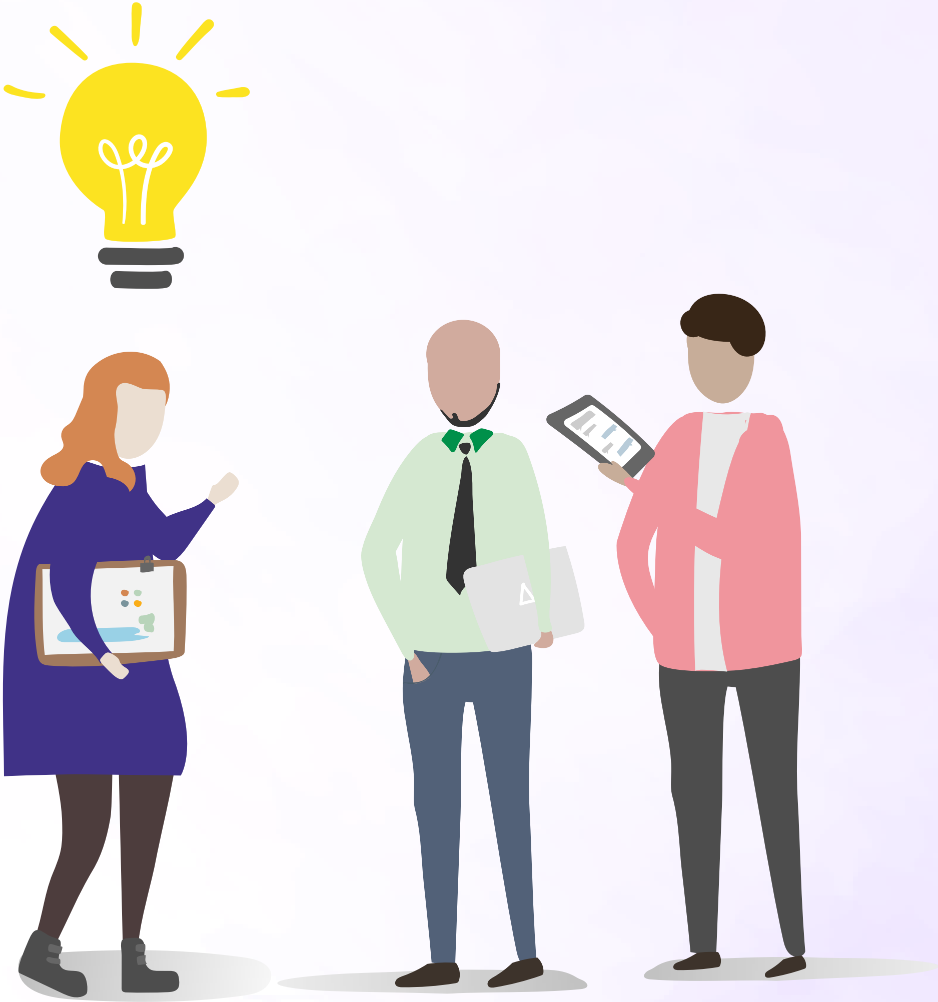
Case study 2. Establishing mental health surveillance[53]

In 2019, the Federal Ministry of Health commissioned the Robert Koch Institute to develop a concept for population-based mental health surveillance (MHS). To date, an indicator set has been developed, approved by expert consensus and recently piloted. The aim of the MHS is to inform mental health prevention and service improvement by monitoring the determinants of mental health, the prevalence of mental health problems, care services utilisation, quality and costs, as well as health outcomes and other social impacts such as labour market participation and poverty risk. The indicator set focuses on MHS of the adult population; however, there are plans to also develop indicators for children and young people.

There is a general lack of data on patient-reported outcome measures for people with depression

Although patient-reported outcome measures (PROMs) are collected by some institutions for the purpose of research, there are no systematic national- or regional-level commitments or guidelines for these data. There is no official strategy or commitment to collect PROMs systematically in any area of healthcare in Germany, including mental health services.[56]

Efforts are, however, being undertaken by some larger university hospitals and psychiatry departments to use and develop PROMs. These aim to measure the effects of the care provided and strengthen the patient-centredness of services. The Federal Ministry of Health has commissioned a brief review of the international experience and use of PROMs in Germany.[57] No further plans have been announced, but it is hoped that the publication of the review will stimulate dialogue between research, practice and policy.[58]



Engaging and empowering people with depression

Clinical guidelines acknowledge the importance of engaging people with depression and their loved ones in treatment

Clinical guidelines emphasise the therapeutic triad of patient, carer and healthcare professional.[24] Guidelines for the treatment of depression state that people need to be informed about both the implications of their treatment and treatment alternatives. Organisations representing people with depression and their loved ones participated in the development of clinical guidelines on depression, as well as professional standards for psychotherapists.[24 36]

Patient preference is listed in clinical guidelines as a key determinant of the choice of treatment, in addition to clinical factors, severity of symptoms and disease history.[24] Guidelines recommend the use of evidence-based patient information and decision support tools to strengthen participation from people with depression and their loved ones. They outline the requirements for shared decision-making and emphasise the role of education and information available.[24] However, pressures on time and resources can undermine efforts to engage the person's loved ones, and their involvement in the development of treatment plans can be less than ideal.[26]

Financial support is available for carers of people with depression

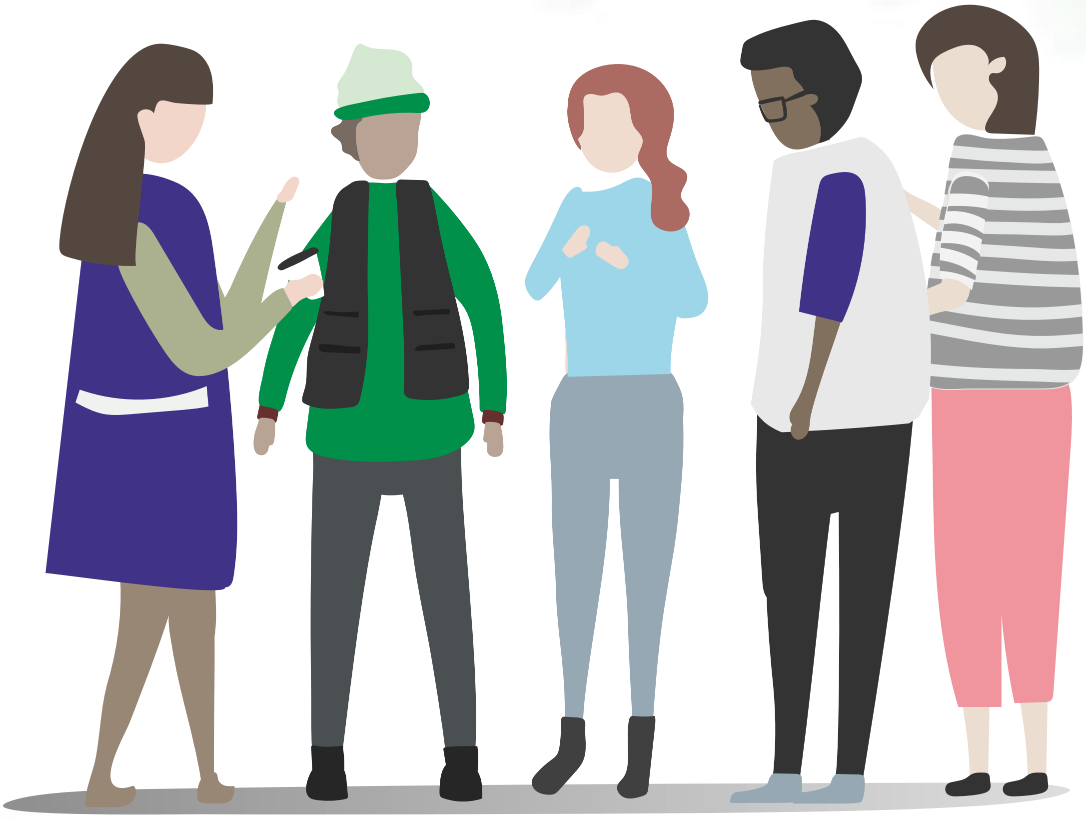
Family and informal carers can receive financial support (Pflegegeld) if they are the main carer for someone with severe depression on a long-term basis.[59] Mandatory long-term care insurance pays about €300–900 per month depending on the level of assessed care need, with depression being a recognised cause of the need for care.[59] This money is paid to the person with depression following a needs assessment and eligibility check, and can be used to compensate friends and family for informal care they have provided.[60]

Peer support is not recommended in clinical guidelines, although it is promoted by self-help groups and is available in some workplaces

Peer support is not yet fully established as a therapeutic support option. It is already available in some settings (**Case study 3**), but according to an expert interviewed for this report, not all people understand its role and purpose, and there is a need for better information and education for both people with depression and healthcare professionals.[26]

Case study 3. Peer support in the workplace[61]

Some large employers support projects that introduce peer support in the workplace. Deutsche Bahn (Kollegiale Depressionsbegleiter) initiated a peer support project to reduce the stigma of depression and provide peer-to-peer support for employees. Employees with experience of depression act as peers and receive training on how they can provide advice to and support colleagues with depression. In 2019, ten peer supporters were trained in offices in Frankfurt and Berlin.



Harnessing technology to improve access to care

Remote consultations and other digital tools are increasingly becoming available to people with depression in Germany

Telemedicine use has increased in Germany owing to the COVID-19 pandemic.[62] Video consultations were authorised for reimbursement in 2017,[63] but initially they were used infrequently. The total number of video consultations increased from 3,000 in 2019 to 1.2 million in the second quarter of 2020 (April to June), with psychotherapy seeing the steepest increase. At the same time, the number of doctors and psychotherapists offering video consultations increased from 168 to more than 31,000.[64]

A range of digital tools are available for people with depression, usually used in addition to face-to-face consultations.[50] These include mobile apps for stress reduction and meditation, online therapies for people who are waiting to start therapy, video sessions with psychotherapists and online programmes based on CBT.[65]

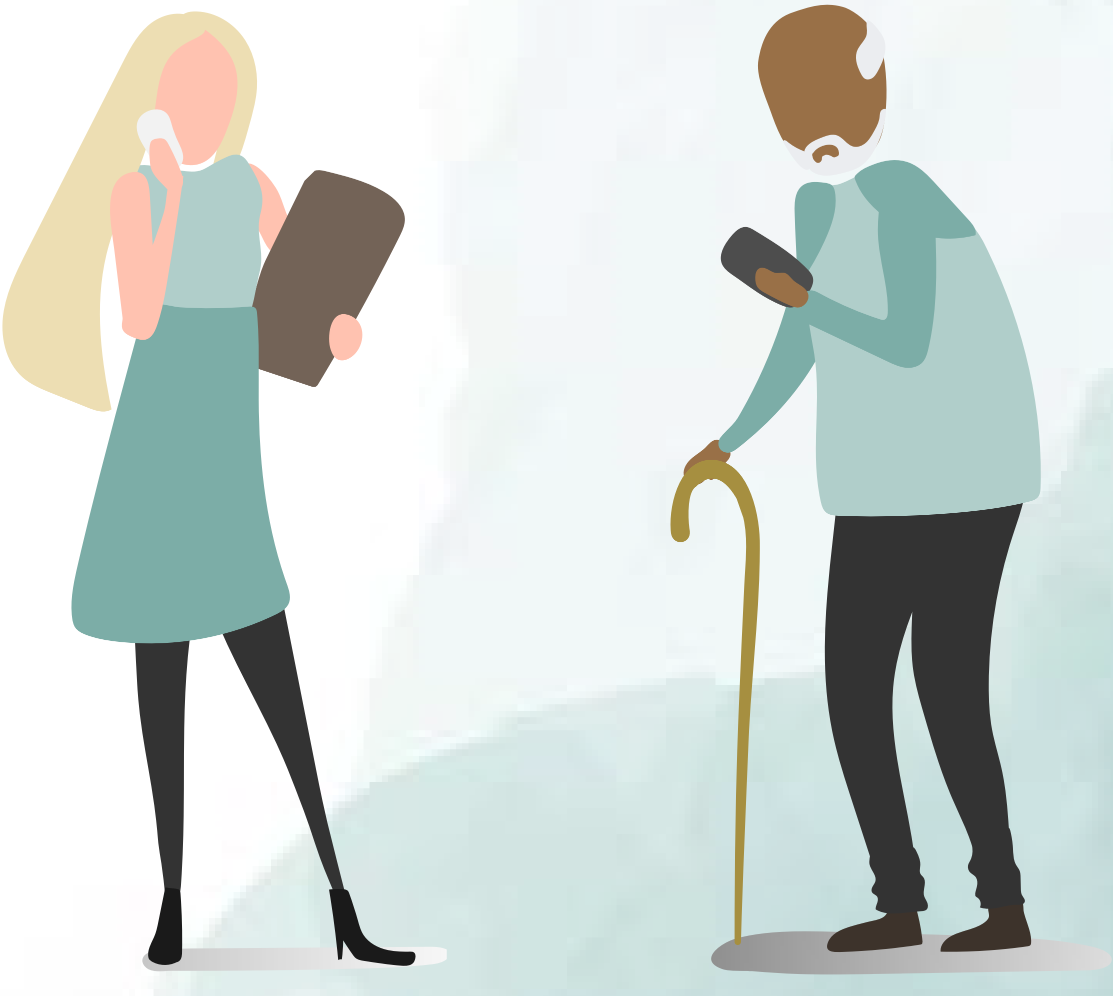
The government is supporting practitioners and people with depression to choose the most appropriate digital options by developing a list of approved applications. The Federal Institute for Drugs and Medical Devices (BfArM) has begun to collate a list of digital applications (DiGA-Verzeichnis) that are approved for use and reimbursed by all sickness funds.[66] The DiGA directory currently includes four digital applications for depression. These are permanently available or preliminarily available, pending the emerging evidence:[66]

- Deprexis – an online self-help programme based on CBT that can be used in combination with face-to-face consultations
- HelloBetter Stress and Burnout – an online educational programme conveying coping strategies based on CBT
- Novego: Depressionen bewältigen – an online support programme for people waiting to begin psychotherapy, which can also be used alongside or after face-to-face consultations
- Selfapy – a programme based on CBT, which is tailored to the needs of individuals and monitored by a psychotherapist.

People interested in digital tools can check online whether their sickness fund will pay for their use.[65] Some sickness funds also reimburse the use of other tools, but this is highly variable. Some tools are well established and reimbursed by larger funds, while others are seen as being more experimental or targeted at a specific user group such as younger adults.

Electronic prescriptions are not yet routinely available in Germany, but trials are underway to prepare for a full roll-out which could facilitate easier access to medication for depression

Since July 2021, electronic prescriptions have been piloted in the federal states of Berlin and Brandenburg, and they are expected to be rolled out nationwide in due course.[67] Roll-outs of other remote applications – including electronic patient records, remote case management meetings, electronic sick notes and electronic doctors' letters – are also being considered and have the potential to benefit people with depression.



Conclusion and recommendations

> ‘In Germany, only a fraction of people with depression are treated according to clinical guidelines. We are missing many important opportunities to prevent mild to moderate depression from becoming more severe.’
>
> **Ute Lewitzka,**
> **University Hospital Carl Gustav Carus, Dresden**

Healthcare services for people with depression are robust and well developed. However, there are still gaps because of substantial regional variation in access to suitable healthcare providers and therapies, in both ambulatory and hospital settings. For ambulatory psychotherapy in particular, waiting times can be long for people with depression.

Improvements to the continuity of care for people with depression are beginning to be implemented. These include the introduction of a care pathway for people with chronic and recurring depression through a disease management programme, and the formation of mental health networks to improve the coordination of care for people with severe illness.

There are gaps in the collection and use of data on depression. There is currently no systematic collection of data on prevalence, service utilisation and patient outcomes for the purpose of care planning, although some service utilisation data exist through the collection of health insurance claims data within the reimbursement system.

Clinical guidelines emphasise the importance of involving people with depression and their loved ones in diagnosis and treatment. The role of peer support in recovery has yet to be fully recognised and is mostly promoted by self-help groups and by some employers in the form of pilot projects. Financial support for informal carers of people with depression is available through statutory long-term insurance, with the size of payment depending on the level of assessed care need.

Progress in the use of technology to improve access to care for depression is promising. During the COVID-19 pandemic, the government significantly reduced barriers to some remote technologies, such as video consultations and digital applications in support of therapy. However, the use of technologies and remote services in practice is highly variable. Electronic prescriptions are currently being piloted and are expected to be rolled out in due course.

Priority recommendations

Joined-up and comprehensive depression services

- Continue to develop and roll out programmes that promote better coordination of care, which support people throughout the course of their illness and are tailored to their needs and preferences, irrespective of their location or insurance status. Specifically, guidance for the implementation of the new disease management programme for chronic and recurring depression should be finalised and communicated widely among healthcare professionals and people with depression, as well as their loved ones.
- Support GPs and other non-specialist providers in following clinical guidelines to improve diagnosis and care of depression by encouraging and incentivising them to undertake training as part of their continuing professional development.
- Prioritise the development and roll-out of preventive and specialist services for specific groups with depression, including children and young people, older adults, and vulnerable groups such as people who are homeless or refugees.

Data to drive improvements in depression care

- Scale up comprehensive mental health surveillance, following good progress at the pilot stage with the support of the Federal Ministry of Health, and apply it to children and young people in addition to adults. Federal/regional governments and sickness funds should be encouraged to use data that will be collected for service planning, monitoring and improvements.
- Consider how PROMs could be widely and systematically collected and used to drive improvements in care for people with depression and other mental health conditions, building on initial work in this area by some larger university hospitals.

Engaging and empowering people with depression

- Establish peer support networks as part of routine care and provide financial support to formalise and sustain those arrangements, including the development of guidelines to clarify peer supporter roles and responsibilities.
- Provide better information to people with depression and their loved ones about their role in supporting therapy and recovery. This would complement existing arrangements that allow for financial support for carers of people with depression. Time must be allocated during the medical consultation process to support genuine joint decision-making.

Harnessing technology to improve access to depression care

- Support and sustain efforts to establish and expand telemedicine, including increasing the number of applications for depression that have been approved and are reimbursed by sickness funds (Deprexis, HelloBetter, Novego: Depressionen bewältigen and Selfapy).
- Develop remote treatment options, including digital applications, to address the needs of people who are currently underserved and may have difficulties accessing traditional services, including children, young people and older people. Remote treatments should be tailored to the needs and the digital aptitude of specific patient groups.

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