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HEALTH SERVICES RESEARCH ON PEOPLE WITH MENTAL DISORDERS IN THE INTEGRATED CARE SYSTEM 'GESUNDES KINZIGTAL'

Health Needs Assessment and Appraisal of Innovative Approaches to Strengthen Outpatient Care

Master Thesis

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Abstract

Introduction: Mental disorders are a rising issue for the health care systems worldwide. In Europe, 20- 25% of the burden of diseases is caused by these illnesses. In Germany, the prevalence pertains 31% and the most frequent diagnoses are anxiety, substance misuse and affective disorders. Still stigmatized, the level of health care for mentally ill people is inadequate. In many cases the illness is not discovered. However, diagnosed patients are treated with delay or never. In addition, ambulatory treatment places are insufficient and the lack of a holistic approach across the different medical sectors is causing challenges for the patients. This thesis will identify different innovative models which provide a higher level of attention to mentally ill patients and at the same time strengthen the outpatient care. Models of integrated care are one option to overcome the barriers of the divided medical sectors with the objective to accomplish improved care quality with an optimized treatment process while keeping the economic aspects in sight as well.

Methods: An adapted health needs assessment is conducted for people with mental disorders based on literature research and an analysis of routine data in the integrated care system 'Gesundes Kinzigtal'. The appraisal of the innovative approaches of the outpatient care is done through a focus group discussion with experts from 'Gesundes Kinzigtal'.

Results: The comparative analysis of data from Germany and 'Gesundes Kinzigtal' shows several similarities, for instance a prevalence of mental disorders of around 30% and several parallel diagnoses exist. There are multiple approaches in Germany for a strengthened outpatient care available, but quite often with missing transparency and evaluation processes. The experts in the focus group discussion made two suggestions for an enhanced care of mentally ill people.

Conclusion: The different approaches of ambulatory care illustrate the awareness of health care providers and policy that innovative projects are necessary for a better health care of people with mental disorders and for a handling of the rising demand.

Keywords: Integrated care, Gesundes Kinzigtal, Mental disorders, Health services research, Health needs assessment, outpatient care

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List of Abbreviations

ACT	Assertive Community Treatment
AOK	‘Allgemeine Ortskrankenkasse‘
BKK	‘Betriebskrankenkasse‘
BPtK	‘Bundespsychotherapeutenkammer‘
CM	Case Management
DAK	‘Deutsche Angestellten Krankenkasse‘
DALY	Disability Adjusted Life Years
DCM	Dementia Care Manager
DGP	‘Dachverband Gemeindepsychiatrie e.V.’
E- Health	Electronic Health
Et seq.	And the following
F- Diagnosis	Mental disorders are categorized in the group F00- F99 in the ICD catalogue
FGD	Focus Group Discussion
GAPSY	‘Gesellschaft für Ambulante Psychiatrische Dienste GmbH‘
GK	Gesundes Kinzigtal
HNA	Health Needs Assessment
HSR	Health Services Research
HT	Home Treatment
HV	Home Visit
IC	Integrated Care
ICD	International Classification of Diseases
ICGK	Integrated Care Gesundes Kinzigtal
i.i.	Individual Interview
LKK	‘Landwirtschaftliche Krankenkasse’
MQNK	‘Medizinisches Qualitätsnetz Ärzteinitiative Kinzigtal e.V.’
n.v.	No Value
PA	Practical Assistance
r.	Row

SHI	Statutory Health Insurance
SMS	Short Message Service
SGB	Social Code Book
UHE	University Hospital Eppendorf
UPD	‘Unabhängige Patientenberatung Deutschland‘
TK	‘Techniker Krankenkasse’
WHO	World Health Organisation

1. Introduction

Mental disorders are a widespread disease of the 21st century. According to the World Health Organisation (WHO) (2015), mental disorders are "[…] one of the top public health challenges in the WHO European Region […] (p.1)" and that an investigation in mental health is "[…] essential for the sustainability of health and socio- economic policies […] (p.1)". Mental health issues are amongst others the main cause of disability and early retirements and the affected people have a lower life expectancy. At the individual level, patients are facing stigma and discrimination (WHOc, 2015). In Europe, the most frequent diagnoses are anxiety, depression, sleeping disorder and alcohol addiction (RKI, 2015). One in five Europeans get a depression during the course of their life. Every third adolescents suffering from depression commits suicide. The prevalence of dementia is rising and causes especially invalidities in the older generation (Pomerleau, et al., 2008).

In the last couple of years, there is a rising awareness about mental disorders in Germany. For a longer period, the importance of the diseases was underestimated due to a lack of reliable data (Schulz, et al., 2008). Wittchen & Jacobi (2001) point to a grave undersupply of people with mental disorders based on the analysis of the Mental Health Supplement from the German Health Interview and Examination Survey in 1998. The illness is rarely recognized in the primary care and thereby supplied later or never (Harfst & Marstedt, 2009). There is a treatment gap despite effective treatments exist (Kohn, et al., 2004). However, ambulatory treatment places are lacking (Bühring, 2003) and people stay longer in the hospital (Knieps & Pfaff, 2015).

Bengel (2015) argues that the German health care system is not prepared for the increasing demand of patients with mental disorders (Stoschek, 2015). The current health care system is divided and specified on their tasks leading to a discontinuity of a need adapted care. One solution was introduced by law with the integrated care (IC) concept, §140a SGB V. The new and innovative concept of IC shall incentivize more quality and efficiency through optimized treatment processes. Moreover, it shall lead to more flexible structures in the rigid health care system and support a more holistic approach across the different medical sectors (Mühlbacher & Ackerschott, 2007). Usually, IC systems exist for a specific patient

group or disease. One exception is the IC model in the South of Germany, called ‘Gesundes Kinzigtal’ (GK). The population based model is successful in improving the experience of care, in enhancing the health of the population as well as in reducing the costs per capita of health care (Hildebrandt, 2014). Mental disorders are also prevalent in GK and cause high expenditures as well as a high number of sick leave days (see chapter 5.1.2.2.).

Health services research is a growing field with a focus on more specific treatment processes, especially related in the light of an aging population with an increase of treatment needs. It is an interdisciplinary approach, which examines the processes, results and accompanying conditions of health care with scientific methods (Koller, et al., 2009). Furthermore, it contributes to the development of evidence based health care concepts (Pfaff, 2003).
This thesis will focus on health services research related to people with mental disorders and its ambulatory provision. Organisations like the ‘Dachverband Gemeindepsychiatrie e.V.’ (DGP) emphasises that moving forward the focus should lay on ambulatory care instead of stationary care for mentally ill people (DGP, 2012). The ‘Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen’ (Gerlach, et al., 2014) recommends that in rural areas the ambulatory care can result in improved overall care for patients while keeping expenditures under control. The writer chose for the analysis of such a rural area the Kinzigtal in Baden- Württemberg, Germany where no compilation of innovative psychiatric programs was done yet.

The aim of this paper is to investigate, which innovative ambulatory model is adequate for people with mental disorders in GK and beyond. At first the master thesis will highlight the objectives of the paper followed by the presentation of important terms being health services research, mental disorders, the concept of IC, and the practical example GK in Baden- Württemberg. The fourth chapter will describe the methods as well as materials used for achieving the objectives. The next chapter will explain the results of the health needs assessment and will also describe the appraisal of the innovative approaches. In chapter six a discussion about the methods and results takes part and the last chapter closes with the conclusion as well as the outlook.

2. Objectives

The research objective of the master thesis is to investigate which outpatient health care model for mentally disordered people seems to be most adequate for the integrated care system ‘Gesundes Kinzigtal’ (ICGK) leading to enhanced care and health outcomes.

In order to achieve that, health services research occurs for mentally ill patients. The supply situation of this patient group will be identified and analysed within the geographical scope of Germany in general as well as GK in particular. The pattern of health care utilization of one high- cost patient in GK exemplarily demonstrate his flow through the system.

Further, the thesis will assess innovative approaches related to ambulatory care for mentally disordered as well as their current state of research and evaluation. To provide a better overview of these analyses a classification grid based on the scope of services in the writer’s own design has been developed.

In conclusion the aim of this paper is to appraise these approaches regarding their feasibility and practicality within defined categories.

3. Definitions

This chapter deals with important terms of the thesis. At first, health services research is described, followed by mental disorders. The third sub item defines the concept of IC. Afterwards, the fully IC system GK is characterized.

3.1. Health Services Research

According to Lohr & Steinwachs (2002), health services research (HSR) is "[…] the multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care, and ultimately our health and well- being. Its research domains are individuals, families, organizations, institutions, communities, and populations (p.16)." The term 'health services research' originated in 1966 in the United States of America to answer health policy concerns regarding quality and costs of care as well as the access to it (Lohr & Steinwachs, 2002). The central idea is the optimisation or replacement of existing standards. Therefore, the recognition and overcoming of progress barriers is crucial. A mixed method approach is a requirement of sustainable research strategies (Schmacke, 2004).

Summarised, HSR is an interdisciplinary approach, which examines the processes, results and surrounding conditions of health care with scientific methods. In Germany, the field of HSR is relatively new and the quality of the methods in studies often criticized as there are no uniform standards at the moment available (Koller, et al., 2009).

3.2. Mental Disorders

There exists no common definition about the term ‘mental disorders’. It is difficult to determine characteristics from the outset due to a multiplicity of symptoms. A mental disorder is described as a clinically meaningful behaviour and experience pattern which is characterised by:

- Disorders of psychological, biological or behavioural function (for example strains of the regulation of the mood),
- Suffer,
- Impairment and loss of freedom, or
- A high risk of self- damage (for example suicide) (Walter, 2009).

The World Health Organisation (2015) defines mental disorders as a broad spectrum of problems with different symptoms. In general, the illness is characterised as a combination of abnormal thoughts, emotions, behaviour and relationships with others. Most of the mental diseases can be treated and effective strategies to prevent them exist. The access to the health system and to social services for the treatment as well as social support are essential for the care of patients with psychiatric issues. Determinants[1] of psychological health and disease do not include only individual features like feelings or the capacity to manage own thoughts. Even social, cultural, political and surrounding factors like working conditions influence the risk to develop a mental illness (WHOa, 2015).

For the diagnosis and classification of diseases, the International Classification of Diseases, Tenth Edition (ICD- 10)[2] of the WHO is prevalent. With the aid of the classification, homogeneous analyses of incidence, prevalence and other relevant questions can be made. Mental disorders are placed in the category F00- F99 (WHOb, 2015). The master thesis refers to this classification system due to its widespread use.

Besides the classification system Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition[3] of the American Psychiatric Association is mentionable.

[1] For further information: Social determinants of health, http://www.who.int/social_determinants/en/. Access on 4th August, 2016.
[2] For further information: www.icd-code.de. Access on 25th May, 2016.
[3] For further information: http://allpsych.com/disorders/dsm/. Access on 4th August, 2016.

It lists all psychological diseases with causes, statistics and approaches for the research for an optimised treatment (Heffner, 2015).

3.3. Integrated Care

According to § 140a (1) SGB V, the concept of IC is either a different service sectors crossing or an interdisciplinary care.

Until now, the care in the statutory health insurance (SHI) in Germany occurs in different service sectors, with a strong specialization and division of tasks. The missing coordination at the cutting points of the sectors leads to a discontinuity of treatment processes and impedes a need adapted care for patients. The sectoral budgeting and the fragmented coordination of the treatment courses are the main reasons for an increase in the utilization of services and higher expenditures in the SHI. The rather new and innovative concept of the IC makes incentives for more quality, economy and optimized treatment processes. The insurances and service providers are allowed to make contracts for the insured people autonomously. From that, new forms of organizations and company networks can develop with new offers and compensation schemes. The law for IC was introduced in 2000, but with poor economic structures of implementation. Four years later, the Modernization Act of the SHI offered a more flexible approach. The main aim of IC is to bring more flexible structures to the rigid health care system and to improve a sector crossing cooperation for a better treatment quality and to benefit from the efficiency potential (Mühlbacher & Ackerschott, 2007).

Schreyögg, Weinbrenner, & Busse (2013) describe the following aspects as essential of the IC model:

- A successful integration, with the process of the treatment in the foreground and to overcome sectoral boundaries;
- A co-operation of the service providers regarding the aims and contents of care;
- A coordination of the different activities and disciplines;
- An efficient communication about performed diagnostic and therapy;
- A continuously transfer of information.

The following figure 1 (originally from Gerlach, et al., 2009, p.165) shows the concept of IC.

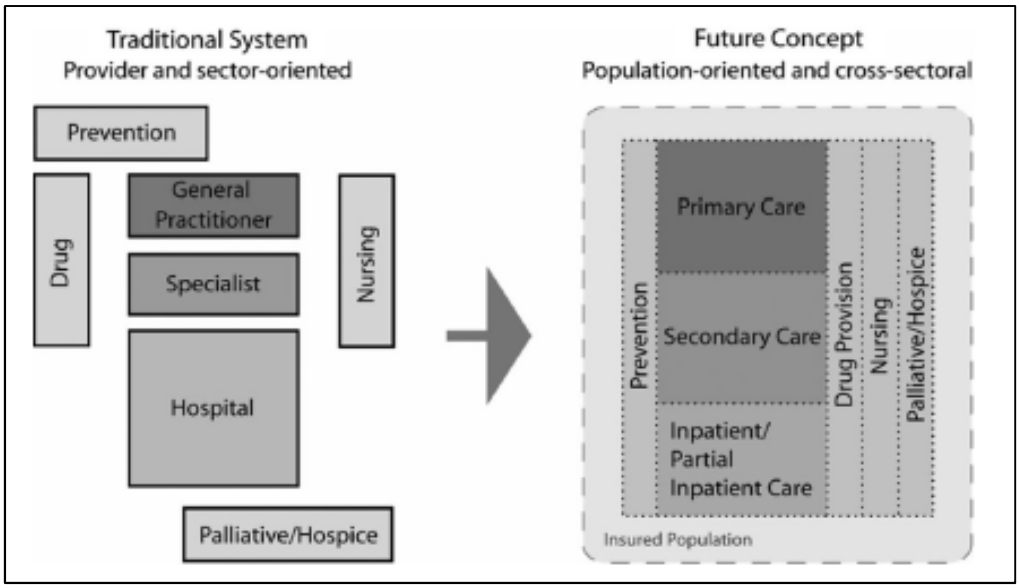


Figure 1: From sector- to community- oriented care (Hildebrandt, Schulte, & Stunder, 2012, p.220; modelled after Gerlach, et al, 2009, p.165)

The fragmented division of tasks in the traditional system is visible. On the opposite stands the IC model with its sector- crossing and population- orientated care. The different stakeholders of the health care system work together for a better care of the patients (Gerlach, et al., 2009).

Integrated Care in the Psychiatric Field

The concept of IC also took its way into the psychiatric area. First in 1975 with the Psychiatry Enquiry[4], the following four ultimate principles were formulated for the care of mentally ill people in Germany:

- Supply in the community,
- Tailored and comprehensive care of all mentally ill and disabled people,
- Need adapted coordination of all service sectors, and
- Equalisation of psychiatric and somatic patients (Kunze, 2009).

[4] For further information:http://www.dgppn.de/schwerpunkte/versorgung/enquete.html. Access on 22nd February, 2016.

Humans with mental strains need low threshold offers, prevention of fractured sectors and a permanent cooperation and coordination of the providers for a good care and treatment. These claims are intended to go with the IC in fulfillment (Weatherly & Lägel, 2009). According to the 'Psychenet' (2014), the IC concepts aim to achieve a better performance in health care delivery in a qualitative as well as in an economic way. Furthermore, relatives and the surrounding shall be involved in the care.

In 2006, estimated 1,500 IC contracts were concluded with just 21 in the psychiatric field and usually in a minor extent (Kunze & Priebe, 2006). According to the statistics of the 'Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e.V.', 61 projects were counted in the psychiatric field in 2011 (Psychenet, 2014).

3.4. The Fully Integrated Care System 'Gesundes Kinzigtal'

According to Gerlach, et al. (2014) better coordination and communication across a region as well as need adapted care of different age groups within a population seem to be important to achieve structural efficiency and effectiveness, especially considering the aspect of demographic change. GK is an exemplary model of this recommendation having been a lighthouse project for many years.

The ICGK is the first population based IC system in Germany that is accountable for the care of the insured people in all health sectors and indications. The 'Gesundes Kinzigtal GmbH' coordinates and manages the ICGK since 2006. One year before the company was found by the regional physicians' network 'Medizinisches Qualitätsnetz Ärzteinitiative Kinzigtal e.V.' (MQNK) and the management company 'OptiMedis AG' in Hamburg. The MQNK holds a proportion of 66.6% and the other third of shares is owned by the OptiMedis AG (Hildebrandt, et al., 2012).

The ICGK aims to reduce the morbidity rate, especially the ratio of incidence and prevalence of chronic diseases, with an effective and sector- crossing organisation besides investments in prevention programs. The aim is for the quality of care to

remain as a minimum the same and improve the health benefits for the patients themselves (Siegel, et al., 2012). The philosophy of the IC model refers to the 'Triple Aim' approach (Berwick, et al., 2008): improving the experience of care while enhancing the health of populations, and reducing the health care costs per capita (Hildebrandt, 2014). Health care occurs in co-operation with patients, medical professionals as well as the health insurance companies. Almost 31,000 people from the cooperating insurances 'Allgemeine Ortskrankenkasse' (AOK) in Baden-Württemberg and 'Landwirtschaftliche Krankenkasse' (LKK) in Baden-Württemberg are part of the ICGK due to their regional role within the health care system. In addition, external research partners run studies looking at the impact of the overall health state of the population in Kinzigtal as well as the related expenditures to make comparisons to the rest of the population in Baden-Württemberg of which close to four million AOK and LKK insured people in the state (Hildebrandt, et al., 2010).

Looking at funding of the GK, at the beginning of the IC model, an initial funding was received from health insurance companies which ended in 2007. Since then the Gesundes Kinzigtal GmbH funds itself from the annual shared savings. The company is financed by a saving remuneration contract with the AOK and LKK. Consequently, the company has to work cost efficient while achieving improved health results and increasing patient satisfaction to get a share of the saved expenditures from the two insurance companies (Hildebrandt, 2014).

Patients can enrol in the program of the IC model for free. In 2012 a number of 8,062 members were enrolled in the model receiving access to different offers within the health care system from co-operation partners of the ICGK. The patients are not restricted in their choice of physicians and agree on individual treatment plans and desired outcomes with their doctor of trust. The Gesundes Kinzigtal GmbH provides different health programs and cooperates amongst others with associations and companies in the region (Hildebrandt, 2014). The patients do not get a financial incentive for the enrolment in the IC model. Instead, they have to feel confident about the improved quality of care and the health benefits it will bring (Siegel, et al., 2012). Each member receives an electronic patient file accessible to all service providers recording utilization data of the health care system (Hildebrandt, et al., 2012).

4. Material and Methods

HSR on people with mental disorders was conducted using qualitative as well as various quantitative methods (i.e. mixed method approach).

Health Needs Assessment

An adapted health needs assessment (HNA), originally from Cavanagh & Chadwick (2005), functioned as a guideline and framework for the analysis of the health care situation of people with mental disorders. A HNA is used in the field of health promotion and education. The term 'need' is defined as the difference between a current situation and a more preferable one. The actual position has undesirable characteristics motivating somebody to a worthwhile situation (Gilmore & Campbell, 1996). Somerville, Kumaran & Anderson (2012) define the need as the ability to benefit from the health care. Inequalities of the health care shall be reduced by prevention, treatments or social changes.

A 'needs assessment' is a planned process which identifies the reported needs of an individual or a group. Another person can appraise the needs, rank them according to their significance and plan steps to address them. A needs assessment is a logical starting point for individual activities and the development of programs. The analysis of the needs can be repeated to check the effect of the program. There is a broad spectrum of implementation for the professionals in the public health sector: efforts for a program development can be built on the reported needs, changes and trends can be evaluated over a certain period, and the target group can be characterised in detail (Gilmore & Campbell, 1996). A HNA includes epidemiological, qualitative and quantitative methods to describe a health problem of a community. Moreover, it is an objective and valid method to examine need adapted health services. A need adapted care is of enormous importance due to rising costs and limited resources in the health care system (Wright, et al., 1998).

Cavanagh & Chadwick (2005, p.21) developed five steps for a successful implementation of a HNA, see figure 2 below.

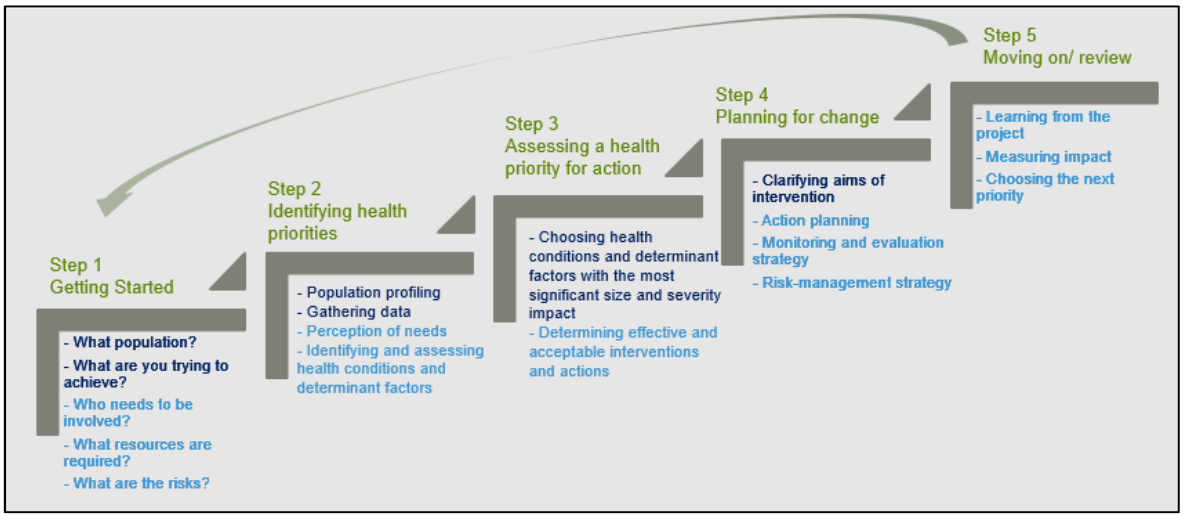


Figure 2: Adapted Health Needs Assessment, originally from Cavanagh & Chadwick (2005) (own design)

Due to length limitations of this thesis not all elements of a complete HNA could be considered. The sub items of the five steps marked in dark blue color in above figure 2 could be incorporated into this thesis. The author chose these items in order to achieve the objectives in the given period of writing the master thesis.

According to Cavanagh & Chadwick (2005), the first step of a needs assessment describes the target population and in what way it relates to national or regional priorities. Furthermore, the aims of the analysis are defined (p.21 et seq.). In the second step a population profiling takes place as well as a prioritization of health problems. Extensive information about the target group shall be collected as well as identified needs and outstanding factors that have an impact on health (p.25 et seq.). The third step includes the determination of a health condition and factors with the most significant size and severity impact (p.36 et seq.). The next step involves the planning for change and intervention. Tasks and activities are determined which meet the defined objectives (p.42 et seq.). The focus of the thesis is on that step. In the adapted HNA, models for a strengthened outpatient care are introduced and classified. Step five contains an adapted performance describing the stepped care model instead of a retrospect to the project. According to Bower & Gilbody (2005), the stepped care model constitutes an analytical framework for a need adapted and efficient supply.

At the beginning of the adapted HNA, an initial literature research has been conducted. Challenges arose when trying to find studies in Germany related to the topic of this thesis due to an underestimation of psychiatric diseases for a longer period (Schulz, et al., 2008). Therefore, only limited data exists. A basic knowledge of the distribution of the disorder exists since the Mental Health Supplement from the German Health Interview and Examination Survey in 1998 (Wittchen & Jacobi, 2001). The main sources for literature and research documents has been the data base PubMed as well as Google Scholar. In the title and abstract of the studies and documents, the terms in table 1 (with synonyms) and combinations of them were sought in English and German.

General data	Outpatient health care models
Mental or psychiatric illness/ disorder/ health, health care/ supply service, health services research, ambulatory/ outpatient care, treatment/ therapy, depression, anxiety, integrated care, Germany, health needs assessment	Case management, collaborative care, home treatment, assertive community treatment, peer support, need adapted treatment, open dialogue, telemedicine/ psychiatry, stepped care, e- health, non- medical assistance

Table 1: Entered terms for the literature research (own design)

Criteria in scope were national data, psychological projects and topics dealing with health services research. Out of scope were studies focusing on one disease.

Moreover, a hand research in famous portals in Germany took part. Major payers like the ‘Techniker Krankenkasse’ (TK), ‘Deutsche Angestellten Krankenkasse’ (DAK) and ‘Betriebskrankenkasse’ (BKK) publish annual reports about their insurance clients. Professional societies like the ‘Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e.V.‘, the ‘Dachverband für Psychotherapie’, the ’Bundespsychotherapeutenkammer‘ (BPtK), and the ’Unabhängige Patientenberatung Deutschland‘ (UPD), deal with mental disorders and make recommendations for a better care. Self- governance stakeholders like the ‘Kassenärztliche Vereinigung’ were other sources.

Furthermore, influential media such as the ‘Ärztezeitung’ or ‘Ärzteblatt’ were interesting. Federal institutions are basic sources of information, for example the ‘Robert Koch- Institut‘, the ‘Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen’, the ‘Statistisches Bundesamt’ as well as the ‘Bundesministerium für Gesundheit’. In a final step, supra- national bodies as the WHO were another reference.

Research based on secondary literature and documents was done on outpatient health care models at Google and cross- references of publications, hospitals and similar. Additionally, the knowledge obtained at two national congresses[5], where the author participated, has been incorporated into the paper. Further, telephone conversations took place with people in authority of the two existing mental programs in GK to gather in- depth knowledge as wells as discussing initial problem solving methods (see appendix 1).

HSR occurred on the basis of routine data of the two cooperating insurances in Baden- Württemberg which are provided to the OptiMedis AG by the Gesundes Kinzigtal GmbH in the scope of the supervision of the IC model. The analytic tool which was used is the ‘Bissantz DeltaMaster’. Furthermore, the program Microsoft Excel helped to identify high- cost patients[6] and to perform calculations and comparisons.

Appraisal of Innovative Approaches

For the appraisal of the innovative ambulatory approaches a focus group discussion (FGD) was performed based on the adapted HNA model.

According to Tausch & Menold (2015), there is a rising popularity in using a FGD. However, methodological requirements are scarce and standard evaluation methods are lacking. That is why, a FGD must be based on the market and social research. With the aid of this method subjective experiences of day to day activities can be reconstructed and help to build hypotheses related to so far limited researched and complex topics. When conducting such discussion, it is

[5] ’Deutscher Kongress für Versorgungsforschung‘, 07.-09.10.2015 in Berlin; ’Neue Versorgungsformen- Ambulante multiprofessionelle Behandlungsteams, internationale Vorbilder und die Umsetzung in Deutschland‘, 19.11.2015 in Kassel.

[6] High- cost patient: a patient with the main diagnose ‘mental disorder’ showing high overall costs in GK.

recommended that participants belong to the same hierarchy within their field ensuring that the researchers get a complete and authentic picture of opinions (Tausch & Menold, 2015). Krueger and Casey (2009) define a focus group as a "[…] special type of group in terms of purpose, size, composition and procedures. The purpose of conducting a focus group is to listen and gather information. It is a way to better understand how people feel or think about an issue […] (p.2)". The people possess similar characteristics important to the researcher (Krueger & Casey, 2009). A group discussion is a specific survey and at the same time more than a questioning of several people. It is a discursive exchange of views and arguments with a possible modification in the course of the discussion. It is a non-standard oral interview in a group with the aim to gather information. A group situation is more realistic and relevant in everyday life than an individual interview. Therefore, it leads to useful results (Lamnek, 2005). Morgan & Bottorff (2010) summarize in their article that there is a wide range of decisions how do conduct and design a focus group. There exist basic decisions at one level, for example who are the participants or how to moderate the discussion. The researchers must decide on their own what is relevant for their goals and with which methods they can achieve them. Therefore, the authors constitute that there "[…] is no single right way to do focus groups (p.579)" (Morgan & Bottorff, 2010). Focus groups usually consist of five to ten people, ranging from four to twelve. "The group must be small enough for everyone to have opportunity to share insights and yet large enough to provide diversity of perceptions (Krueger & Casey, 2009, p.6)". A moderator should guide the interaction of a group as well as a note taker supplements the oral text in written keywords. The group interview lasts circa one till two hours (Rabiee, 2004).

The method of a FGD for this paper was chosen for several reasons. Firstly, the method focusses on the goals of the researcher (= author) and can be arranged flexible (Morgan & Bottorff, 2010). Secondly, a FGD can generate a large amount of data in a relatively short amount of time (Rabiee, 2004). Thirdly, the FGD serves to determine opinions of a group, to gather information and for purposes of exploration. This FGD is conducted only once instead of several times and has an academic approach (Lamnek, 2005). Openness was a big issue in the preparation

process towards the people as well as towards the research situation to get uninspected and instructive information (Lamnek, 1995).

The planning of the FGD for the master thesis started in January 2016. A program coordinator in GK helped to recruit the participants and to organize the meeting. The person knows the existing structures of the fully IC system and has the contacts for an easier recruitment. With this help, the date of the FGD was set on Wednesday, 27th April 2016, from 6:30 pm until 8:30 pm in the 'Gesundheitswelt Kinzigtal'[7] in Hausach, Southern Germany. Furthermore, the meeting included the possibility for physicians to get points for further training from the National Medical Association.

The participants of the FGD are experts, who work in the IC system and know its structure. They are involved actively, when it comes to new projects. In the end, the manager of OptiMedis AG and GK took part in the discussion, as well as two program coordinators, three physicians[8], one medical assistant and one person doing patient coaching and home visits. Eight experts, the author and a trainee dealt with the topic of innovative ambulatory health care models and their feasibility in ICGK. One project coordinator was not able to attend the discussion after all but offered a short individual interview before the FGD, lasting twenty minutes. Having a broad occupational variety supported the ambition to gather different opinions during the discussion and to obtain a better overall picture of the research topic.

The author had a dual function as a researcher and a moderator. The discussion was not planned based on leading questions but rather open ended questions supporting a flexible flow of information and opinion exchange. Different materials and formats were used for the preparation of the discussion and an informed consent was obtained. A matrix of the ambulatory health care models, classified by their services (own design), was handed out. A short description of the models was on the back side (see appendix 2).

[7] For further information: http://www.gesundheitswelt-kinzigtal.de/. Access on 2nd June, 2016.
[8] One general practitioner, one specialist for neurology, one specialist for internal medicine.

The evaluation criteria of the value benefit analysis for the ambulatory models were established in co-operation with OptiMedis AG and are an own design, see following table 2.

	Patient Satisfaction	Health	Costs	Satisfaction as service provider	Feasability	Points
Case Management/ Patient Coaching						
Non- medical Assistant						
Home Treatment						
E- Health						
Peer Support						
Integrated Care Network						
Other Supply Models						
Stepped Care						

Table 2: Value benefit analysis of the ambulatory models (own design)

The Triple Aim (see point 3.4) is the philosophy of GK and important for the realization of new projects. Hence, those criteria (costs, health and patient satisfaction) were chosen for further analysis. The satisfaction as service provider as well as the feasibility of the projects in the IC system are the other two criteria. The author summarized all projects and models into eight groups: case management/ patient coaching, non- medical assistant, home treatment, electronic health (e- health), peer support, integrated care network, other supply models, stepped care.

The participants of the FGD were asked to rate the projects anonymously on a handout (see appendix 3) as follows: three points for the best project, two points for the second best and one point for the third place. Afterwards the handouts were collected. The points were accumulated by the author on a flipchart in front of the participants. The count of points helped to display in a simplified manner the trend of ratings. This trend scheme served as the basis of discussion.

Both surveys, the FGD and the individual interview, were recorded with an audiotape and transcribed in machined form by the author. A transcription is defined as a transmission of an audio or video recording in a written form. A transcript is produced by the simple typing by hand (Dresing & Pehl, 2011). The transcription rules- in style of Dresing & Pehl (2011)- are in appendix 4.

The analysis and evaluation of the transcribed FGD and interview were done according to Krueger & Casey (2009). The author of this paper voted against

Mayring (2008) as he describes the qualitative content analysis in general and Krueger & Casey (2009) specified on focus groups.

Krueger & Casey (2009) constitute that the purpose should drive the analysis. Therefore, twelve categories were composed as seen in figure 3 below (own design).

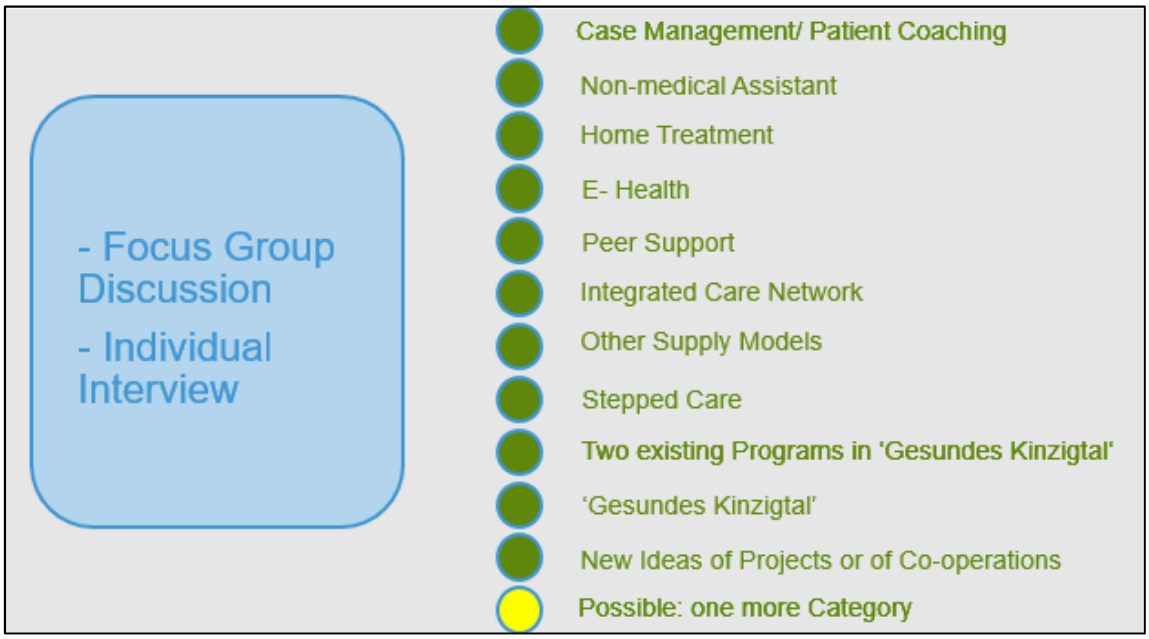


Figure 3: The twelve categories for the analysis of the focus group discussion and of the individual interview (own design)

The development of the categories[9] for the analysis occurred for the FGD as well as for the individual interview as they have the same purpose. The eight groups of outpatient models from the value benefit scheme were chosen as categories, led by the purpose of the FGD: case management/ patient coaching, non- medical assistant, home treatment, e- health, peer support, integrated care network, other supply models, stepped care. The two existing mental programs of GK 'PsychotherapieAkut' and 'Besser gestimmt' are in one category. The category ten is the special feature of the IC system GK itself. Moreover, new ideas of projects or of co-operations build the next category. If there arises another important topic to the group, the analysis shall be open for one more category. Openness is an

[9] The allocation of the categories was done with MAXQDA. For further information: http://www.maxqda.de/. Access an 5th May, 2016.

important feature in planning focus groups (Krueger & Casey, 2009). As the whole group shall rate an innovative project for a possible implementation in GK, frequency, specificity, extensiveness and emotions (Krueger & Casey, 2009) are not important for the analysis.

5. Results

This chapter presents the results of the thesis. At first, the outcome of the HNA will be explained and then the findings of the appraisal from the innovative ambulatory approaches presented.

5.1. Health Needs Assessment for Patients with Mental Disorders in 'Gesundes Kinzigtal'

This sub chapter deals with the application of the adapted HNA for the vulnerable group of mentally ill people in ICGK. In a population based IC system, the methodology of a HNA can be optimal adopted focussing on a comprehensive view and an improvement of the health scoped by a regional population. The supply situation of patients with mental strains meets the requirements of a HNA in consideration of the variability and their effect on the target group. It is correspondingly a suitable object of analysis.

Therefore, the adapted five step HNA is applied. The description and performance of the analysis is analogous to figure 2.

5.1.1. Structure of the Context

The target population of the adapted HNA is the patient group with a diagnosis in the psychiatric field living in the region Kinzigtal, Germany. According to the ICD-catalogue, mental disorders are documented from the health care providers in the F- category 00 to 99. Hence, focus of the thesis are those patients which have been grouped under a psychiatric diagnosis by the AOK and LKK Baden-Württemberg.

The aims of the adapted HNA are to identify the health care situation of mentally ill people and to compile innovative models or projects for a strengthened outpatient care in GK (see point 2).

5.1.2. Identification of Health Priorities

A comprehensive recording of all health problems from the target population and their subjective needs, shown in figure 2, was not possible due to the large scope.

The focus on mental disorders happened on the basis of a literature research as well as on the increasing presence in the public. Also, there is an interest of the IC model itself to give even greater consideration to mental disorders. However, it should be mentioned that the overall research situation was rather limited.

In the subsequent section, the health care situation of mentally ill people in Germany is described. The bullet 5.1.2.2 includes the analysis of people with a F-diagnosis in ICGK. The sub item 5.1.2.3 involves a contrasting juxtaposition to find out if data of national health services also occur in the ICGK and to what extent divergences exist.

5.1.2.1. Mental Disorders in Germany

In the last couple of years, there is a rising awareness about mental disorders in Germany. In the past the severity of this disease group was underestimated due to a lack of reliable data. The Mental Health Supplement of the German Health Interview and Examination Survey in 1998 helped to improve the general knowledge and understanding of psychiatric illnesses. According to this study, the prevalence of mental diseases is at 31% (Jacobi, et al., 2004), with more affected women (37%) then men (25%). Furthermore, almost 40% of the people with a F-diagnosis had more than one mental disorder (Schulz, et al., 2008). Current studies in the population point to a high prevalence of psychological abnormalities for children and adolescences. An early diagnose can prevent a chronical course and sequelae (RKI, 2015). Wienberg (2014) explains that there is no rising number of patients with mental disorders except of those induced by the demographically increase in age- related mental disorders. In addition, there is an increase in the use of psychiatric- psychotherapeutic services. A more comprehensive coding in the ICD- catalogue occurred implicating a specification of diagnoses (RKI, 2015).

In Germany, common mental disorders are anxiety, disorders caused by psychotropic drugs, and affective disorders (Schulz, et al., 2008). Looking at alcohol addiction, two percent of women and five percent of men suffer from this disease (RKI, 2015).

The care of patients with a F- diagnosis takes place in a hospital, semi- residential or ambulant. In Germany, the patients benefit from medical rehabilitation and from services with the objective to actively participate in society and employment (RKI, 2015).

The general practitioner is for many patients with a mental disorder the first and most important place to go (Dietrich & Goesmann, 2015). Nearly 66% of the patients remain exclusively at the general practitioners' practice, while 21% of the affected people go to other service providers. Almost two- third of the psychiatric patients are not treated for their mental disorders as only a small portion report a problem by themselves. As a consequence, mental disorders are rarely recognized and treated later or never (Harfst & Marstedt, 2009).

The therapy of mental disorders is typically done through psychotropic drugs or psychotherapy, often times also through a combination of both. Looking at the differences of care across the various German states, it is striking that the ambulatory health care of psychological psychotherapists is not equally distributed. The new federal states in Germany are greatly disadvantaged (Schulz, et al., 2008). According to Melchinger (2011), there is an oversupply of psychiatric care in university and larger cities, and partly an undersupply in rural regions. Disadvantaged groups of psychotherapeutic care are mainly older as well as chronically ill people.

A survey from Friedrich, et al. among practicing psychotherapists showed a lack of treatment places. Over half of the adult patients cannot be treated, often due to missing spaces on treatment programs. Only patients with neurotic disorders and depression get sufficient care (Bühring, 2003). Adults have to wait for an outpatient psychiatric treatment spot in average 4.6 months (Schulz, et al., 2008). Almost 25% of all psychiatric diagnoses are allotted to people older than 60 years. However, just six percent of them receive a psychotherapy (KVB, 2009). Wittchen & Jacobi (2001) report that only 36.4% of all mental disorders are treated. Therefore, the majority of patients remain untreated. Furthermore, rehabilitative services are not sufficiently available (BPtK, 2013). At the UPD, the topic of ambulatory treatment is one of the most important ones within the area of mental disorders. Almost 43% of the people concerned remark problems regarding waiting time and unreachable supply structures (UPD, 2013).

Not only the outpatient sector is facing challenges regarding an adequate provision. Also the stationary field has problems, for example a rising number of cases. The insurance TK reports about 50,000 stationary cases of people with depression, schizophrenia or personality disorders in the year 2009 (TKb, 2010). According to the health report of the BKK, patients with the diagnose depression had the highest number of hospital days. Altogether, every one in five with a psychiatric diagnosis is treated long- term in the hospital (Knieps & Pfaff, 2015). The ‘Statistisches Bundesamt’ calculates a rapid increase of numbers of cases for mentally ill people in hospitals with a shrinking length of stay (GBE-Bund, 2015). Therefore, an effect of a revolving door emerges. The readmission rate within one year accounts for 40% in clinics for psychiatry and psychotherapy (Wienberg,

2014). A systematically follow- up investigation of infirmary patients does not exist, at an outside estimate in pilot projects (Kivelitz, et al., 2015).

Annual reports of health insurances provide information about the status of the insured illness. In the health report of DAK, 14.6% of all cases are attributable to mental disorders in the year 2013. In 2004, it was only 8.3%. Mental disorders are on the third place of sick leave, behind muscular skeletal and respiratory diseases. Furthermore, there is an increase of the affected quota[10] with ascending age (DAK, 2014). Mental disorders provoke an average sick leave time of 34 days within a year and this is significantly longer than physical discomfort. For example, cardiovascular diseases manifest for sick leave on average twenty days per year. Mental disorders are one of the main reasons for long- term sick leave[11]. Mental disorders are among the employees on the second place (18.5%) of long- term sick leave cases and on the first place (32.3%) among unemployed people (BPtK, 2013). This development is also impacting companies in two ways. The ratio of early retirements caused by mental illness is causing companies to lose a part of their workforce and at the same time the annual insurance payments have to be paid at an earlier stage. The BPtK discovered in a study in 2012, that 42% of the early retirements were caused by mental disorders with an average onset age of 49 years. Therefore, psychiatric diagnoses are the leading cause for early retirements, followed by muscular skeletal diseases (BPtK, 2013).

On the economically side, there is an increase of expenditures for the group of F-diagnoses. According to the Statistics Portal, the direct costs[12] of mental disorders rose since 2002 by 70.6% to a total of 33 billion euro in 2012 (Statista, 2015). In the year 2008, it was just 28.7 billion euro. The group of mental disorders is on the third place at the direct costs with a portion of 11.3% and behind cardiovascular (14.5%) and digestive (13.7%) diseases (RKI, 2015). The ‘Statistisches Bundesamt’ calculated for every inhabitant with a mental diagnosis 350 euro in the year 2008. Only patients with cardiovascular (450 euro) and with digestive (420 euro) diseases are more expensive (GBE-Bund, 2016).

[10] Affected quota: the percentage of people having at least one incapacity for work in the basic year (DAK, 2014).
[11] A long- term sick leave is defined as an illness lasting for a minimum of six weeks. After six weeks of sick leave, the health insurances are responsible for the payment of sickness benefit (BPtK, 2013).
[12] The expenditures include medical curative treatment and provisions for prevention, rehabilitation or care.

Bengel (2015) argues in the 'Ärztezeitung' that the German health care system is not prepared for the increasing demand of mental disorders. The higher demand is based on better detection rates, overall less stigmatisation, higher acceptance and better treatment options. Besides these advancements in the psychiatric field, there is still a well- known under- supply for years. The reasons for lack of care are manifold ranging from problems occurring at the cutting points of the separated sectors, long waiting times for treatment as well as an under- supply of certain patient groups like multimorbid people, migrants or handicapped people. Furthermore, the allocation for the first diagnosis of a mental disorder is not always clear, which manifests itself in a variety of overlapping diagnoses in the various sectors and from different service providers. In addition, rising mental issues at somatic illnesses are a challenge for the stakeholders in the health care system (Stoschek, 2015).

Mental disorders rarely appear isolated and enhance the risk of accidents or other diseases. Accumulated these have significant consequences to the life expectancy (Whiteford, et al., 2015). According to the WHO (2015), people with mental strains die earlier than the general population, statistically often up to twenty years. One reason for the low life expectancy is the high suicide rate. However, the main reason is the prevalence of chronical diseases like cardiovascular illness, cancer and diabetes, as well as poor access and poor quality of care (WHOc, 2015). Co-morbidity[13] is a common phenomenon in almost all mental disorders (Jacobi, et al., 2004).

The concept of the DALY (disability adjusted life years) is an international dimension to calculate the burden of diseases. It adds up the years of life lost due to premature death and due to time lived in a compromised health state (WHO, 2016). In Germany, mental disorders are on the fourth place of DALYs, behind cardiovascular diseases, cancer and muscular- skeletal complains (Plass, et al., 2014). Moreover, lost years of employment can be calculated from incapacity to work, invalidity and premature mortality. In the year 2006, almost four million years of employment in total were lost, placing mental disorders on the second position with 16.1% (Nöthen & Böhm, 2009).

[13] Comorbid: existing simultaneously and usually independently of another medical condition. Access on 16th August, 2016 from http://www.merriam-webster.com/dictionary/comorbid.

Besides all the facts and numbers, a mental disorder has a huge impact on the person itself. People concerned report about a reduced quality of life and a huge burden, mainly by discrimination and social stigma. Furthermore, there is a higher risk of learning problems, addictions and other health problems (Moock, 2014).

5.1.2.2. Mental Disorders in ‘Gesundes Kinzigtal‘

Routine data from the AOK and LKK Baden- Württemberg in the supply region GK were used for the analysis in the year 2013. A total number of 32,071 insured people was evaluated.

In ICGK, 28.3% of all insured persons were diagnosed with a mental disorder. There is a significant growing prevalence since 2006, with an increase by close to 50%. Especially, the group of citizens being 80 years and older showed a rising prevalence. In this age group, the number of people with a F- diagnosis almost doubled in the last five years (2009: 610 patients, 2013: 1,199 patients). People with a psychiatric diagnosis have an average age of 51.5 years with a slightly predominating female ratio of 58%. In total, 32.6% of women and 24.8% of men in GK have been diagnosed with a mental disorder. All age groups were affected by mental problems.

Stress and somatoform disorders (F40- F48) are the most diagnosed group within the psychiatric scope with nearly 45%, followed by affective disorders (F30- F39). Mental disorders caused by substances (F10- F19), hold with 20.3% the third place. Considering the single diagnoses, depression (F32: 30.5%), somatoform disorders (F45: 20%), mental disorders caused by tobacco (F17: 15%), and reactions to severe stress and adaption disorder (F43: 13.8%) are most frequent.

Around 75% of the patients with a F- diagnosis were treated by a general practitioner. In addition to their general practitioner, almost fifteen percent went to a psychotherapist and circa five percent have seen a gynaecologist. Altogether, 866 patients received a psychotherapy treating most often affective disorders and neurological, adaption and somatoform disorders. Furthermore, there is an increase of prescriptions for psycho- analeptics since 2006 by +62% and for psycho- leptics by +68%.

In the year 2013, almost 31% of the employed people were not able to work due to mental illness. On average their sick leave lasted 44.8 days. From the 2,773 people on sick leave, nearly 26% were ill long- term.

Nearly five percent of all patients in the hospitals in GK had a mental disorder as a main diagnosis. Of those 78% had contact with their general practitioner before. The most frequent diagnoses in the hospital setting were schizophrenia, depression and mental disorders due to alcohol. The average length of stay from the 261 patients were 32.4 days. The longest stays with an overall of 1,343 days (22 patients, Ø 61 days) had patients with a severe depressive episode without psychotic symptoms (F32.2). Furthermore, 30% of the patients in hospital were treated long- term. In the past five years, the readmission rate in the hospital within one year pertains 25%[14].

Since 2004, the number of cases with a F- diagnosis doubled in the general hospital (2013: +100%) and in the psychiatry (2012: +110%). The psychiatry listed the highest total expenditures for mental disorders with 1.1 million euro, followed by the general hospitals (243,000 euro) and rehabilitative and curative service providers (106,000 euro). Furthermore, in the outpatient sector of the supply region increased a total cost of 1.1 million euro. The costs in the hospital amounted to 1.9 million euro. Looking at the hospital expenditures for the different disease groups, the most expensive ones were the affective disorders with 750,000 euro, followed by schizophrenia with 285,000 euro. In the ambulatory field, the most expensive group were the neurological, adaption and somatoform disorders with 368,000 euro, followed by affective disorders (309,000 euro).

Moreover, an increase of the expenditures per patient by +27% is recorded in the past five years. The costs include sick pay, costs for doctors, hospital costs, costs for rehabilitation and course of treatment, other services[15] as well as drug gross[16]. Altogether, a patient with a mental disorder caused costs on average of 4.000 euro and is therefore as double as expensive than the average psychiatric patient in

[14] Analysis of quarters, 2009- 2013: within 365 days (= five successive quarters) patients were registered in minimum in two successive quarters (own calculation).
[15] Other services: curing and aid (for example bandage), physiotherapy, travelling expenses.
[16] Drug gross: without contracts for discount and with own portions.

Baden- Württemberg. There is a negative contribution margin[17] per patient of -518 euro, with an increase of seventeen percent since 2006.

The most frequent comorbidities in 2013 of people with mental disorders were high blood pressure (29%), acute infections of upper respiratory tracts (21%) and astigmatism. Anti- inflammatory and anti- rheumatic drugs (36%), antibiotics (36%), homeopathic drugs (31%) as well as analgesics (23%) were the leading prescriptions of drugs. This points out to the fact, that mental disorders often may occur in combination with chronical complains. This fact is emphasized by the individual consideration of high- cost patients, too. It is conspicuous that psychiatric diagnoses often occur in combination with somatic illnesses like cancer, stroke, dialysis, cardiovascular problems and back pain. It is not possible to make a statement in what way a F- diagnosis is caused by a somatic disease or if it is diagnosed during a physical examination.

For patients with the main diagnosis mental disease, longer courses of the illness and several parallel diagnoses exist. An overview was established showing the different mental diagnoses, used service providers, sick leave days, hospitalisation and the respective costs in figure 4 (own design). The different colours point to the different diagnoses since 2005. The numbers behind a service provider indicates that the patient went to several of them. The overall costs per year include sick pay, costs of hospital visits, other services and ambulatory costs.

[17] According to the World of Business Management: A contribution margin is the difference between the proceeds and the variable costs. The contribution margin measures how much a product contributes to cover the fix costs. Access on 20th January, 2016, from http://www.welt-der-bwl.de/Deckungsbeitrag.

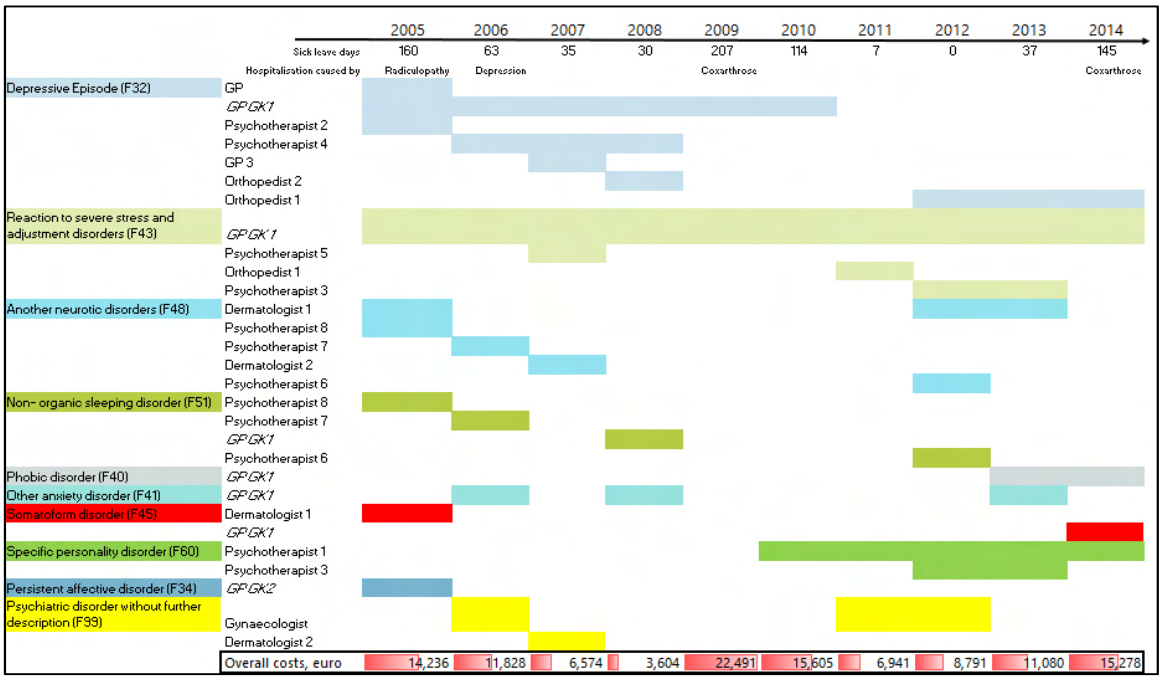


Figure 4: One high- cost patient in GK with different diagnoses, sick leave days, hospitalisation, service providers and overall costs (own design)

Legend of figure 4: GP= General practitioner; GK= Gesundes Kinzigtal; written cursive= service partners of GK.

As seen in the picture above, high- cost patients are diagnosed from various service providers (co-operation partner and external provider) with different mental disorders. The upcoming figure makes the health care utilization of an expensive patient in GK transparent. The author analysed a few other high- cost patients, which showed similar courses. For reasons of clarity, only one patient is shown. This example was shown and shortly discussed in the focus group, too.

5.1.2.3. Comparative Analysis

In this sector, the analysed data of GK and the research results of mental disorders in Germany are compared to contrast HSR of a population in one area with services received in another. The comparative approach in a HNA is a powerful tool for health services to investigate (Stevens & Gillam, 1998).

It was not possible to find references for all values which is the reason for marking some items with ‘n.v.’ (no value).

General data		'Gesundes Kinzigtal' (2013)	Germany
Portion of F- diagnoses		28.3%	31%
Two or more F- diagnoses		43.2%	48%
Affected age groups		All	All
Gender distribution		♀ 32.6% (58.1%), ♂ 24.8% (41.9%)	♂ 25%, ♀ 37%
Frequent diagnose groups	1st place	Neurological, adaption and somatoform disorders	Anxiety
	2nd place	Affective disorders	Disorders caused by substances
	3rd place	Disorders caused by substances	Affective disorders

Table 3: Comparison of general data in ICGK versus Germany (own design)

In table 3 data for Germany were used from Schulz, et al. (2008) as well as from Wittchen & Jacobi (2001) and for GK from the year 2013. It is perceptible that similar prevalence's exist in ICGK (28.3%) and in Germany (31%) (Wittchen & Jacobi, 2001). All age groups are affected with a slightly higher number of women both in GK (32.6%) and in Germany (37%). Almost the half of the patients are diagnosed with two or more mental diseases (ICGK: 43.2%, Germany: 48%) from the stakeholders in the health care system (Wittchen & Jacobi, 2001). The most frequent diagnoses are in both examined populations affective disorders, neurological, adaptive and somatoform disorders and illnesses caused by substances in a different order (Schulz, et al., 2008).

General practitioner	'Gesundes Kinzigtal' (2013)	Germany
Only general practitioner	54.1%	66%
Additional help of other service providers	15% psychologist, 5% gynaecologist	21%
Detection rate	n.v.	50%

Table 4: Comparison of care at general practitioners' place in ICGK versus Germany (own design)

Harfst & Marstedt (2009) reported in the Health Monitor about the care of mentally ill people at family doctors practices. Almost two- third of the patients remained only at their general practitioner. In GK, the family doctor is the only contact person for 54.1% of the patients. Additionally, fifteen percent of these patients see a psychologist and five percent a gynaecologist. Throughout Germany, every fifth person diagnosed with a mental disorders seeks extra help. At the general practitioners' place, only half of mental disorders are recognized. Some of these disease are even less diagnosed. In this regard, no statement can be made in the IC model in the south of Germany.

Hospital	'Gesundes Kinzigtal' (2013)	Germany
Percentage of F- diagnoses as main diagnosis	4.8%	5.9%
Most frequent diagnoses	Alcohol, schizophrenia, depression	Depression, schizophrenia, personality disorder
Average length of stay	32.4 days	25 days
Long-term treatment	30.3%	21.6%
1st place	Severe depressive episode without psychotics	Depression
Readmission rate within one year	25% (in hospitals)	40% (in clinics for psychiatry and psychotherapy)

Table 5: Comparison of stationary indicators in ICGK versus Germany (own design)

The data about Germany in table 5 are from different sources. According to Schulz, et al. (2008), almost six percent of the diagnoses in the hospital belong to the psychiatric field. In the ICGK, this portion of all main diagnoses accounts for nearly five percent. Depression and schizophrenia numbers most frequently in both sample scopes. The average length of stay of patients with a F- diagnosis is in GK 32.4 days and in Germany 25 days where more than one in five patients with a mental diagnosis is treated long- term in the hospital (Knieps & Pfaff, 2015). In GK, the number is even higher (30.3%). The leading diagnosis at the long- term treatments in the hospital is depression (Knieps & Pfaff, 2015). Wienberg (2014) describes a readmission rate of 40% in clinics for psychiatry and psychotherapy. The hospitals in the region Kinzigtal manifest a rate of 25% for patients with mental disorders.

Psychotherapy		'Gesundes Kinzigtal' (2013)	Germany
Rate		9.55% (with F-diagnosis)	1.23% (measured from total population)
Waiting time		n.v.	In average 4.6 months
Frequent diagnoses	1st place	Depression	Neurosis
	2nd place	Neurological, adaptive and somatoform disorders	Depression
Duration		n.v.	38.6 up to more than 100 meetings
Psycho- analeptics (prescriptions since 2006)		61%	29%

Table 6: Comparison of psychotherapeutically care in ICGK versus Germany (own design)

Almost ten percent of the patients with a mental diagnosis received a psychotherapy in GK. Melchinger (2011) points out in an article, that more than one percent of the whole population in Germany receives therapy every year. The average waiting time of an ambulatory treatment for adults amount to 4.6 months (Schulz, et al., 2008). The number of sessions varies in Germany from 39 up to more than 100 meetings (Melchinger, 2011). There is no statement possible in GK regarding the two criteria mentioned before. The frequently treated diagnoses at a psychologist in ICGK were depression and neurological, adaptive and somatoform

disorders. In Germany, the treated diagnoses are converse (Bühring, 2003). In both populations, there is a rising number of prescriptions from psycho- analeptics since 2006. In GK, there is an increase of +61% and in Germany the number rose by +29% (RKI, 2015).

Sick leave	'Gesundes Kinzigtal' (2013)	Germany
Days in average	44.8	39.1
Shares of the top ten diseases from sick leave days	n.v.	14.6%
Shares of the top ten diseases from sick leave cases	n.v.	5.1%
Patients with F- diagnosis and sick leave	30.6%	n.v.
Long- term ill	25.6%	18.5%

Table 7: Comparison of sick leave data in ICGK versus Germany (own design)

In ICGK, patients with a F- diagnosis were in average 44.8 days unable to work, whereas the BKK calculated for their insured clients a mean of 39.1 sick leave days (Knieps & Pfaff, 2015). At the DAK, five percent of all sick leave days are due to mental disorders. They take the third place (14.6%) at the length of sick leave days (DAK, 2014). There is no value available in GK about this information. From the 9,068 patients in GK diagnosed with a mental disorder, almost one- third (30.6%) are on sick leave. One in four sick leave prescriptions (25.6%) accounts for a long- term treatment in GK. The proportion of mental disorders to the long-term sick leave cases is among employees in Germany at 18.5% and is the second leading cause of long- term illnesses (BPtK, 2013).

Economically statements are not compared due to different data bases. In the subitems 5.1.2.1 and 5.1.2.2, evidence about the costs and expenditures was given.

The comparative anlysis shows almost similar data in GK and in Germany, with a few exceptions. That is the reason, why approaches for outpatient interventions for mentally ill in Germany could be implemented in ICGK. The facts demonstrate an urgent need for action.

5.1.3. Prioritisation of the Need

This chapter deals with the prioritisation of the need on the basis of a comprehensive analysis about the target population (see figure 2). However, a focus on mental disorders occurred in advance. Instead of a prioritisation of the need, a summary about the higher demand of care for mentally ill people is given. On the basis of the literature research and the quantitative, regional data analysis the following statements can be made:

- The people concerned have an individual as well as a societal burden.
- Different diagnoses are made parallel from different stakeholders in the health care system.
- Only the half of patients at the general practitioners' place are diagnosed with a mental disease although the practice is the first person in contact in the primary care. Oftentimes, mental disorders remain untreated.
- There is a rising number of cases in hospitals. In general, there is an ascending use of services in the psychiatric field.
- There is a growth of early retirements and of sick leave days due to mental disorders.
- Mental disorders cause increasing expenditures and costs in all areas.

The current fragmented health care system seems to be insufficient for the care of mentally ill people in Germany (see point 5.1.2.1). At the moment, the recommendation 'outpatient before inpatient care' rarely occurs. Moreover, the 'S3- Leitlinie'[18] recommends a community based care catering to the needs of the patients (DGPPN, 2013). The DGP (2012) underlines in its paper for IC that an ambulatory care instead of a stationary care is significant for the promotion of mental health.

The increasing presence of mental disorders as well as a predominantly stationary care illustrate the relevance for innovative approaches in the ambulant sector. On one hand, this shall reduce the workload of the general practitioner. On the other hand, more possibilities of care for the patients and relatives can be offered and care at home can be facilitated. Furthermore, the extension of an outpatient health

[18] For further information: http://www.awmf.org/leitlinien/awmf-regelwerk/ll-entwicklung/awmf-regelwerk-01-planung-und-organisation/po-stufenklassifikation/klassifikation-s3.html. Access on 10th July, 2016.

care may counteract the imminent lack of physicians, especially in rural areas (Gerlach, et al., 2014) like in Kinzigtal.

Worldwide, the topic mental disorder and its effects on the society receives growing attention in the last couple of years, among others from the WHO, Regional Office for Europe (WHOc, 2015). Germany deals with the rising presence and higher supply of demands of mental disorders, too. The illness 'depression' is one of the eight National Health Aims[19] and underpins the relevance of mental disorders.

5.1.4. Approaches of Innovative Interventions to Strengthen Outpatient Care

In this chapter, national as well as international projects and models are assessed for a strengthening outpatient care for people with mental disorders in GK.

Sometimes, a delimitation was difficult as several concepts include aspects of other models. A reason could be the lack of consistent definitions about basic concepts and borders (Nolte & McKee, 2008). The author of the master thesis looked mainly for national projects. According to Nolte & McKee (2008), it is difficult to transfer a project from a (health care) system into another one.

The models characterised below, range from a case manager and non- medical assistant to multi- professional teams treating at home. Projects of telemedicine will be described as well as internet interventions. Moreover, a network of IC for mentally ill people is introduced as well as other forms of care. Additionally, the two existing psychiatric programs in GK are declared. Finally, the concept of a stepped care model is explained as a structural framework including multiple and various interventions. The following figure 5 represents an overview of the ambulatory projects and their particular services (own design).

[19] For further information: http://gesundheitsziele.de/. Access on 2nd March, 2016.

	PA	PA+HV	HV	Telemedicine	E- Health	IC- Model	therap. Center	24h/ 7d	Sociotherapy	Room to retreat	Training
Case Management/ Patient Coaching		x		partly		partly		partly	x		
Collaborative Care	x								x		x
'Jena- Paradies'	x			x					x		
'Entlastende Versorgungsassistentin'		x							x		x
Dementia Care Manager		x		x	x						
Home Treatment			x			partly		x	x		
Assertive Community Treatment			x					x			
Need Adapted Treatment			x					x	x	partly	
Peer Support				x					partly		
Telemedicine in Western Pomerania				x							
'Gesundheitscoach' (KKH)				x							
Deprexis®24					x			x			
'DepressionsCoach' (TK)					x			x			
'NetzWerk psychische Gesundheit'			x	x		x		x	x		
'Integriertes Versorgungszentrum'			x				x	x	x		
'GAPSY'			x			x		x	x	x	
Stepped Care						x			x		x
'Besser gestimmt'	x			x					x		
'PsychotherapieAkut'				x							

Figure 5: Classification of ambulatory projects with the respectively service types (own design)

Legend of figure 5: PA= practical assistance; HV= home visit; x= include the service type; partly= different performances of the intervention include a portion of the service; KKH= 'Kaufmännische Krankenkasse'; 'GAPSY'= 'Gesellschaft für Ambulante Psychiatrische Dienste GmbH'; green marked fields= incorporate relatives; blue marked fields= programs in ICGK.

The projects are described in the following sub items in a chronological way.

5.1.4.1. Case Management and Patient Coaching

Internationally, the case manager is famous and wide spread, especially in Anglo-American countries (Ivezic, et al., 2010). A case management (CM) aims to a need adapted support, supervision, encouragement and supply of people. Professionals in the social and health care system can qualify as a case manager, so that processes in the system can be managed in an effective and efficient way. Another task is the organisation of collaborations. The affected person participates in all processes. A good quality of care shall be guaranteed (DGCC, 2012). The CM represents a good support for people with long lasting and complex needs. Ross, Curry, & Goodwin (2011) established a guideline for a successful implementation for a better coordinated care. CM can only be successful, when certain key factors are considered.

In general, the literature shows different results of the effects of a case manager. On one hand, researchers report positive treatment effects regarding managing of symptoms, quality of life and satisfaction (Kivelitz, et al., 2015). CM works best in samples, where participants tend to a high number of hospitalisations by reducing

the number of cases in hospitals (Burns, et al., 2007). On the other hand, researchers found no effect with respect to the use of a case manager. The different results could be based on diverse methods and groups in the studies (Gensichen, et al., 2003). The German experts V. Aderhold and N. Greve (2015) constitute the model old and ineffective[20].

One practical example for the use of a case manager is in the 'NetzWerk psychische Gesundheit/ SeGel seelische Gesundheit leben' from the Awolysis GmbH[21]. Among other supply programs, the case manager is responsible for the start and coordination of non- stationary treatment services and ensures the cooperation with consultants. Furthermore, companies like the 'HL Casework GmbH' offer CM for mentally ill people (HLC).

In Germany, the ambulatory socio- therapy[22], § 37a SGB V, can be brought into account and the content is similar to CM.

Another related concept to the CM is the patient coaching. According to the Federation of Managed Care, patient coaching is an important step towards an individual medicine. It helps the patients to use the health care system in a different and more efficient way (BMC, 2015).

5.1.4.2. Non- medical Assistant

The term 'non- medical assistant' includes in the federal states of Germany different outpatient offers of trained staff in cooperation with general practitioners. This model can be brought into account since January 2015 (KVB). The German Medical Association fixed a delegation agreement by law, §63 (3c) SGB V. The following text presents three different projects of a non- medical assistant in Germany.

[20] Symposium ‚Neue Versorgungsformen- ambulante multiprofessionelle Behandlungsteams, internationale Vorbilder und die Umsetzung in Deutschland', 19.11.2015 in Kassel.
[21] For further information: http://www.awolysis.de/netzwerk-psychische-gesundheit-segel-seelische-gesundheit-leben/versorgungsangebote/vincentro-koordinationsstelle-und-fallmanagement/. Access on 18th June, 2016.
[22] For further information: http://www.prowoberlin.de/de/hauptmenue/angebote/soziotherapie.html. Access on 23rd March, 2016.

Collaborative Care

The subproject IV of the network 'Psychenet' in Hamburg[23] at the University Hospital Eppendorf (UHE) aims to support the self- management of patients with mental disorders. According to Zimmermann et al. (2015), the complex and low-threshold consulting intervention is currently evaluated. This tandem cooperation shall relieve the workload of the general practitioner by a nurse. The project takes place in the rooms of the participating family practitioner. The nurses function as a social and case manager and the nurses offer trainings for the patients and relatives. Furthermore, there are conversations at the start and end of the treatment process. First results are decreasing complains, an improved state of health and a reduction of distress for the general practitioner (Zimmermann, et al., 2015).

A similar example is the 'Jena- Paradies' (patient activation for anxiety disorders) providing treatment material in addition to the standard therapy for patients with anxiety. The program includes the elements patient information, guidance and motivation for independent exercises. Moreover, a self- help book or rather diary goes along with the therapy. The doctor talks with the patient and the staff in the practice calls the people concerned to question the course of symptoms and of the treatment. The results are transferred to the general practitioner immediately. The project is in the phase of evaluation (Gensichen, et al., 2014).

'Entlastende Versorgungsassistentin'

The 'Entlastende Versorgungsassistentin' is a contact person in neurological, neuropsychiatric and psychiatric practices exercising visits at home. The specialized staff prepares psychoeducational groups and trainings for patients and relatives. Also, the assistant documents the medication as well as required examinations and helps in administrative issues. There are certain conditions necessary to attend the advanced training finishing the first time in 2014 (AEKWL). The author could not find information on an evaluation process of these trainings.

[23] For further information: http://www.psychenet.de/ueber-psychenet/teilprojekte/hausaerztliche-versorgung.html. Access on 23rd February, 2016.

Dementia Care Manager

W. Hoffmann from Greifswald introduced the concept of the Dementia Care Manager at the German Congress for Health Services Research in October 2015 in Berlin.

The DCM is implemented and evaluated since 2012 with the aim of an early detection of dementia and a need adapted treatment. The general practitioners are supported by trained nurses, called dementia care manager (DCM). After a comprehensive diagnostic investigation and an initial conversation with the doctor, the DCM visits regularly the patients and relatives at home. The DCM records and systematically improves the individual health care situation, for example symptoms and medication. The general practitioner and the DCM are in a regular contact via phone or iPad. An own computer software was developed, so that the physician gets immediately current information and can take action. First positive results are an early detection of dementia, an improved identification of needs and therefore planned interventions (Thyrian, et al., 2015).

5.1.4.3. Home Treatment

The implementation of home treatment (HT) is partly done in Germany. In other countries, HT has been practiced for longer and coexists with other approaches of the outreach community mental health treatment. The focus of this mobile crisis team is the acute treatment of the patients (Gühne, et al., 2011). There is evidence that HT is effective for people with severe mental disorders. However, an academic void exists regarding the structures and processes as well as long- term effects. In general, studies show a reduction of hospitalization, less suicidal thoughts, improved functional status of the patients and an improved satisfaction with the treatment. The networks, which offer HT, are similar, but differ in the concept of IC in Germany. The effectiveness of HT consists of regular visits of the patients in their home and in the takeover of the responsibility for health and social matters (Stegbauer, et al., 2013).

One example of HT in Germany is the 'Integrativ Psychiatrische Behandlung' at the Alexianer Hospital in Krefeld[24], existing since 1998. All patients in the heterogenic group of mental disorders can be treated, except people diagnosed with primary addictions. This treatment was evaluated several times and is characterized among other things by a high effect size and a low or comparable hospitalization rate compared to international studies (Runge & Horn).

Assertive Community Treatment

Already in 1995, Scott & Dixon report positive results of an assertive community treatment (ACT) for patients with schizophrenia: reduction of the number of cases and length of hospitalisation, increased retention of the treatment, and saving costs in the short and middle term (Scott & Dixon, 1995). Internationally, ACT is well known and practiced, for example in Singapore (Low, et al., 2013).

This form of intervention is not implemented in Germany yet. However, it is offered as a part of the 'Hamburger Modell' at the UHE in Hamburg[25]. A multi- professional team of psychiatric experts treats the patient in the home environment and offers a treatment usually carried out stationary. The treatment includes a crisis intervention, prescription of medication as well as the integration of relatives. ACT is available 24/7. In general, there is a total care for the patients with reduced stationary treatment (Ohm, et al., 2009).

Need Adapted Treatment and Open Dialogue

These both similar forms of treatment were promoted by the experts V. Aderhold & N. Greve at the symposium 'Neue Versorgungsformen- Ambulante multiprofessionelle Behandlungsteams, internationale Vorbilder und die Umsetzung in Deutschland' in November 2015 in Kassel. They introduced the concepts with important and positive results.

[24] For further information: http://www.alexianer-krefeld.de/unsere_angebote/krankenhaus_maria_hilf_psychiatrische_kliniken/klinik_fuer_allgemeinpsychiatrie_und_psychotherapie/integrative_psychiatrische_behandlung_ipb. Access on 4th August, 2016.

[25] For further information: http://integrierte-versorgung.psychenet.de/sites/default/files/publications/IV-Psychose%20Hamburger%20Modell.pdf. Access on 4th August, 2016.

The need adapted treatment and the open dialogue[26], originally from Finland for patients with schizophrenia, evolved further in the last few years. The first therapeutically meeting with people in a psychosis occurs within 24 hours, often with the concerned at home. In the therapy session, a general practitioner, psychologist, social worker and close relatives or friends attend. With the patient together, problems are discussed and treatment courses developed. Nothing happens without the patient. A selective use of neuroleptics is possible as well as individual therapies take place. The focus is the stabilisation of the patient and the normalisation of the situation. In the first days of the therapy, meetings can be every day. After a while, sessions can occur five to seven times per year. In general, less psychotic symptoms, a higher proportion of full working capacity, and other positive results could be achieved (Aderhold & Greve, 2009).

The 'NetzWerk psychische Gesundheit/ SeGel' from the Awolysis GmbH offers in their broad treatment spectrum a need adapted care, too[27].

However, it should be noted that this form of intervention is internationally little known and limited literature exists.

5.1.4.4. Peer Support

The concept of the peer support is based on the thought, that people experiencing trouble or an emergency and survived this situation, can offer other persons in similar situations support, encouragement, hope and guidance. Until now, the intervention is popular by addiction, traumata or cancer. The potential of the peer support is nearly unused in the psychiatric field (Davidson, et al., 2006). However, a review including only randomised controlled trials, point to little evidence of the effectiveness of the peer support for people with mental disorders (Lloyd-Evans, et al., 2014).

At the UHE, the concept of the peer support was successfully implemented. The supply exists from people concerned for concerned and also from relatives for

[26] For further information: https://antipsychiatrieverlag.de/verlag/titel/leseprobe/9783925931383.pdf. Access on 16th December, 2016.
[27] For further information: http://www.awolysis.de/netzwerk-psychische-gesundheit-segel-seelische-gesundheit-leben/versorgungsangebote/aufsuchende-behandlung/. Access on 16th August, 2016.

relatives. The consultants get a training and are accompanied by regular coaching and supervision. The peer advisor offers assistance in crises, listens, informs about existing services and connects to self- help groups. The attendance lasts for six months. The evaluation of the concept shows several positive results: high satisfaction with the treatment and more met needs, improvement of the symptoms and less substance misuse, and reduction of hospital stays. The concept of the peer support from the UHE was adopted in ten psychiatric clinics respectively located in Hamburg (Mahlke, et al., 2015).

5.1.4.5. E- Health

E- health summarises applications, where modern technologies of communication and information are used. This includes for example applications of the telemedicine, where processes of treatment and support are exchanged via safe data connections (BMG, 2015).

Also, interventions on the internet count as e- health. Similar terms of e- health in the literature are e- mental health, tele- mental health and tele- psychiatry offering psychiatric interventions on the web. It is striking, that the terms are used differently in the literature.

Telemedicine

This concept is internationally established, mainly in the United States of America, and achieved besides some limitations many positive effects: better access to services, saving costs and a higher number of treated patients (Deslich, et al., 2013). In Germany, few projects and sources indicate a beginning of telemedicine.

Technology based support or mobile care are contacts via telephone or personal digital assistance, for instance psychotherapy via telephone or video conferences. Mobile support has many advantages: overcoming barriers in the access and use of services, reduction of the intensity of interventions and therefore maybe a reduction of costs, or an improved effectiveness of treatments. Especially in rural areas, poor or limited transport options are a barrier in the access as well as

constant participation to psychosocial treatment (Depp, et al., 2010). In Germany, there are many rural areas with a low availability of psychotherapeutic services. The awareness of potential benefits of telemedicine concepts is hardly present (van den Berg, et al., 2011). Generally, the telemedicine has many options to optimize the health care. It should be considered as part of an overall concept and be tested (Gerlach, et al., 2014).

One successful example is the 'Telefon- und SMS- basierte telemedizinische Konzept für Patienten mit psychischen Erkrankungen'[28] in Mecklenburg- West Pomerania. N. van den Berg introduced this project as one of the contributors on the German Congress for Health Services Research in October 2015 in Berlin. The patients discharged from a psychiatric clinic, are accompanied further via calls or text messages from trained staff. This low threshold intervention shall overcome the time until the next treatment to attend acute crisis and to plan necessary interventions (van den Berg, et al., 2011). The results of the pilot project were presented at the congress, which were among others a significant reduction of anxiety, satisfaction with the treatment and a non- significant reduction of depression. The project shall be continued and established in the standard care in ambulatory institutions (van den Berg, et al., 2015).

Another example of a mobile support is the 'Gesundheitscoach' from the 'Kaufmännische Krankenkasse' for mentally ill people which started in 2007. It was implemented successfully in several states (Herbarth, 2015). There is a fixed health coach for every participant so that conversations can build up on each other and trust can develop. Every coach can support nearly 130 people diagnosed with a mental illness. Positive results are for example an improved quality of life by preventing or mitigating crises as well as an improved care without cost increase by reducing the time spent in hospitals (Freudenstein & Lägel, 2009).

Web Based Intervention

Frequently, the internet is the first place to go for people searching information. It is an alternative to the classic inward consulting with many advantages. The

[28] For further information: http://telemedizin.fokus.fraunhofer.de/index.php?id=27&pId=354&backPageNum=0&no_cache=1. Access on 21st January, 2016.

anonymity can reduce the interpersonal discomfort that some people concerned feel. Another positive fact is the increased knowledge of the patients and a modified health behaviour. On the other side, a high number of treatment discontinuation is possible. Altogether, the evidence of internet based interventions is mixed. This approach is not suitable for all patient groups and further research is necessary (Paul, et al., 2013).

A famous example in Germany is Deprexis®24. This tool is offered for patients with depression additionally to the psychotherapy. The program was tested in several independent studies and the effectiveness of the reduction of depressive symptoms as well as an improvement of social functioning confirmed (Meyer, et al., 2009). The tool can be used on smartphones, iPad or computer. The patient gets a text message or electronic mail with practical suggestions, motivating tips and thoughts to cope with everyday life. Moreover, regular questionnaires capture the mood development and symptoms (Deprexis, 2015).

Since 2014, the TK is offering the 'DepressionsCoach', which is currently being evaluated. The intervention is for people with a mild to moderate depression. The participants get structured tasks, they do intensive writing and exercise multimedia based audio and video training, partly with written feedback from therapists (TK, 2015).

5.1.4.6. Integrated Care Network

The DGP (2012) advocates IC models for patients with mental disorders. These networks aim at a community based treatment to reduce hospitalisation and the number of therapy breakups. Specialists and general practitioner, psycho- and socio-therapists, occupational (ergo) therapist, nurses, (day) clinics, psychiatric institute ambulances as well as psychiatry experts are involved. All services are financed by the participating insurances, corresponding to SGB V. Also houses or rooms for retreat are offered.

A famous IC network in Germany is the 'NetzWerk psychische Gesundheit' from the TK. It is community based and considers the current situation of the concerned person. A carer and one person from the coordination centre support the patient

during the different elements of the treatment. The offer is available at all times and in an acute crisis, phone calls or house visits are guaranteed. Socio- therapy or ambulatory care are abounding (TKa, 2010). Other successful IC projects are the ‘Psychiatrisch- Psychotherapeutisches Netzwek’ in Mecklenburg- West Pomerania (Möws & Lägel, 2009) and the ‘Psychiatrie Initiative Berlin Brandenburg’ (Hoffmann, et al., 2016).

5.1.4.7. Other Supply Models

The ‘Integriertes Versorgungszentrum’ in Gießen stands out by a setting overarching treatment promising continuity for the people concerned. The centre is characterised by one treatment team in one location with one overall concept and one management. In one apartment building, different treatment options are offered:

- Day time clinical treatment,
- Night time clinical treatment,
- Ambulant treatment,
- Ambulant outreached treatment,
- Open inpatient treatment,
- Basic non- specific services (Franz, et al., 2009).

With this broad range of supply, the patient has the possibility from the outset to choose a need adapted and stepped approach treatment. The evaluation shows at least the same outcome to other units of the psychiatric clinic and generates a high satisfaction of the patients (Franz, et al., 2009).

The ‘Gesellschaft für Ambulante Psychiatrische Dienste GmbH‘ (GAPSY) in Bremen is an outpatient nursing service offering additional socio- therapy and the network IC retreat rooms. With these three cornerstones as well as medical and drug supply, GAPSY realizes a concept of IC (GAPSY).

5.1.4.8. ‘PsychotherapieAkut’ and ‘Besser gestimmt’ in ‘Gesundes Kinzigtal’

There exist two programs for mentally ill people in ICGK- ‘PsychotherapieAkut’ and ‘Besser gestimmt- die Depression im Griff’.

The program ‘PsychotherapieAkut’[29] offers patients in an acute psychiatric crisis help by providing them with an appointment within one week with a psychologist. Patients can apply for up to seven meetings (Hildebrandt, et al., 2010).

A telephone conversation with the program coordinator in November 2015 (appendix 1a) functions as baseline for the following information. The fast help is well accepted by the patients and is used in around 80% of all cases. The general practitioner makes the initial contact with the psychologist and asks for free treatment places. Then, the patient has to call the therapist to fix a date. In the beginning of the treatment, the patient has to fill out a questionnaire, which is queried one month after completion of the treatment via phone again. Patients who participated in the program are not allowed to attend again for two years. Currently, there is no online support program available, but the coordinators talked about this issue repeatedly.

Information about the program ‘Besser gestimmt- die Depression im Griff’[30] was received from the program coordinator via a phone conversation conducted by the author in November 2015 (appendix 1b). The program is for patients with a mild to moderate depression and includes an early detection and treatment of the illness. The physicians receive training to better recognize signs of depression. Medical assistants undergo extra training for becoming a case manager to enable them to accompany the patient for six months. There is a telephone appointment four weeks after the end of the treatment, where the course is measured by a questionnaire. At the moment, there is no offer for a group therapy since this has not been well accepted in the past. Despite the fact that the number of people suffering from depression is increasing the program director remarked that they

[29] For further information: http://www.gesundes-kinzigtal.de/gesundheitsangebote/programm-psychoakut.html. Access on 20th January, 2016.
[30] For further information: http://www.gesundes-kinzigtal.de/gesundheitsangebote/programm-depression.html. Access on 20th January, 2016.

are experiencing a decrease in patients applying for the program. Reasons are unknown to the program direction.

5.1.5. Model with a structured framework: Stepped Care

In the last step of a HNA (see figure 2), a review of the project and future interventions for other health priorities should be discussed. It was not possible to establish a complete HNA with a detailed approach for interventions. Therefore, a retrospection is not wise nor possible. Instead of this, a stepped care model is described. It combines different aspects of the before mentioned programs and offers an analytical framework for treatment recommendations.

The stepped care model is considered as part of the IC concept and is internationally widely applied. It identifies different treatment options for patients regarding the severity of their illness. The model consists of several steps beginning with the recognition of the disease by the general practitioner, up to a psychotherapy or hospitalisation (Coyle & Doherty, 2010). Stepped care organises the availability of services and helps with the choice of the most effective intervention. The least intensive action suitable for the patient is offered at first. If the intervention achieves positive results, it limits the burden of the disease as well as the costs as the intensity of treatment has been kept a minimum (NICE, 2011). Hence, an important requirement of the use of a stepped care model is the availability of a variety of low threshold as well as more intensive treatment options (Hermens, et al., 2014). Coyle & Doherty (2010) describe the necessity of the self-correction of the model. The reaction of the clients with respect to the treatment plans should be captured regularly to make corrections well in time. Thus, an optimal treatment is guaranteed adapting the intensity step by step. However, the concept supports the view of the service providers and is not patient centred. The following figure 6 from Coyle & Doherty shows a stepped care model for the diagnose depression.

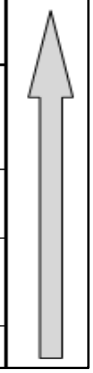
Step	Severity	Care giver	Treatment	Intensity
5	Risk to life Severe self-neglect	Inpatient care Crisis teams	Medication Combined treatments ECT	
4	Treatment-resistant Recurrent Atypical Psychotic	Mental health specialists Crisis teams	Medication Complex psychological interventions Combined treatments	
3	Moderate or severe depression	Primary care team Mental health specialist	Medication Psychological intervention	
2	Mild depression	Primary care team	Watchful waiting Guided self-help Computerised CBT Brief interventions	
1	Recognition of difficulty	GP	Assessment	

Figure 6: Stepped Care Model for the diagnose depression (Coyle & Doherty, 2010, p.1)

Since 2004, the concept is adapted worldwide in clinical guidelines for depression (Franx, et al., 2012). Taking the illness depression as an example, the stepped care model aims to improve the differentiation of the different degrees of depression, to reduce the chance of overtreatment in case of less serious forms and to avoid a lack of treatment in cases of severe depression. The specialized resources within the field should take care of patients who require their support the most. Researchers in the Netherlands found significant results during their studies of the stepped care model. They recognized a higher detection rate, an increase in treatment with minimum interventions and an increased use of health services (Gidding, et al., 2014). Contrary to their study other researchers describe a non-effectiveness of the model when it comes to older patients being 75 years or older (van der Weele, et al., 2012). This statement in turn is controversy to a study from van't Veer- Tazelaar et al. (2010), where a combination of interventions was successful. It reduced the risk of incidence of the illness by 50% in comparison to the normal care. Therefore, costs were saved.

A successful implementation of a stepped care model depends on the innovative approach itself, the professionals, the patients, the economic context and other factors. The barriers are a deficit of resources, an under- developed information system and different attitudes of the multi- disciplinary team regarding the illness and the treatment (Hermens, et al., 2014). With the help of the model, the general practitioner as the first person of contact shall be strengthened as well as the primary care in general. A comprehensive care is the main aim. A culture of teamwork is the key factor in the supply of mentally ill people (Hermens, et al.,

2014). Consequently, the limited places of psychotherapeutic treatment can be used efficiently (Bower & Gilbody, 2005).

For a number of other diseases being smoking, back pain, alcohol abuse, migraine, anxiety, eating disorder, methadone addiction, and depression the stepped care model already exists. In addition, there is a small number of studies available which evaluate a complete stepped care model but the information around the acceptance of the model is limited. Generally, the concept has the potential to improve the efficiency of psychotherapeutic offers. However, the most optimal content and organisation of the model is still unknown (Bower & Gilbody, 2005). The National Institute for Health and Clinical Expertise has developed a guideline of a stepped care model for patients with most frequent mental disorders (NICE, 2011).

5.2. Appraisal of the Innovative Approaches

After the performance of an adapted HNA for mentally ill people, this chapter builds up on this analysis to evaluate the compiled projects. To appraise the different ambulatory approaches, a FGD with experts in GK took place (see point 4.). In addition, as earlier mentioned, an individual interview also took place to discuss the different approaches.

The group felt it was difficult to rate the different projects and innovative approaches with the evaluation scheme (appendix 3) by allocating ranking points to the different projects. The general sentiment was that the topic was complex and sufficient information about the projects was missing to enable them to take a decision. Besides the missing information nearly all interventions are still in an evaluation process where no decisive statements could be made. In addition, the different approaches are for different target groups (r.229 et seq., FGD) and hence difficult to compare. All of the projects are in the beginning and the verdict is still not out in regards to their success and impact on the patients (r.277, FGD). Therefore, the assessment of the benefits of the different projects cannot be made yet (r.726, FGD).

Consequently, the evaluation of the FGD was more difficult for the author than expected. During the FGD topics switched quickly and some projects were hardly mentioned. For the individual interview the time was insufficient to cover all aspects of the different treatment approaches.

The evaluation of the FGD followed the categories as listed in figure 3.

Case Management

Regarding the CM, one participant raised that they are not aware what this form of treatment actually entails (r.142, FGD) and the discussion for this option was limited. However, a combination of CM, coaching and social counselling is offered in GK by one qualified person (r.732, FGD). This offer is well used and the need for expansion exists, therefore a second person shall be employed (r.660, FGD). CM was not discussed in the individual interview.

Non- medical Assistant

The next option non- medical assistant was discussed in the individual interview during the first five minutes. The ICGK applied to function as a training school for general non- medical assistants, not specialised on mental illness. The topic ‘mental disorders’ was planned to be the content of a module (r.9 et seq., i.i.). One participant of the FGD saw an advantage in the home visits made by the assistant as it is a simple check- up on the patient evaluating in which state the person is and when the doctor has no time to do so (r.317 et seq., FGD). Furthermore, the assistant is seen as a supportive alternative and relieves the workload of the general practitioner (r.592 et seq., FGD). Two participants argue, that they would not delegate tasks on a psycho- therapeutic level. They advised they would prefer to go themselves (r.610, FGD). Further, it was raised if non- medical assistants are sufficiently trained to evaluate mental disorders and episodes of the disease. However, it was noted that a number of medical colleagues demonstrate bad manners towards patients with mental disorders and hence a non- medical assistant might at times be the better choice to visit patients at home (r.613 et seq., FGD). In summary, not only the qualification of the assistant is important

(r.618, FGD; r.31, i.i.), but also the collaboration with the doctor and trust for the patient are crucial (r.656, FGD). Especially in rural areas the need for the general practitioner to do the home visits is great as patients only trust them with their treatment. The existing results show positive reports and good general acceptance from patients for this treatment option (r.43, i.i.).

Home Treatment

The third category HT was not discussed as its own topic during the individual interview. Within the FGD, it was mentioned with limitations as a supportive possibility (r.880, r.1020, FGD). It can work for very serious cases when physicians cannot get the patients into the practice (r.883, FGD). A combination of peer support and home treatment is mentioned as an opportunity for less severe cases (r.298, FGD).

E- Health

GK evaluated the offer of an online provider from Switzerland but it was found to be too expensive for the small region (r.343, FGD). At the moment, GK does not offer any internet program (r.326, FGD). In general, it is seen as a supporting platform (r.329) and the need for it has been recognized considering the change in generation being vastly tuned towards the internet usage. Concerns build around privacy protection (r.337, FGD) but also the feasibility and seriousness of the provider to develop a platform to meet the requirements of such an online tool (r.139, i.i.; r.342, FGD). A layperson cannot decide, if he or she will receive adequate feedback (r.141, FGD). The risk of misuse also exists (r.895, FGD). However, it was emphasized during the FGD that today everything focusses on the internet (r.146, i.i.). Another important question came up during the discussion who would be responsible for building the offers (r.94, FGD; r.150, i.i.).

The advantage of the care consultation by telephone is seen in the flexible availability. Even at 10 pm a coach can still be called (r.340, FGD). One disadvantage is the potential control over the patients. For some people, it is good and required to have strict monitoring. But for others, calls intervene too much into

the privacy (r.126, i.i.). There are hotlines available, where people can get help. This does not exist in GK, but in it is seen as an option to implement. Last year, cooperation dialogues took part with a company for family care without any success yet (r.108 et seq., i.i.).

Peer Support

The peer support is a possible opportunity for less severe cases (r.298, FGD). It is a good approach to involve people concerned and to create transparency. Not only the professionals shall do trainings, presentations or workshops (r.69 et seq., i.i.). The 'INSEA'[31] self- management program in GK has similar characteristics. It is for people with a chronical burden. One course took already part and people with mental disorders participated, too. There is a tandem cooperation between an affected person and a professional. The group shares their experiences and learn from each other (r.72 et seq., i.i.). A peer approach could be interesting but there could be irrational fear and concern in the rural area, that another person knows too many personal information about the problems gossip might begin (r.91, i.i.).

Integrated Care Network

The participants of the FGD talked briefly about the IC network for people with mental disorders, developed by the TK. One month ago, different results about the network were published. According to the controlling department, the program is not a success but the management claims it is a success. The reason for the contradicting statements is not known (r.125, FGD).

Other Supply Models

The category of other health care models was rarely evaluated. One participant argued regarding the 'Integriertes Versorgungszentrum' in Gießen, that he does not know how big the house is, for how many patients, and he has no idea about it (r.236, FGD). In the individual interview, other supply models were not reviewed.

[31] For further information: http://www.gesundes-kinzigtal.de/gesundheitsangebote/angebote-fuer-mitglieder/insea-kurse-bei-gesundes-kinzigtal.html. Access on 16th June, 2016.

Stepped Care

The participants of both surveys had in general problems in understanding the concept of a stepped care model (r.871, FGD; r.190, i.i). It is just a placard and nobody knows, who works in it and what other opportunities may exist (r.877, FGD). One participant said, that it sounds all good but difficult to implement in reality. One of the concerns is the speed of organising a team which takes care of the patient (r.162, FGD). Another person argued that the model leaves too little room for flexibility and is subjective, not self- determined by the patient (r.205, i.i.). On the hand, it is useful for offering a broad range of possible interventions or information, so that the patient can choose the best for him or her (r.212, i.i.). One member of the FGD argued that the stepped care model has similarities to the existing management program for depression in GK, which was never really put into effect (r.146, FGD). This comment was followed by the remark that they tried to implement such a program years ago. They wanted to arrange crisis interventions, too. However, it failed due to insufficient funding, staff, and space (r.152 et seq., FGD).

'PsychotherapieAkut' and 'Besser gestimmt'

The two existing psychiatric programs in GK were discussed in the focus group. The program 'PsychotherapieAkut' functions well, is easier to handle and covers to an extent the problem of the other program for patients suffering from depression (r.553 et seq., FGD). It consists of a sufficient contingent of medical psychologists and psychotherapists as well as a good combination of supply and demand (r.761, FGD).

The program 'Besser gestimmt' enrolled a patient actively two years ago (r.773, FGD). The members tried to find reasons for problems, like inhibitions and insecurity of the medical assistants to execute if they are not in practice (r.779, FGD). Another reason is the rigid structure of the program, which restricts the routine running of a practice. Flexibility is an important issue in a generally ambulance (r.582, FGD). The program was based on the 'PRoMPT'[32] study and

[32] For further information: http://www.allgemeinmedizin.uni-jena.de/content/forschung/depression/prompt/index_ger.html. Access on 14th June, 2016.

GK purchased this validated program of primary medical depression management (r.545, FGD).

Maybe, GK organized a little bit an internal competition with the two programs (r.563, FGD).

The Integrated Care System ‘Gesundes Kinzigtal’

A participant claimed that GK has a good basic concept which is becoming more harmonious during the last few years. The communication works in general well with some room for improvement (r.167, FGD). The general sentiment of the participants is positive towards the work done so far (r.947, FGD). It is important to have a wide range of treatment options to optimize the care for the patients (r.322, FGD). For the recording of treatments, the ICGK is using a central electronic patient file which does not work as needed. The functionality exists but it is not meeting the requirements of the day to day work (r.412, FGD). As a side comment it was mentioned that patients, who have a good general practitioner supporting them in getting an appointment with a specialist the waiting time is substantially shortened (r.434, FGD). The fully IC system has many contacts and are networked. GK knows roughly, how many clinics deal with a mental issue or how many self- help groups exist (r.226, i.i.).

In the region, a factory for disabled people persist for a longer period. People with mental disorders work there, are trying to be stabilized and to get into work or into an internship (r.222, FGD).

One member of the focus group compares the existing interventions with a construction kit, so what kind of help or programs are available in GK for people with mental disorders and what program could be expanded or implemented new (r.915, FGD). There are doctors and psychotherapists available and programs like ‘PsychoAkut’ exist (r.758, FGD). Furthermore, patient attendance as well as social counselling take place (r.781, FGD). A social- psychiatric service is available offering consultancy for people with an addiction (r.802, FGD). This service also provides meetings in a coffee shop for a limited clientele (r.810, FGD).

New Ideas of Projects or of Co-operations

Right at the beginning, a participant spoke about a possible co-operation partner- the network 'Psychenet'[33] in Hamburg. Everything, that the network had worked on, could be implemented in GK. Moreover, in a proposal for the innovation fond[34], the IC system could function as the practice partner. This can be a chance for an acquiring the financing for the start of new projects (r.1 et seq., FGD). Another idea is an ambulatory psychotherapeutic rehabilitation centre payed by the job office. It is for people aged younger than 25 years, being in a mental crisis and long- term unemployed. This approach shall get the people back to work. It was a model project and an establishment for an outpatient rehabilitation centre is planned (r.173 et seq., FGD). Another option could be a co-operation with universities (r.357, FGD). An offer also came from the company Elsevier[35], which calculates scores of patients developing an illness (i.e. mathematical modelling). With the help of the scores, people are aware of risky patients and can intervene as required. The Advisory Council of GK reject this option, because the modelling was estimated to be too cumbersome and expensive (r.387 et seq., FGD). A 'Terminservicestelle' from the Association of SHI Physicians was immediately evaluated as worse. One participant heard that people came to the appointments with a specialist from far away and they said it was not so good or no necessity at all (r.420 et seq., FGD). The information about a psychological treatment via the internet was discussed very low level. The participants had overall more concerns regarding this option than they were in favour (r.1062 et seq., FGD). There was also discussion about a qualified nursing service and it was argued if GK could arrange such service, or if there is such an outpatient care in the region in general. It was however concluded that GK could not find such a service and that there are insufficient specialised nurses available in the region (r.629 et seq., FGD).

[33] For further information: http://www.psychenet.de/. Access on 22nd August, 2016.
[34] For further information: https://www.vdek.com/fokus/innovationsfonds.html. Access on 14th June, 2016.
[35] For further information: https://www.elsevier.de/. Access on 14th June, 2016.

New Category- Approaches of Solution

If the IC system plans to implement a new project, it shall cover a broad spectrum of diseases (r.686, FGD). The focus group formulated two approaches for a solution:

1. There shall be a second person executing the mixture of CM, coaching and social counselling. Home visits are included, too. The application procedure started already (r.821, r. 1021, FGD).

2. A central agency in the internet answers mental concerns. A familiar person is working there with necessary competences. There is the flexibility to answer, when it suits (r.909, r. 977, FGD).

One member thought about locally systems, which can be improved. This person reports on bad experiences with day clinics. It is difficult to transcribe a patient due to long waiting times (r.1009, FGD). In the individual interview, there was no time thinking about new approaches.

A lot of facts point to the need of an individual intervention. For every case, the service provider has to find out the best way (r.296, FGD). A new intervention has to suit to GK and everybody should execute it with a possibility to monitor (r.901, FGD).

6. Discussion

The field of HSR has only become more prevalent in recent years. Consequently, no specific method applicable best for this scope has been identified at this stage which is the reason for the use of various methods throughout this paper.

In this chapter it is the purpose to discuss the strengths and weaknesses of the different methods while addressing the adapted HNA at first followed by the appraisal of the focus group debate.

6.1. Discussion of the Health Needs Assessment

A HNA is a good possibility to determine priorities for improving health and to tailor its services while addressing demographic changes and having limited health care resources available (Wright, et al., 1998). The concept of the HNA was exercised for people with mental disorders. However, due to the limitation in scope it was not possible to perform a complete HNA. Further, other factors impacting the health state of a mental disordered patient, like causation of the disease or living conditions, are not included as the thesis dealt with health services research only. As highlighted before the thesis focused on step four of the HNA which is the reason other solutions for unmet needs of patients suffering from mental disorders were not taken into account. Furthermore, the needs were assessed through literature research and routine data. Research with direct participation of patients has not been conducted.

In general, the topic ‘mental disorders’ was underestimated for a long period which is the reason for having had to use multiple times data from the German Health Interview and Examination Survey dating back to 1998. Prior to 1998 there has not been any recording of reliable sources. Henceforth, as stipulated before mental illness is quite young research field and it is not possible to perform comparisons of care models or treatment processes in general. Moreover, even today studies done about various diseases within the overall scope of ‘mental disorders’ are limited with unreliable data. Just a few institutions like the ’Robert Koch- Institut’

establish general reliable data. Other institutions are more specified on a topic or are regionally based.

The author searched only in the database PubMed and at Google Scholar for freely accessible articles representing a big limitation of the thesis. The literature search in well-known German portals and for ambulatory projects was done by hand. Therefore, no claim of completeness is given. It is possible that more data about outpatient models for mentally ill people exists which could not be found due to publishing or other reasons. Furthermore, the compilation of the ambulatory health care models occurred predominantly through electronic sources, so the significance is questionable. Statements about medical malpractice cannot be made and neither if the data or the interventions are adequate (Wittchen & Jacobi, 2001).

The broad spectrum of the literature is based on different methods of collecting data. Additionally, definitions of terms have been diverse and unaligned. For instance, the high number of non- treated patients can include different treatment rates depending on the disease. The group of mental diseases is very heterogenic (Wittchen & Jacobi, 2001). Generalizations are difficult. Also, there exist different structures of supply and health care in regions which are rarely investigated in detail.

The prevalence of mental disorders remained the same since 1998, but the illness is more present in the public and media due to the progression to a wider general acceptance. It is no longer a taboo topic. However, mentally ill people are still discriminated (WHOa, 2015). It is assumed that the increasing prevalence of mental disorders in GK is caused by rising enrolments into the IC system and by a growing number of aging people. The example of one high- cost patient in GK is very specific and cannot be generalized, but made his flow through the system transparent and worth knowing. Patients from other insurances in other regions may show different courses.

Data related to sick leave capture only people who are employed. If people are three days sick or less they do not need a sickness certificate (Boedeker & Berkels, 2005). Some diagnoses are possibly not captured as people continue to go to work.

According to Bühring (2003), corresponding to the survey of Friedrich et al., waiting times can occur in individual cases due to the wish of the patient for a particular therapist. The article summarized the psychotherapeutically health care situation in a defined area so that a general application to Germany is not possible.

Another weak point is the assumption that there is a direct correlation between a mental diagnosis and the need for care or treatment. There is no reference, if people without a mental disorder were treated psychologically (Wittchen & Jacobi, 2001).

The comparative analysis of the two populations showed a tendency and provided an informative overview. Similar facts are not surprising since both analyses are in Germany. However, the facts are based on different databases.

The use of routine data presents further limitation of the HNA. The analysis with routine data in the region Kinzigtal is based on insured people within the two co-operating insurances. Therefore, the analysis is very specific. To ensure that all data of people enrolled in the program was complete, data from 2013 had to be used. Data from 2014 was not yet complete at the time of the analysis.

The availability of routine data from SHI for scientific analyses in HSR is constantly increasing. However, the plausibility and validity need to be examined critically (Horenkamp-Sonntag, et al., 2015). Claim data can be used for comparisons, whether with benchmarks, over time or with other health care providers (Powell, et al., 2003). The secondary data can give indications to frequencies of a disease. They are primarily collected for billing purposes, though they offer from a scientific view various evaluation possibilities (Grobe & Dräther, 2015). Generally, the use of routine data is inexpensive, not time consuming and reflect the medical daily activities. Patients or participants are rarely necessary and interviewer or recall bias cannot occur. However, systematic mistakes are possible (Gothe & Buchberger, 2015). A disadvantage of claim data is that no specific relation to the research question exists (Scholten, 2016). Furthermore, there is no guideline for the ambulatory coding of diseases available (Grobe & Dräther, 2015). Diagnoses, which are not relevant for the treatment, are maybe not captured. Services of self-pay patients are not included (Horenkamp- Sonntag & Verheyen, 2012). Moreover,

some physicians code more precisely or in a different way due to different reasons being time, observation or accuracy (McKee, 1993). Routine data cannot explain causation.

The two different sources, on one hand literature and on the other routine data, provide a comprehensive view about a population. However, not all needs of people with mental disorders could be illustrated.

6.2. Discussion of the Appraisal

The individual interview served the need to receive a broader spectrum of opinions and a deeper insight of ambulatory approaches. Several topics and projects were discussed despite the limited time. The interview was held spontaneously without a questioning routine and it is not representative.

A FGD is a specific survey and leads to useful results. The group discussion, performed for the master thesis, provided a first overview of the spectrum of opinions about innovative approaches in the ambulatory care for mentally ill people in GK. The participants met the criteria of homogeneity as they share the similarity of working in GK having different occupational backgrounds. To ensure an overall pleasant atmosphere it was valuable that the participants knew each other beforehand. During the discussion two participants took on the role of leading the conversation. Participants with a more introvert nature did not have the chance to voice their opinions to the same extend but everyone was in a position to share their opinion freely.

The author represents a bias due to the double function being a moderator as well as a partial participant of the group discussion. With the use of a neutral moderator it could have been possible to achieve different results during the FGD. The author had no possibility to influence the refusal of the appraisal scheme by the group. With the aim to conduct the FGD through openness and flexibility (Lamnek, 2005) the author was not in a position to determine the ongoing course of the meeting. The rejection of the scheme can be explained by the fact that focus groups tend to produce trivial results when the topic is too complicated (Krueger & Casey, 2009).

The appraisal of the ambulatory projects may have been easier with a containment or preselection.

A severe challenge to appraise the projects was the question of seriousness i.e. who is offering the model and how professional are the people involved. Transparency related to these concerns is important for rating the ambulatory approach and group them into good and not good. During the discussion it became apparent that knowing who the responsible person behind the different models was tremendously important for the FGD participants to evaluate the quality and effectiveness of each model instead of making factual choices. The author could rarely clarify these questions due to the lack of findings.

GK refused some offers of co-operations or projects due to economic or other reasons. The implementation of new structures requires knowledge, qualifications, time, staff and other resources. Besides the new concept of IC and the promise of a flexible organisation, GK has to hold on to predefined structures of laws and insurances.

It was mentioned in the FGD that physicians cannot transfer patients to day clinics in the region. However, day clinics are necessary as they integrate and combine stationary and ambulatory care (DGPPN, 2013). E- health has been criticized due to privacy concerns. However, this position reflects a difference in generation considering the youth being more tuned towards anything related to the internet with less concerns around privacy security and so on. The model of stepped care was considered very critical despite of positive results made in studies in other countries. HT can be imagined in combination with peer support which would be a new approach and hence the author could not find any literature. Concluding the discussion, two solutions where proposed being a second permanent position with several qualifications and a central agency in the internet.

Altogether, the group responded somewhat restrained and critical towards new approaches. Nevertheless, the group discussed the different models regarding their feasibility in GK and tried to find solutions. The results were discussed in the group and one solution which was planned beforehand is now officially implemented. The meeting can be seen as a baseline for further discussions or to gain further insights to adapt programs.

7. Conclusion and Outlook

The multidisciplinary approach of HSR occurred for this paper more on the level of organisational structures and on the access, quality and costs of health care. Furthermore, barriers of supply were described. The HSR is trying to optimize existing standards. Within the thesis it was the objective to reflect this ambition through identifying the different innovative models for mentally ill people which were then evaluated within the FGD. The focus group and individual interview were a great opportunity to discuss the current developments in the ambulatory health care of mentally ill people with their advantages and disadvantages. Two approaches were selected to even improve the supply situation in the fully IC system.

The adapted HNA points to several problems related to the health care situation of mentally ill people in Germany as well as in GK. Beside the limitations of the different data bases, the comparative analysis of both populations showed a trend development, namely an inadequate one. Despite of missing transparency and lack of information about the current evaluation state the different approaches of ambulatory care illustrate the awareness as well as the willingness to act of health care providers and policy. Innovative approaches are necessary for an individual and need adapted health care of people with mental disorders while coping with the rising demand.

For people with complex issues emerged IC with different offers as the best method (Goodwin, 2015). Therefore, GK is already on the right track and with a possible expanding of their psychiatric programs they will become even better.

Generally, scientific evaluation of projects in the field of prevention, early diagnosis and treatment has to be stronger claimed and implemented (Lademann, et al., 2006). When considering the viewpoint and experience of people concerned within the psychiatric sector it would be possible to concentrate on outcome focused parameters with the objective to improve quality of life, social functioning and impairment as well as social inclusion instead of concentrating on parameters lead by symptoms (DGPPN, 2013).

Furthermore, the German population needs better information about the nature, content, accessibility, success and financing opportunities of mental disorders as there is limited knowledge about it and fears of being stigmatized still linger. There exist a manifold and differentiated structure of health care in the ambulatory and stationary field with a considerable capacity of supply (Schulz, et al., 2008). The establishment of a national register could help to collect standardised data about the health care situation of mentally ill people as it is the case for other diseases like cancer ('Zentrum für Krebsregisterdaten'[36]). For ensuring the quality of psychiatric care an agreement about the financing of same is essential. Otherwise the debates and recommendations for alternatives will be ongoing (DGPPN, 2014). Psychosomatic consultation hours at work could counteract early retirements or long sick leave caused by mental disorders. This offer is currently not wide spread in Germany but it generates high satisfaction among workers and company physicians (Preiser, et al., 2015).

According to the WHO (2015), the promotion, prevention and treatment of mental disorders are "[…] fundamental to safeguarding and enhancing the quality of life, well- being and producitivity […] of society as a whole (p.1)." The focus of care should be on the expanding role of the primary care and working in partnerships as well (WHOc, 2015). However, qualified staff is needed, especially in rural areas. An option to regulate regional differences could be offers for research, education or teaching (Wittchen & Jacobi, 2001). Further research on mental disorders is needed. On one hand, determinants of help- seeking and health care delivery are essential since pathways to an adequate mental health care seems to be influenced by diverse factors. On the other hand, comprehensive analyses within the complex area of co- morbidities are crucial as they affect onset, course and severity of the single disorder involved (Jacobi, et al., 2004).

In the last couple of years, the research field of mental disorders and their treatment is growing. GK with its population- and community- based care is a pioneer supporting a holistic approach which is needed to treat mentally ill people.

[36] For further information: http://www.krebsdaten.de/Krebs/DE/Home/homepage_node.html. Access on 6th August, 2016.

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Statutory Declaration

I hereby declare that I wrote this thesis without any assistance and used only the aids listed. Any material taken from other works, either as a quote or idea have been indicated under ‘List of References’.

Date & Place: _____

Signature: _____

Kathleen Kuhlmann

Appendix

Appendix Number 1a

Telefonprotokoll ‚Psycho Akut'

OptiMedis AG

Teilnehmer:	Petra Zimmer, Kathleen Kuhlmann	
Veranstaltung:	Telefongespräch	Datum: 02.11.2015
Thema:	Programm ‚Psychotherapie Akut' in Gesundes Kinzigtal (seit 2007)	

Fragen Kathleen Kuhlmann	Antworten Petra Zimmer
Sind 7 Sitzungen zu wenig/ zu viel?	Unterschiedlich, aber die Patienten kommen immer unter. Danach muss man 2 Jahre warten, um das Programm wieder nutzen zu können.
Besteht irgendein Optimierungsbedarf?	Nein, momentan nicht. Es ist ein Gruppenangebot im Gespräch.
Wie ist die Auslastung bzw. Beanspruchung?	Ich schätze, dass circa 80% des Angebots ausgelastet ist. Das Programm wird meiner Meinung nach sehr gut angenommen.
Wie kommt man in das Programm?	Man geht zum Hausarzt seines Vertrauens und dieser telefoniert mit Psychotherapeuten und fragt nach freien Plätzen. Damit übernimmt der Hausarzt die erste Hürde. Dann muss der Patient selbstständig anrufen, um einen Termin verbindlich abzusprechen.
Werden Angehörige miteinbezogen?	Nein.
Sind auch Kinder im Programm?	Nein, nach unserer Krisendefinition ist das Angebot nur für Erwachsene.
Wie viele Personen sind momentan im Programm eingeschrieben?	Ich habe gerade keine Zahl im Kopf, jedoch ist die Zahl kontinuierlich steigend.
Inwiefern besteht eine telefonische Betreuung?	Zum Einstieg beantworten die Patienten einen Fragebogen, der dann nach Ende der Behandlung (1 Monat später) telefonisch abgefragt wird.
Wird Hilfe via Internet angeboten?	Aktuell wird dies nicht verfolgt, ist aber immer wieder Gesprächsthema.

OptiMedis AG

Gibt es psychiatrische Tageskliniken in der Umgebung?	Ja, 3: in Offenburg die Klinik an der Lindenhöhe, die Winkelwaldklinik in Nordrach, Celenus Klinik Gengenbach; bei allen bestehen Kooperationen.
Wie viele Psychotherapeuten sind Leistungspartner?	8 Psychotherapeuten im Kinzigtal
Was ist ihre Erfahrung- treten psychische Störungen vermehrt allein auf oder in Kombination mit somatischen Erkrankungen?	Dazu kann ich Aussage treffen.

Petra Zimmer

Appendix Number 1b

Telefonprotokoll ‚Besser gestimmt'

OptiMedis AG

Teilnehmer: Dirk Konnegen, Kathleen Kuhlmann

Veranstaltung: Telefongespräch **Datum:** 02.11.2015

Thema: Programm ‚Besser gestimmt' in Gesundes Kinzigtal

Fragen Kathleen Kuhlmann	Antworten Dirk Konnegen
Wie ist die Auslastung des Programms?	Momentan sind 24 Personen eingeschrieben. Wir haben das Problem, dass die Einschreibezahl zurück geht und wir wissen teilweise nicht, woran es liegt. Denn die Personen, die Depressionen haben, werden nicht weniger (das wissen wir aus Analysen).
Was ist die Zielgruppe?	Patienten mit einer leichten Depression, um diese frühzeitig zu erkennen und zu behandeln.
Erhalten die Ärzte Schulungen?	Ja, um Depressionen besser zu erkennen.
Wie erreichen Sie Leute, die nicht den Hausarzt aufsuchen?	Gar nicht.
Im Internet habe ich gelesen, dass Gruppentherapie angeboten wird. Wie wird diese angenommen?	Die Gruppentherapie wird aktuell nicht angeboten. In der Vergangenheit war die Hemmschwelle zu groß und es wurde schlecht angenommen. Wir arbeiten an einem neuen Flyer.
Was ist die Qualifikation des Case Managers?	Eine medizinische Fachangestellte erhält eine Schulung, sodass eine intensive 6- monatige Begleitung eines Patienten möglich ist.
Wie sieht die weitere Betreuung aus?	Es gibt einen Telefontermin nach 4 Wochen. Es wird nach dem PHQ 9 Fragebogen der Verlauf dokumentiert, wobei die Suizidfrage schwierig ist.
Gibt es Ideen für Optimierungen?	Ein Internettool wird in Erwägung gezogen, da wir von dem positiven Nutzen gehört haben.

Dirk Konnegen

Appendix Number 2

- Case Management/ Patientencoaching
  - Für Patienten mit lang andauernden und komplexen Gesundheitsbedarfen; Effekt umstritten
- Collaborative Care (am UKE)
  - Niedrigschwelliges Beratungsangebot in Hausarztpraxis mit Gesundheits- und Krankenpfleger zur Selbstmanagementförderung des Patienten
- Jena Paradies (Patient activation for anxiety disorders)
  - Therapiematerialien bereit gestellt für Patienten mit Panikstörung
  - Selbsthilfebuch+ telefonische Abfrage des Symptom- und Behandlungsverlaufs
- Entlastende Versorgungsassistentin in Westfalen- Lippe
  - Haus- und Heimbesuche, Schulungen
- Dementia Care Manager
  - Frühzeitige Erkennung und bedarfsgerechte Behandlung der Demenz
  - Hausbesuche, eigenes Computersystem
- Home Treatment-> Assertive Community Treatment
  - International angewendet; in Dtl. am UKE- multiprofessionelles Team bietet Behandlung im häuslichen Umfeld (akute Behandlung für eine begrenzte Dauer)
- Bedürfnisangepasste Behandlung& offener Dialog (in Finnland)
  - Erste therapeutisches Treffen mit Menschen in einer Psychose innerhalb 24h
  - Kennzeichen: Flexibilität und psychologische Kontinuität
- Peerbegleitung
  - Potenzial weitgehend ungenutzt, wird am UKE angeboten
- Telemedizin, Bsp. in Vorpommern
  - Telefonische Weiterbetreuung nach psych. Behandlung; Erfolg: Projekt wird in Regelversorgung übernommen
- Telefonischer Gesundheitscoach (KKH)
  - Pro Teilnehmer fester Gesundheitscoach
- Deprexis®24
  - Zusätzliches Onlineangebot zur Psychotherapie mit motivierenden Tipps und Fragebögen
- DepressionsCoach (TK)
  - Strukturiertes Aufgabenprogramm, Schreibaufgaben, Audioschulungen; teilweise schriftliche Rückmeldung vom Therapeuten
- Integrierte Versorgungsnetzwerke
  - Bsp. TK: Bezugsbegleiter und Leitstelle unterstützen bei verschiedenen Elementen der Behandlung
- Integriertes Therapeutisches Zentrum, in Gießen
  - Ein Behandlungsteam in einer Räumlichkeit mit einem Gesamtkonzept in einem Wohnhaus
- GAPSY, in Bremen
  - Amb. Psych. Pflegedienst+ Soziotherapie+ Rückzugsräume
- Stepped Care
  - Analyt. Rahmen der Behandlungsoptionen je nach Schwere der Erkrankung

		PA	PA+HB	HB	E-Health	IV- Model	24h/ 7Tage	Soziotherapie	Rückzugsraum	Schulung
	Case Management/ Patientencoaching		x		teilweise	teilweise	teilweise	x		
Nicht-ärztl. PA	Collaborative Care (am UKE)	x						x		
Nicht-ärztl. PA	Jena- Paradies	x			x			x		
Nicht-ärztl. PA	Entlastende Versorgungsassistentin		x					x		x
Nicht-ärztl. PA	Dementia Care Manager		x		x			x		
	Home Treatment			x		teilweise	x	x		
	Assertive Community Treatment			x			x			
	Bedürfnisangep. Behdlg.& offener Dialog			x			x	x	teilweise	
	Peerbegleitung				x			teilweise		
E-Health	Telemedizin (Bsp. in Vorpommern)				x					
E-Health	telefonischer Gesundheitscoach (KKH)				x					
E-Health	Deprexis®24				x		x			
E-Health	DepressionsCoach (TK)				x		x			x
	Integrierte Versorgungsnetzwerke			x	x	x	x	x	teilweise	
Weitere Vers.modelle	Integr. Therap. Zentrum in Gießen			x			x	x		
Weitere Vers.modelle	GAPSY in Bremen			x		x	x	x	x	
	Stepped Care		x		x	x	x	x		x

Appendix Number 3

	Gesundheitsnut-zen	Versorgungserle-ben	Wirtschaftlich-keit	Zufriedenheit als Leistungs-partner	Umsetzbar-keit	**Punkte-vergabe**
Case Management/ Patientencoaching						
Nicht- ärztliche Praxisassistenz						
Home Treatment						
E- Health						
Peerbegleitung						
Integriertes Versor-gungsnetzwerk						
Weitere Versor-gungsmodelle						
Stepped Care						

Appendix Number 4

Transcription rules, in style of Dresing & Pehl (2011):

- The words said are transcribed. Existing dialects are translated into standard German.
- Abbreviation are not transcribed. The form of a sentence is kept even when there are syntactic mistakes.
- Breaks are not relevant and therefore not labelled.
- Statements like ‘mhm’ or ‘äh’ are transcribed.
- The accent of words is not important and therefore not labelled.
- Every new speaking contribution gets an own passage. Occasionally, time marks are integrated. Every row in the transcript is numbered.
- The (emotional) reactions of the participants are not of interest as well as the non- spoken actions.
- The identification of the participants and of the moderator occurs with their initials.
- Babble of voices is marked as general discussion. Non- understandable hecklings or comments are marked as those.

- The content of the presentation of the author is not transcribed. The discussion about the example of one high- cost patient, the task for the participants as well as statements of the author are roughly transcribed.
- Persons or names said by the participants, were excluded like ‘(Name)’.