RE THINKING SCHIZOPHRENIA

Phase III: Country Profiles

Rethinking Schizophrenia in Germany: Schizophrenia and Brain Health

EBC European Brain Council

EPA

UNIVERSITÄT ZU LÜBECK

LMU LUDWIG-MAXIMILIANS-UNIVERSITÄT MÜNCHEN

GBC GERMAN BRAIN COUNCIL

Organisations Supporting this Document

European Psychiatric Association (EPA)

Global Alliance of Mental Illness Advocacy Network - Europe (GAMIAN-Europe)

European College of Neuropsychopharmacology (ECNP)

European Federation of Associations of Families of People with Mental Illness (EUFAMI)

Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde e.V. (DGPPN)

European Scientific Association on Schizophrenia and Other Psychoses (ESAS)

Deutsche Gesellschaft für Biologische Psychiatrie (DGBP)

Authors

Dr. Léon Franzen: Group Leader, Department of Psychiatry and Psychotherapy, University of Lübeck and University Hospital Schleswig-Holstein

Dr. Isabel Maurus: Deputy Director, Clinic for Psychiatry and Psychotherapy, Ludwig-Maximilian-University Munich

Prof. Stefan Borgwardt: Chair, Department of Psychiatry and Psychotherapy, Research Group Translational Psychiatry, University of Lübeck

Prof. Peter Falkai: Director, Clinic for Psychiatry and Psychotherapy, Ludwig-Maximilian-University Munich

Consultation

Prof. Andreas Bechdolf: Chief Physician, Clinic for Psychiatry, Psychotherapy and Psychosomatics, Vivantes, Berlin

Prof. Christoph Correll: Director, Department of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, Charité – Universitätsmedizin Berlin

Prof. Rebekka Lencer: Senior Physician, Track Psychotic Disorders, University Hospital Schleswig-Holstein, Lübeck

Prof. Nikolaos Koutsouleris: Professorial Chair in Precision Psychiatry, Department of Psychiatry and Psychotherapy, Ludwig-Maximilian-University Munich

Gabrielle Glocker: Representative of the German Federal Association of Relatives of People with Mental Illness

Bianca Rudloff: Peer Support Worker, Track Psychotic Disorders, University Hospital Schleswig-Holstein, University of Lübeck

Frederike Schröpfer: Occupational Therapist in Psychiatry; Doctoral Candidate, Department of Psychiatry and Psychotherapy, University of Lübeck

Prof. Andreas Meyer-Lindenberg: German Brain Council

Bernhard Seidenath: Healthcare Policy Decision-Maker, Christian Social Union (CSU) Bavaria

Health insurances

Collaborators and Editors

Vinciane Quoidbach: Research Project Manager, European Brain Council (EBC)

Pavel Mohr: Vice-President, Czech Psychiatric Association; President, Czech Brain Council

Executive Summary

Key Insights and Challenges

Germany is a country with exceptionally high healthcare spending, including significant investment into mental health services, and is underpinned by strong foundations in evidence-based care. The national S3 schizophrenia guideline1 (S3-Leitlinie Schizophrenie) in Germany—updated as a "living guidelines" since 2025—promotes a biopsychosocial, multimodal approach, which emphasises psychotherapy, psychosocial support, early intervention, lifestyle measures, and shared decision-making alongside pharmacotherapy. It now also promotes trauma-focused approaches. Awareness of the guideline among professionals is high, but implementation and adherence vary considerably. Germany is notable for offering psychotherapy without co-payments or strict session limits. The country has also had a long history of early detection and intervention (early psychosis intervention EPI), contributing to international discourse on concepts and practicing low-threshold access in several larger cities. Recent extensive initiatives (e.g., CARE2, soulspace, DZPG3) have expanded the EPI infrastructure, professional training, and the use of artificial intelligence (AI)-based risk prediction, which displays promising potential to reduce the duration of untreated psychosis (DUP) and improve patient outcomes.

Innovations in precision psychiatry, digital mental health interventions (DiGAs), and lifestyle-based treatments further highlight Germany's research strength. AI-driven stratification models aim to personalise care. Exercise and lifestyle interventions are increasingly recognised as core treatments. Rehabilitative sports and DiGAs can be prescribed to individuals with mental disorders. Community-based alternatives to hospitalisation, such as inpatient-equivalent treatment (IET/StäB), and more flexible regional budgets, have demonstrated cost-effectiveness and better outcomes in pilot regions.

Key challenges exist despite substantial investment in mental health. People living with schizophrenia in Germany often experience care as a fragmented experience and find it difficult to navigate. Differences across the 16 federal states in legislation, funding models, and service availability lead to uneven access, regional disparities, and limited coordination between services. As a result, many patients face long delays before receiving appropriate care, are treated repeatedly in hospital settings, and must organise complex care pathways largely on their own. Funding structures that prioritise hospital beds over flexible budgets further limit recovery-oriented, community-based treatment and disrupt continuity of care, particularly during the transition from child and adolescent to adult services.

Timely access to EPI remains inconsistent. Many individuals experience prolonged DUP due to seeking help late, stigma, and limited nationwide coverage of low-threshold EPI services with secure long-term funding. Although psychotherapy is formally recognised as a cornerstone of care, patients with schizophrenia often struggle to access it in practice because of long waiting times, limited disorder-specific training among therapists, and structural disincentives to treat severe mental illness in outpatient settings. Similarly, evidence-based pharmacological treatments are not consistently available: long-acting injectables and clozapine (an antipsychotic medication primarily used to treat severe mental health conditions, and treatment-resistant schizophrenia) remain underused, reflecting regulatory, infrastructural, and economic barriers rather than patient need.

Interventions that support long-term recovery and physical health—such as exercise, lifestyle, nutritional, and digital interventions—are insufficiently available outside inpatient care, despite evidence of benefit. Limited workforce capacity, fragmented funding, and restrictive approval processes constrain their broader implementation.

Further unmet needs affect daily life and long-term outcomes of patients, including limited treatment options for negative symptoms, persistent stigma, language barriers for migrant populations, and insufficient involvement of relatives and carers in shared decision-making. Finally, fragmented documentation systems and restrictive data-sharing frameworks hinder the use of digital tools and integrated health data, reducing care coordination and slowing down system-wide learning and opportunities for improvement.

Emerging Opportunities

The recently strengthened network of better-trained EPI specialists could capitalise on efforts in precision psychiatry. These efforts, supported by AI, focus on multimodal biomarkers and national research infrastructures (e.g., DZPG). This major area of innovation aims to improve individualised detection and treatment by exploiting neural, cognitive, genetic, and clinical data. Further adoption of EPI approaches like 'soulspace' could provide dedicated crisis centres alongside a 24-hour crisis hotline for people in distress nationwide – placing EPI within the heart of the community. More ongoing initiatives bid for wider implementation in the coming years. These include tailoring EPI to specific high-risk groups during adolescence, improving the transition from child and adolescent to adult care, training programmes that increase knowledge and guideline adherence among professionals, and vocational programmes aimed at recovery and reintegration. Distributing and promoting lifestyle interventions beyond inpatient settings represents a promising area.

Policy Priorities Moving Forward

The outlined challenges faced in the absence of a single national mental health strategy and fragmented healthcare system call for substantial changes on structural, clinical, and policy levels. These include:

- The strengthening of EPI nationwide, backed by a solid funding structure and political agreement across federal states.
- A simpler legal framework for community treatments could result in more sustained effects and improve care of underserved groups.
- The funding of better training for all healthcare professionals on schizophrenia and comorbid somatic symptoms.
- Increased and faster implementation of successful research into standard care.
- Adoption of international standards for the introduction of new pharmacological treatments.
- A greater focus on prevention and recovery by extending vocational and housing support.
- The provision of anti-stigma programmes for society and professionals alike.

Key Priorities

- Shortening the duration of duration of untreated psychosis (DUP) and duration of untreated illness (DUI) and addressing the youth mental health crisis by achieving nationwide, standardised early psychosis intervention (EPI) starting in adolescence.
- Considering multimodal data in individualised early detection, intervention, and treatment decisions and stepped care approaches.
- Building large-scale infrastructure to collect and store data on care outcomes.
- Supporting large-scale initiatives and their implementation across German federal states.
- Strengthening multidisciplinary and cross-sectoral care environments nationwide.
- Strengthening the use of digital mental health interventions.
- Promoting anti-stigmatisation of mental disorders.

A webinar titled `AI-supported prediction and intervention: A comprehensive approach to integrated biopsychosocial schizophrenia care' was held on 4 March 2026 to discuss the country profile in depth with key German stakeholders. The event was organised by the European Brain Council (EBC) and the German Brain Council, together with the Department of Psychiatry and Psychotherapy of the University of Munich and the Department of Psychiatry and Psychotherapy of the University of Lübeck.

Background

As a continuation of the Rethinking Schizophrenia project and the recommendations set out by the European Brain Council (EBC) during phase 2, the third phase presents country profiles of schizophrenia care for three selected European countries, based on strategic considerations.

Here, we provide a country profile of schizophrenia care in Germany, based on a validated template. This profile is based on the most recent data and insights from leading national experts in the field. As the findings outlined in phase 2 of the project (guided the present report), this profile represents a reality check for the recommendations set out by the EBC. The country profile comprises this report alongside a webinar organised by the EBC and the report's authors, titled "AI-supported prediction and intervention: A comprehensive approach to integrated biopsychosocial schizophrenia care," held on 4 March 2026. Both the report and webinar focus on advances in early detection, as well as improvements achieved through lifestyle interventions.

From a broader brain health perspective, Germany has developed strong clinical and research foundations that resonate with the principles promoted by the EBC Rethinking Schizophrenia study (Mohr et al., 2026), particularly regarding prevention, early detection, and coordinated biopsychosocial care across the life course. Nevertheless, in the absence of a unified national mental health strategy and comprehensive psychiatric reform, the system remains characterised by structural fragmentation, regional disparities, and funding mechanisms that limit the full implementation of integrated and recovery-oriented care pathways.

Country Overview

Germany is a central European high-income country with a population of approximately 83.5 million people who have an average life expectancy of 81.1 years (OECD, 2025). Its suicide rate remains slightly below the OECD average (10 vs. 11 deaths per 100,000). It is characterised by low income (Gini coefficient =0.295; Destatis, 2025) but high wealth inequality (Gini coefficient = 0.724; Bundesbank, 2025).

Germany's **GDP** was about €4.7 trillion in 2025. It has one of the highest total healthcare expenditure rates globally, and the highest in Europe, allocating approximately 12% (€564 billion) of its GDP to healthcare, with 11-13% (€62-73.3 billion) of that total healthcare spending directed toward mental health (Wiegand et al., 2025). This results in the 8th highest spending rate per capita in Europe.

Projections for 2025 indicated continued high spending around €5,832 per capita, and direct costs are anticipated to keep increasing due to rising mental health-related sick leave and expanded outpatient services. Historically, over 50% (> €28.6 billion) of the mental healthcare costs in Germany are generated by inpatient and rehabilitation services (Wiegand et al., 2025). 4.8% of total health spending is allocated to prevention measures, but these figures are not specific to mental healthcare (OECD, 2025). Some studies estimate the total annual economic burden of schizophrenia in Germany to range between €9.63 and €13.52 billion (Frey, 2014; IGES Institut, 2024). Adding a societal perspective to these numbers, they can be broken down into €11,304 of direct medical costs and €20,609 of societal costs per patient per year (Frey, 2014).

The psychiatric healthcare system is fragmented, leading to regional disparities, and has not undergone major reforms focused on improving psychiatric care in recent years.

Epidemiology and Burden of Schizophrenia

Schizophrenia can be a debilitating disorder. Its lifetime prevalence rate is 0.5-1%, with slightly higher incidence in urban areas (19 vs. 13 per 100,000 inhabitants; DGPPN, 2025). At present, approximately 800,000 people are living with schizophrenia in Germany (Bundes-Psychotherapeuten-Kammer, 2026). Typically, the disorder's onset occurs between ages 15 and 35, though most onsets occur before age 30. In their early twenties, a stage of life marked by change as well as professional and social challenges, around 1% of people in Germany experience an episode of psychosis, often only once in their lifetime (Theodor-Wenzel-Werk e.V., 2026). While lifetime prevalence does not differ between genders, males receive a diagnosis 3-4 years earlier on average.

Evidence shows increased odds of mortality of the factor 2.38, and an 8.2–11.5 years shorter life expectancy for individuals with psychotic disorders (Wiegand et al., 2025). Besides increased mortality and shortened life expectancy, reductions in the quality of life have also been reported. The risk of developing schizophrenia increases with decreasing socio-economic status and education levels. Comorbidities, such as substance abuse and somatic issues, as well as lifestyle factors play important roles in the development and treatment of the disorder (DGPPN, 2025). Overall, the drivers of the individual and societal burden of schizophrenia are unemployment, insecure housing, and regular inpatient treatment.

Mental Health System and Policy Framework

In Germany, the **healthcare system** is divided into inpatient, inpatient-equivalent, day-clinic, outpatient, and rehabilitation systems, as well as regional outpatient complementary structures. This structure aims to bridge care settings and reduce the structural challenge of fragmentation. Psychiatry itself is separated into child and adolescent psychiatry, as well as adult psychiatry and forensic institutions.

Germany does not have a single **national mental health law**. Instead, each of Germany's 16 federal states (Bundesländer) has laws for mental health policies ('Psych-HG') regulating involuntary hospitalisation and protective measures for people with acute mental health crises including schizophrenia (Zielasek & Gaebel, 2015). It includes provisions for social psychiatric support and, in some reforms, preliminary outpatient services to reduce coercive contacts. Legal protections via state mental health laws regulate compulsory care, while national health policy and public health programs address comorbid risks and integration into broader psychiatric care improvement efforts.

German medical law upholds patient autonomy, informed consent, and confidentiality, with added protections for individuals with mental illness regarding treatment decisions and data privacy. This is embedded within a health system financed largely by statutory insurance, with implementation challenges and regional variation in treatment availability.

Germany counted a total of 403 psychiatric and psychotherapeutic-dedicated hospitals and departments within general hospitals, with a capacity of 57,011 beds and 16,957 day-clinic places (23%). A distinct feature in Germany is the presence of 279 additional hospitals and departments for psychosomatic medicine and psychotherapy, offering a further 12,844 beds and 2,592 day-clinic places (17%)" (Wiegand et al., 2025).

This long-term structure may be somewhat affected by the recent **'Hospital Care Improvement Act'** (KHVVG), which came into force in January 2025 (Federal Ministry of Health, 2024). It is a major reform of hospital financing including a €50 billion transformation fund that aims to shift services toward more outpatient and cross-sectoral care until 2035. This act, however, does not directly impact psychiatric or schizophrenia care, as it focuses on improving somatic care and the distribution of hospitals across the country. Recent changes to psychiatric care include the PPP-RL4 law, which outlines the necessity to increase staff numbers and contact/treatment hours per patient substantially (G-BA, 2025).

Mental **healthcare funding** is integrated into the general healthcare system, primarily funded by mandatory, non-profit statutory health insurance and private insurance. Health insurance coverage has been a legal requirement for all German residents since 2007. 88% of the residents are covered by statutory health insurance while most other residents are covered by private insurance (11%). The latter group is preferentially treated by some doctors. Young men aged 15–24 are the most likely demographic group without insurance coverage (up to 1% of the population), which coincides with the group that is most likely to develop schizophrenia (Wiegand et al., 2025). Substantial funding for innovative projects bridging research and care is also allocated by the Innovation Fund. Central nationwide initiatives including the German Centre for Mental Health (DZPG), have also received a recent 5-year boost of significant funding until 2030. This funding shall be used to improve precision psychiatry across Germany for instance.

Clinical policy for schizophrenia care is built around an evidence-based, consensus-driven, and annually updated **guideline** that guides diagnosis, treatment modalities, and coordination across care settings (latest version from October 2025; DGPPN, 2025).

Since 2025, it has become a living guideline that is constantly being updated. It provides recommendations tailored to different phases of schizophrenia, which emphasise multimodal care including pharmacotherapy, psychotherapy, and psychosocial support. Germany recognises psychotherapy as an important cornerstone of schizophrenia therapy (DGPPN, 2025). It is one of the few countries providing access to psychotherapy without requiring co-payments or placing absolute limits on the number of sessions (Wiegand et al., 2025). Individualised treatment plans with shared decision-making should guide treatment whenever possible. Sectors such as outpatient psychiatrists, general practitioners (GPs), and specialised psychosocial services should collaborate to ensure continuity of care. This most **recent living guideline** provides numerous central best practice recommendations, which are important to be aware of. Nonetheless, their implementation in routine care varies, and guideline adherence needs improvement. Differences between professions exist, with medical doctors showing higher and psychosocial therapists lower levels of agreement (Khorikian-Ghazari et al., 2023).

Access to Early Assessment, Care and Treatment (Status Quo)

The German health insurance system requires all residents to be covered by health insurance, allowing them to receive initial diagnostics and treatment if they become help-seeking. Nevertheless, timely access to existing early detection and intervention centres remains a challenge, with the DUP ranging between 4 and 12+ months, in some cases even more than one year, and the duration of untreated illness (DUI) being even considerably longer (DGPPN, 2025; Lambert et al., 2017; Schultze-Lutter, Rahman, et al., 2015). Late (self-)referral to specialised centres is a key issue driving these durations, as patients have three help-seeking contacts, on average, before receiving adequate treatment (Meisenzahl et al., 2020; Schultze-Lutter, Rahman, et al., 2015), or do not become help-seeking due to a lack of insight into their illness.

As an attempt to improve this situation, Germany has been influential in the development of criteria for the **early assessment of psychosis**, promoting the **basic symptoms concept and indicated prevention approach** (Ruhrmann et al., 2003). This concept and assessments of cognitive impairment have also been featured in a recent guidance on early detection of the European Psychiatric Association (Schultze-Lutter, Michel, et al., 2015; Vita et al., 2022). For decades, a selected group of specialised centres have been practicing early detection and intervention (EPI) of psychosis across Germany (26 institutions by 2012; Leopold et al., 2015). However, nationwide coverage and a unified standard had not been achieved. Sixteen centres offered low-threshold access and 14 fostered collaborative ties to child and adolescent departments (Leopold et al., 2015). Most centres have low-entry barriers by not requiring referrals from a specialist. Though, help seekers have to show their health insurance card, which did not let this help-seeking behaviour go unnoticed and prompted many to be careful of taking this step-in fear of negative consequences, such as being denied certain insurance or jobs due to a potential mental illness diagnosis on their record. Usually, these specialised centres are anchored within outpatient care with ties to inpatient wards. This structure provides the opportunity for phase-specific treatments and a quick hand-off within the same institution, tailored to a patient's individual needs. Often, neurocognitive assessments have been included as a part of German EPI approaches (Stüble et al., 2024).

Only recently, larger local initiatives such as 'soulspace' (Bechdolf et al., 2024) have facilitated low-threshold access in crisis within the community without the need to show an insurance document.

This leading concept provides dedicated crisis centres throughout the city of Berlin alongside a 24-hour crisis hotline for people in distress – placing it within the heart of the community. Recently, soulspace received a funding extension. Another country-wide study using stratified early intervention (CARE) has resulted in a larger-scale training initiative of EPI specialists from adult as well as child and adolescent departments (Bommhardt et al., 2025). As well, it promoted unified standards and the concomitant assessment of neuro-, psycho- and social cognitive domains using artificial intelligence (AI) algorithms to assess the risk of transition across Germany. Preserving this recently established network of 35 approachable centres, could build the basis for numerous evidence-based benefits, including better and earlier intervention, a reduced DUP, and ultimately better functional outcomes. Both initiatives' coverage of help-seekers aged as young as 15 aligns with recent international recommendations of prioritising youth, as many mental illnesses have their onset in adolescence (McGorry et al., 2024; Uhlhaas et al., 2023).

These voluntary care pathways must be differentiated from forced admissions and coercive measures. Germany has several ways of forced admission with strict requirements. The system takes great care in evaluating the necessity of these measures, placing the final decision in the hands of a judge (Zielasek & Gaebel, 2015). Overall, German psychiatric departments have reduced fixations and coercive measures (Wiegand et al., 2025).

Treatments

Beyond early assessment, according to the most recent guideline, every patient with schizophrenia **should receive low-threshold access to care** (recommendation #137; DGPPN, 2025). This requires effective interdisciplinary coordination of psychiatric, psychotherapeutic, psychosocial, and general medical fields and experts, and measures. The teamwork of these shareholders together with the patients should be a key characteristic of the system (#138; DGPPN, 2025). Thus, it is noteworthy that all areas/forms of treatment are available to patients across Germany. Nevertheless, these treatments, have been focused on mitigating symptoms instead of achieving recovery. The current funding structure makes it difficult to achieve coordinated action between sectors and selecting the most appropriate form of treatment according to the disorder's phase. It also does not incentivise outpatient doctors to continue expensive and effective prescriptions from inpatient treatments.

Cognitive Behavioural Therapy (CBT; psychotherapy) is weakly recommended by the recent national guideline as a first-line intervention (#128a), though, it is preferred before pharmacological treatments (#128b; DGPPN, 2025).

While evidence on its superior efficacy in preventing transition to psychosis is not unequivocal, better treatment adherence has been reported (Bechdolf et al., 2023). In people diagnosed with a first episode of psychosis or multi-episode schizophrenia, CBT has a grade A recommendation. Germany is also one of the few countries providing access to psychotherapy without requiring co-payments or placing session limits (Wiegand et al., 2025). Nevertheless, structural issues of the remuneration system, which do not incentivise outpatient psychotherapists to treat severely ill patients, lead to discriminatory access and limit this strength. Furthermore, schizophrenia and psychosis-specific psychotherapy receive only limited attention during the training of prospective psychotherapists. This leads to uncertainty among therapists and, in many cases, to reluctance or refusal to treat patients with this diagnosis (Heimkes, 2024). Although waiting times for first appointments have decreased between 2011 and 2018 (BPtK, 2018), waiting times for therapy are often longer than three months in general and even longer for people with schizophrenia (Wiegand et al., 2025).

Negative symptoms, such as reduced motivation, social withdrawal, diminished emotional expression and reduced speech, have been increasingly recognised by national guideline as a core dimension affecting long-term functioning and quality of life, but they often remain insufficiently targeted in treatment decisions. This may be rooted in limited evidence for effective pharmacological interventions. The use of atypical antipsychotics (e.g., amisulpride, aripiprazole, quetiapine, cariprazine) is standard in practice and preferred over typical antipsychotics. Specific agents like cariprazine (Reagila®) have been studied for relative benefits on negative symptoms in clinical trials and are available in Germany. These antipsychotic treatments may have some residual impact on negative symptoms, as a by-product. Pharmacotherapy alone, still shows limited direct efficacy, often with only modest direct effects, on core negative symptom domains. Adjunctive treatments include cognitive behavioural therapy (CBT) targeting motivation, social engagement, and functional outcomes, cognitive interventions, and antidepressants (Bschor, 2022; Rummel-Kluge et al., 2006).

Visiting treatment options (e.g., inpatient-equivalent psychiatric care (IET/StäB) or Assertive Community Treatments5 could help to achieve a focus on functional outcomes. In Germany, these treatment options are especially recommended when the risk of treatment discontinuation or homelessness is present in a particular case (#142; DGPPN, 2025). Visiting or home treatment models aim to keep people in their social context with intensive support rather than traditional hospitalisation, and can be used for acute psychotic episodes, including schizophrenia, that would require traditional inpatient care. Legal basis and reimbursement are set nationally.

Lifestyle and Exercise Interventions

Lifestyle interventions, including physical activity, nutrition, smoking cessation, and sleep improvement, are associated with substantial benefits for both physical and mental health. Their overarching aim is to reduce health inequalities and premature mortality among people with mental illness through sustainable, lifestyle-focused care. The recent European Psychiatry Association (EPA) guidance assigned both combined lifestyle and structured exercise interventions the highest level of evidence (Maurus et al., 2024). Accordingly, lifestyle interventions should be regarded as core components of psychiatric treatment and offered to all individuals receiving mental health services. In addition, to allow for adequate evaluation of physical health risks, regular **assessments of lifestyle factors**, such as dietary behaviour and physical activity, should complement routine assessments of anthropometric measures and laboratory parameters.

In Germany, **exercise-based interventions** tailored to the needs of people with schizophrenia are recommended (#80; DGPPN, 2025) but are still largely restricted to clinical trials or inpatient settings. A retrospective analysis of selected billing data from 2,693 patients revealed that only 23% of patients participated in routine care exercise therapy during a one-week observation period, with a mean weekly duration of 36 minutes. Strikingly, participation rates were even lower among individuals with schizophrenia, highlighting a substantial gap in care (Brehm et al., 2020). These rates may also be driven by an absent relationship of objective and subjective physical fitness parameters in individuals with schizophrenia (Rippe et al., 2025).

In the outpatient care setting, **rehabilitative sports** have been prescribed for individuals with mental disorders since 2020, allowing cost-free participation, although these programs are not tailored specifically to the needs of people with schizophrenia. Awareness of this option remains limited, and specialised programs with appropriately trained exercise professionals still need to be improved and expanded.

Concerning interventions aimed at **optimising sleep** amongst schizophrenia patients, the current evidence base remains insufficient (Maurus et al., 2024). Generally, major barriers to the implementation of lifestyle interventions remain, including limited time, resources, workforce capacity, and insufficient structural support.

Key Challenges: Early Diagnosis, Access to Treatment, Service Gaps

Current key challenges for the health care of patients with psychosis in Germany encompass systemic and treatment-availability challenges.

Many care pathways exist, particularly in a **fragmented psychiatric healthcare system** like the one in place in Germany. A **lack of integration and coordination** between different mental healthcare sectors is problematic for severely ill patients, as the responsibility of organising treatment beyond psychiatric wards lies in patients' hands. In general, Germany has the second highest number of beds per capita for inpatient treatment in Europe with 131 beds for every 100,000 people (Wiegand et al., 2025). This worrying number is complemented by relatively lengthy inpatient stays of 25 days on average for mental disorders, and frequent re-hospitalisation of the same patients in psychiatric departments, speaking against treatment efficiency. Relatedly, service gaps are not rooted in a limited capacity of beds for inpatient treatment, but rather have their origins in forcing most patients into hospitals who either do no longer need inpatient treatment or cannot sustain inpatient treatment success within their community during outpatient treatment plans.

More importantly, the German healthcare system's fragmentation has led to strong regional disparities and separation of sectors, including inpatient and outpatient departments. Care that adheres to most recommendations of the national guideline requires hospitals to engage in time-consuming and complex negotiations with individual health insurers, further exacerbating **regional disparities**. This economic framework has severe implications for current schizophrenia treatment, as the negotiated budgets are mostly based on the number of beds and do not take the form of **'regional budgets'** that can be used to choose the most appropriate treatment option given the phase of a patient's illness (#10; DGPPN, 2025). In this respect, it undermines the selection of the most appropriate treatment, disrupts continuity of care, and weakens the carefully established but often fragile therapeutic relationship between patient and therapist. This structural funding issue also affects the availability of a seamless **transition from child and adolescent** to adult clinical care, as outlined by the Lancet Commission (McGorry et al., 2024). Such a transition is not the current national standard, leaving it in the realm of individual specialised centres. Thus, the economic structure and incentives result in severely ill patients, including those with schizophrenia, receiving insufficient care.

While **the most recent guideline promotes a biopsychosocial approach to treatment** that extends beyond pharmacological care and is widely recognised by official bodies and institutions, several factors can complicate its implementation and limit equitable access to innovative treatments.

First, better functional outcomes may be achieved through **standardised and centrally coordinated nationwide EPI**, which is not supported by the current German healthcare system. EPI should be characterised by **low-threshold access to all residents**, even though the most likely demographic without health insurance are young men aged 15–24 (up to 1% of the population). However, EPI has been taking the form of individual projects with limited specialised staff, which have often been tied to university hospitals in larger cities, resulting in geographic barriers (Leopold et al., 2015). While recent initiatives enabled the training of more specialised EPI staff, challenges regarding the **standardisation of diagnostic tools** and harmonisation of methods for measuring various biomarkers, EPI's long-term funding security, and regional disparities remain. In addition, GPs are often not aware of EPI centres or have specialised knowledge in the early detection of psychosis. These challenges further complicate achieving the major goal of reducing long DUP and DUI by using earlier EPI, as set out in the national guideline (#124; DGPPN, 2025). Recent findings underline the necessity to continue specialised EPI in the long term by showing that such interventions' long-term improvements are questionable when regular care replaces specialised interventions after an initial period (Salazar De Pablo et al., 2026). A lack of nationwide coverage is also noteworthy, as receiving the most appropriate EPI still depends on the place of residence of the patient and the urbanity of the place. For example, many patients have already had multiple touch points within the medical system before approaching an EPI centre or psychiatric emergency department.

As EPI recommendations focus on timely CBT, which is preferred over non-pharmacological interventions, a key concern for EPI and first episode outpatient schizophrenia treatment is that many psychotherapists in private practice are indirectly incentivised to select/accept cases of less severe mental health disorders (<1% of sessions are delivered to schizophrenia patients). This issue results in patients with schizophrenia ending up on **long waiting lists when transitioning from EPI or inpatient to outpatient care**. This situation is further complicated by schizophrenia patients having to **organise their own outpatient treatment themselves**, representing a major challenge for this group. As inpatients, the cultural background of foreign doctors who were trained to focus on pharmacological treatments can complicate the practical implementation of the CBT guideline recommendation. Insufficient care is the consequence once again.

Second, an emphasis on pharmacological treatments, particularly first-generation antipsychotics, results in high healthcare costs and reduced treatment quality, which in turn leads to frequent readmissions and poorer patient outcomes. This could be addressed with the provision of modern therapies, including certain pharmacological interventions, e.g., **long-acting injectables (LIAs) or KarXT** (Azargoonjahromi & Nasiri, 2025). However, Germany ranks last in Europe in the administration of LAIs, and evidence-based gold-standard treatments, including clozapine, are often not implemented.

Reasons for the limited availability of internationally recognised treatments include insufficient time for market introduction and inadequate infrastructure, combined with high upfront costs and stringent entry criteria for pharmacological therapies set by the Federal Joint Committee. Longer drug approval times, due to EMA regulations, play a role as well. **Taken together, these structural barriers discourage companies from bringing innovative pharmacological treatments to the German market.**

Third, the focus on funding allocation, according to the number of beds, challenges the **availability of community-based treatments, such as inpatient-equivalent psychiatric care (StäB)** and **assertive community treatment teams**. StäB is a cost-effective treatment delivered in a patient's community (Weinmann et al., 2022, 2025), where it is most ecologically valid and may have more sustained effects, but it is still only available in limited form. Wider roll-out of such treatments could also facilitate re-integrating patients into regular employment, education, and social life after stabilisation. However, its rigid legal structure for reimbursement needs to be changed.

Fourth, implementing effective **shared decision-making** involving relatives, guardians, and/or carers in an inpatient environment is challenging, as joint consultations have to be carried out after a psychiatrist's official work hours. This results in psychiatrists aiming for a minimum of one consultation with relatives during an inpatient stay, even in cases where more is preferred or needed. Since relatives are often 'forgotten' in these processes in the current mental healthcare landscape, relative associations (e.g., BApK) offer to bridge this gap.

Fifth, limited German **language skills** represent a barrier for migrant patients receiving appropriate care.

Sixth, outpatient services need to be expanded to fully use the benefits of lifestyle interventions. **Digital health tools**, such as smartphone apps for weight loss or sleep improvement, could support this, but they are often not approved for people with schizophrenia because of the inclusion and exclusion criteria used in clinical trials. This gap needs to be addressed in a timely manner.

The final critical challenge relates to the **availability of (research) data for evidence-based improvements**. Currently, Germany has a lack of data evaluating outcomes and treatment efficiency. Germany also lacks standards for unified electronic documentation systems and digitalising clinical psychiatric data. Data protection regulations hinder shareable medical records, which in turn complicates the coordination and delivery of integrated care across regions and systems. **Improving data collection and management efforts** is crucial for evidence-based decision making and systemic reforms. These efforts require the harmonisation of existing and future cohorts, ensuring that these are sufficiently large and consistent to identify meaningful patterns given large heterogeneity among patients. Understanding mechanisms based on these data could enable the development of meaningful biomarkers.

Social and Economic Determinants

Socioeconomic Impact and Workforce Challenges

Mental health-related **sick leave** has been rising in Germany. In 2023, there were 159 days of sick leave due to mental illness per 100 insured people, rising to 182 days in 2024. Among women, 21% of sick leave is due to mental illness, compared to 14.5% among men. Although these numbers are not specific to schizophrenia, they show a recent concerning trend of an increasing mental health burden in Germany. In 2023, mental and behavioural disorders accounted for 6.8% of all registered deaths (Leimer, 2025).

Major negative consequences of schizophrenia are early unemployment, reduced quality of life and life expectancy (by 15–20 years), and increased mortality rates. While specific figures are unavailable, **annual direct costs** per patient are estimated to be €16,000 per annum, plus a multitude of indirect costs (€50,000) due to reduced productivity and increased mortality (Bommhardt et al., 2025; DGPPN, 2025). This sums up to a total annual economic burden of schizophrenia ranging between €9.63 billion and €13.52 billion (Frey, 2014; IGES Institut, 2024).

Key Risk Factors:
Poverty, Employment Status, Education and Housing Availability

Important risk factors of unfavourable outcomes include unemployment and unstable housing, low education, drug abuse, poor insight, and an unhealthy lifestyle. Stigma against (severe) mental illness is also a persistent problem in German society and calls for more targeted support and information for families of patients.

Given this set of risk factors, particularly lifestyle factors (physical inactivity, poor diet, smoking, drug abuse, and sleep disturbances) represent major, modifiable contributors to the existing mortality gap. Though the difficult element of persistence, which is required for an efficient change, represents a crucial challenge that needs institutional, peer, and family support. Additionally, a three-year anti-stigma campaign has shown positive results in cities where these campaigns were run, but no change in other cities without campaigns (Gaebel et al., 2008). While this questions their efficacy on the population level, it shows focused/local improvements when such campaigns are run.

Support Systems

Germany's social security system is supposed to constitute a strong support system, also counteracting risk factors for people with schizophrenia. Its programmes offer an early retirement pension, rehabilitation offers, structural and slow reintegration after illness (Hamburger Model), day-care services, outreach assisted living, sheltered accommodations, protected employment services, subsidised jobs and sheltered workshops, disability benefits, and official care provisions (Pflegestufen). Places in outreach assisted living services and sheltered accommodations have increased at large also (Wiegand et al., 2025).

On a local level, **vocational support** is available through an individual placement and support (IPS) programme, which was implemented in Berlin in 2016 to help patients in psychiatric care find employment (Jäckel et al., 2024). This programme is complemented by the SEEearly (Supported Employment and Education) multi-site randomised controlled trial. The latter has focused on enhancing vocational and educational recovery in young people with early psychosis (Jäckel et al., 2023).

Experts (by lived experience) within the inpatient setting can act as another direct support system, bridging institutions and patients. Their relevance is increasing, as Germany aims to follow shared decision-making. As well, these positions provide former psychiatric patients with an employment opportunity upon specific training being completed.

Additional Unmet Needs of Patients Living with Schizophrenia

Regardless of these support provisions and in addition to the outlined key challenges, patients with schizophrenia face unmet needs that include reducing the risk of comorbid somatic illnesses (#127; DGPPN, 2025) while currently receiving less medical care, and treatment plans not being adapted to the individual's daily capacities of the patients. The social context within psychiatric hospitals requires them to exert good cognitive control/inhibition and adhere to an externally defined structure, which many struggle with. As well, it is also difficult to create situations during treatment that avoid an impression of being judged or evaluated, or a feeling of taking part in a therapeutic setting.

Policy and Innovation

Germany is actively working on managing and improving the mental health of its citizens living with schizophrenia. The most recent guideline **promotes a paradigm-shifting biopsychosocial approach** by clearly recognising that treatment plans solely involving pharmacological interventions are not sufficient for long-term success and well-being. Recommendations for using non-pharmacological treatments, psychotherapy/CBT, psychoeducation, (meta)cognitive and trauma sensitive care training, family interventions, vocational and social skills training, lifestyle and exercise interventions, and occupational therapy are provided (#71, 76, 80; DGPPN, 2025).

National Mental Health Strategy

At present, schizophrenia care in Germany is based on a structured, multi-component national framework including an evidence-based clinical guideline, federal funding of projects and initiatives, a general healthcare reform, and selected country-wide campaigns, initiatives, and studies. These are often siloed by programme or project, often with specific funding sources (e.g., Innovationsfond, public insurers, state ministries) and led by research institutions, health non-governmental organisations (NGOs), or national insurer initiatives. They are implemented through regional public health efforts rather than through centralised federal policy documents.

Nevertheless, Germany has **no single national mental health strategy**. Instead, the 16 federal states (Bundesländer) have their own strategies, plans, and laws addressing mental health, which results in large regional disparities. **Future efforts** should push for a single national schizophrenia strategy document issued by the federal government, analogous to a national action plan, which is backed by secure medium-term funding streams. As well, a national mental health crisis among **German youth** calls for comprehensive action, and quickly. This would include the implementation of a national mental health strategy, a strategic government response to curb rising mental health issues and economic consequences among the younger generation, a reversal of cuts to school programmes, and further school support (Deutschland in English, 2025).

Innovation and Model Projects: Promising New Areas of Treatment

Numerous innovative projects have trialled improvements in schizophrenia care. Many of these operate as federally funded, system-wide quality improvement initiatives aimed at disseminating and embedding evidence-based care into routine practice. Developments in **precision psychiatry** have dominated recent years.

They aim to complement categorical diagnoses with stratification and a new generation of prognostic biomarkers - genetic, inflammatory, metabolic, cognitive, and digital - to support more personalised and effective psychiatric care. Building on multimodal data, precision psychiatry advances diagnosis, treatment, and prevention by predicting disease trajectories and tailoring interventions early through the use of machine learning and AI approaches.

Combining individually tailored EPI using data from brain imaging, neurocognitive assessments, and detailed clinical assessments, the **clinical CARE trial** (Computer-assisted Risk Evaluation in Early Detection) tested an **AI-augmented prediction** algorithm of individual risk to develop psychosis to guide individualised early intervention (Bommhardt et al., 2025). This large-scale effort brought together 35 psychiatric centres from 20 German locations to carry out early detection using the same standard and outlined biopsychosocial data. As part of this process, numerous early detection specialists were trained in clinical and comprehensive neurocognitive assessment, in line with relevant EPA guidance (Schultze-Lutter, Michel, et al., 2015; Vita et al., 2022). The initiative also built on existing early psychosis intervention infrastructures, strengthened them where needed, and established partnerships with health insurance providers. Its goal is the integration into statutory care systems, whose success will be determined in the coming years.

While CARE has tested an EPI model closest resembling the improvements promoted by the Rethinking Schizophrenia project and has been closely integrated into German clinical practice and infrastructures, more initiatives have been working on improving **precision psychiatry in Germany**. For example, the IMPLEMENT EU-project, coordinated by Mannheim, developed frameworks to identify biological subgroups and stratify patients with schizophrenia using high-dimensional data and AI-algorithms. Similar AI-based stratification approaches of schizophrenia subtypes and tailored treatments have been exploring large genomic/phenotypic datasets (Leibniz Future Lab; MHH Hannover), stratified pharmacogenomics to detect treatment resistance early in severe psychiatric conditions including schizophrenia (Psych-STRATA; Fraunhofer Institute & EU), the influence of biological, psychological and environmental factors during adolescence on brain development and mental health (IMAGEN), and deep cerebrospinal fluid phenotyping to better understand molecular signatures of mental disorders (Deep-CSF-inPsych; EU-Horizon 2024–2029). In addition, the DZPG centres have also been pushing precision psychiatry in recent years. Together, these exemplar initiatives underline Germany's focus on developing AI algorithms to improve the prediction and stratification of psychosis risk and clinical trajectories in adulthood.

These efforts in biopsychosocial EPI programmes could be specifically tailored to special risk groups for developing mental disorders early such as individuals born preterm or with low birth weight.

Based on similar cognitive and motor challenges alongside an elevated risk of mental ill-health (Schröpfer, Greif, Eickhoff, et al., 2026), the PASTA project is currently developing tailored EPI, based on multimodal data and AI analyses (Schröpfer, Greif, Dudko, et al., 2026).

Translational work on the pathogenic mechanisms linking genetic variation to biological mechanisms and eventual alterations in psychiatric disorders is also being pursued in Germany. It builds on existing large genome-wide association studies (GWAS) in schizophrenia that have identified hundreds of loci associated with increased risk of the disorder (Singh et al., 2022; Trubetskoy et al., 2022). By investigating the expression of schizophrenia risk genes in the brains of mice and humans, researchers from the Helmholtz Centre Munich identified 29 additional putative schizophrenia genes for a specific phenotype (Garrett et al., 2024). These approaches enable researchers to identify candidate genes and pathways involved in synaptic function and glutamatergic signalling, helping to bridge the gap between genetic discoveries and clinical applications.

Digital Mental Health Applications

Digital mental health interventions have made a push in Germany in recent years (Klein, 2025). Telemedicine was scaled up during the COVID-10 pandemic (Wiegand et al., 2025). Although their use has increased, they still remain underutilised in routine mental healthcare (Weitzel et al., 2023). Offering patients with schizophrenia a validated digital or technology-supported intervention that is supervised by a therapist (e.g., AVATAR therapy; Garety et al., 2024) is recommended by the national guideline as part of a multimodal treatment (#63; DGPPN, 2025).

Germany holds a **directory of all (pre-)approved digital health applications** (DiGA; BfArM, 2026). As of January 2026, 26 out of the 76 listed interventions target mental health conditions and are permanently approved. While one digital application addresses cognitive problems (NeuroNation; #72; DGPPN, 2025) and a few others provide digital psychotherapy (invirto), none of these applications was specifically designed or approved for schizophrenia spectrum disorders (Klein, 2025). This represents insufficient evidence of efficacy specific to schizophrenia, but at least allows for treatment of selected symptoms of the disorder (e.g., cognition), and no risk of harm could be identified (DGPPN, 2025; National Institute for Health and Care Excellence, 2014). In the German context, the designated case manager evaluates progress in patients during regular intervals. Digital psychotherapy has also shown effects comparable to in-person therapy. A major advantage is that applications are either available free of charge or by a psychiatrist, psychologist or GP who can prescribe a DiGA, facilitating equitable access.

Further applications that are currently undergoing testing and research are smartphone-based relapse monitoring that was designed within routine care (ILIA Study; Hiller et al., 2025), KisoLight supporting symptom monitoring, medication adherence, and activity planning (Fässler et al., 2026), and a multi-partner European research initiative focused on strengthening youth mental health support via app-based training and an online platform (YOUTHreach, 2026; 2025-2029).

Lifestyle and Exercise Innovation

Currently, mechanistic studies are underway aiming to better elucidate the mechanisms of physical exercise in individuals with schizophrenia. Two studies are worth highlighting. At LMU Munich, a multimodal approach seeks to provide insights into the mechanisms and predictors of symptom improvement following a three-month professionally supervised exercise training in schizophrenia (clinicaltrials.gov: NCT03466112). This randomised-controlled clinical trial is accompanied by an extensive brain imaging protocol (EEG and MRI), neurotransmitter metabolism, and genotyping. In the OligoTreat study, it is being investigated whether the neuroplastic effects of endurance training can be further enhanced by the additional administration of the antihistamine clemastine, which has demonstrated remyelinating properties (EudraCT #2022-000054-28).

Independent of these mechanistic investigations, the beneficial effects of physical exercise on symptom severity are already well established and could be supported by sstructured approaches evaluating both physical activity and sedentary behaviour (Stubbs et al., 2026). Also, cognitive function can benefit from low-intensity physical activity practiced over sustained periods or a single bout of exercise in individuals with higher baseline fitness levels (Mench et al., 2025). In moving forward, greater emphasis must now be placed on implementation across different care settings, as the outpatient sector has started for individuals with depression in two German studies (ImPuls; Wolf et al., 2024 and STEP.De; Heinzel et al., 2022). Availability of more interventions combining physical exercise and dietary modification is key, as this combination can have an even greater effect on the physical health of individuals with schizophrenia (Maurus et al., 2024).

In summary, lifestyle interventions represent an important add-on, complementary treatment for individuals with schizophrenia. To be effective, such interventions need to be person-centred, flexible, and tailored to individual needs, preferences, and clinical characteristics. Adequate training of mental health professionals and the involvement of specialised staff (e.g., exercise or nutrition specialists) are essential. Creating opportunities for implementation across different care sectors in Germany is required for future interventional success.

Policy Innovations

Policy improvements could be achieved if more federal states and regions adopt existing innovative care models. For instance, the integrated care model uses **regional budgets** that can be allocated to all forms of treatment and care as deemed most appropriate by clinicians. This had been successfully implemented and at reduced cost per patient in the northern German city of Itzehoe (König et al., 2010). It shortened inpatient stays and time spent on sick leave, and improved patients' health-related quality of life during treatment (Wiegand, 2025). Further improvements of the structural ties to outpatient sectors to ensure a sufficient standard of care are necessary to make this model indispensable.

Stepped care models are another innovative area. The University Medical Centre Hamburg-Eppendorf has trialled the trans-sectoral RECOVER model (UKE) in a study with 891 participants. It allocated treatments to patients based on severity, ranging from digital interventions to inpatient care, but aimed at preventing inpatient admissions using assertive community and outreach treatments. This model achieved similar or better treatment outcomes and better cost-effectiveness (Lambert et al., 2024). However, it was neither recommended for nor carried forward to routine care due to claims of showing only minor effects.

This decision and many other care decisions could have benefited from **better data availability**. Recent improvements include the development of a National Mental Health Surveillance System and dashboard (Robert Koch Institute, 2026). Although not specific to schizophrenia, this system provides continuous, systematic data for policymakers and researchers by tracking the mental health status and service use of the population. As well, the "Health Data Lab" was opened for research in 2025 (FDZ Gesundheit, 2026). It provides access to data from health insurance companies with the aim to support medical research and improvements in care.

On a more general note, some initiatives have started tackling persistent stigma and knowledge gaps. Groups such as 'Irrsinnig Menschlich' operate nationwide campaigns against **stigmatisation of mental illness** at schools and companies alike, which also includes stigmatisation of severe mental disorders like schizophrenia. Another area is covered by the capacity-building programme EU-PROMENS. Led by a German consultancy firm, it has been working on increasing numbers of **professionals** being **well-trained** on a comprehensive approach to mental health.

Successful Programmes and Best Practices: Case Studies Effective Intervention

In recent years, Germany has been taking several steps to improve the care of individuals with schizophrenia according to the newest international standards. First and foremost, the current S3 guideline for schizophrenia was implemented as a living guideline on the MAGICapp in 2025 (DGPPN, 2025). This allows for timely updates of recommendations. Similarly, German psychiatrists have played a crucial role in shaping EPI concepts for decades (Klosterkötter et al., 2001; Ruhrmann et al., 2003). With recent advances in precision psychiatry and network initiatives (CARE, DZPG), specialist training and nationwide capabilities in early detection of psychosis have been expanded for adolescents and adults alike (Bommhardt et al., 2025). These improvements in EPI infrastructure and specialised knowledge benefited from a foundation built by predecessor networks including the German Research Network on Schizophrenia (GRNS; Wölwer et al., 2006, 2018). Germany's push for improving and adopting precision psychiatry shall enable more targeted treatments with improved effectiveness, fewer side effects, and better support for individualised clinical decision-making in the near future.

Several **alternative care models** have successfully demonstrated efficacy in challenging issues of the fragmented healthcare system and its focus on inpatient treatment. For instance, regional budgets for integrated care have shown to facilitate cross-sectoral care and cost-efficiency, particularly in their model region, Itzehoe (Wiegand et al., 2025). This success could serve as a model for adoption by more regions, where possible. Also, community-based treatments including StäB have demonstrated cost-effectiveness within a patient's community (Weinmann et al., 2022, 2025). Thereby, reducing the necessity for inpatient treatment and unsustainable improvements after discharge.

Conclusions and Key Recommendations for Policy Action:

- The strengthened EPI infrastructure needs further political backing on a national level and corresponding funding security to be preserved and achieve a shorter DUP.
- Increased and faster implementation of successful research/RCT projects into statutory and standard care.
- Policies need to facilitate the compatibility of research and healthcare for clinician scientists by adapting reimbursement procedures and job funding streams.
- Several innovative AI and lifestyle projects show great promise of improvements, if they can overcome the administrative, legal, and funding hurdles.
- A simpler legal framework for community treatments that would make investments, more jobs, and simple reimbursement procedures attractive. Could also improve the care of underserved groups.
- A simpler legal framework and requirements guided by international standards for the introduction of new pharmacological treatments.
- Schizophrenia should be an integral part of training across all healthcare professions and sectors to prevent stigmatisation and improve overall, holistic treatment. This applies in particular to psychotherapeutic training as well as to the fields of screening and treatment of cardiovascular and oncological diseases.

References

Azargoonjahromi, A., & Nasiri, H. (2025). Efficacy and Safety of KarXT (Xanomeline-Trospium; CobenfyTM) in Schizophrenia: A Systematic and Meta-Analysis Review of Randomized Controlled Trials. *Psychiatric Quarterly*. https://doi.org/10.1007/s11126-025-10226-7

Bechdolf, A., Hanser, S., Baumgardt, J., Brose, A., Jäckel, D., Döring, S., Holzner, L., Aliakbari, N., Von Hardenberg, L., Shmuilovich, O., Gencaggi, D., Schellong, M., Izat, Y., Leopold, S., Ituarte, B. P., & Leopold, K. (2024). Soulspace: Integrated youth mental health care in Berlin Germany: An introduction to the program and a description of its users. *Early Intervention in Psychiatry, 18*(7), 571–577. https://doi.org/10.1111/eip.13522

Bechdolf, A., Müller, H., Hellmich, M., De Millas, W., Falkai, P., Gaebel, W., Gallinat, J., Hasan, A., Heinz, A., Janssen, B., Juckel, G., Karow, A., Krüger-Özgürdal, S., Lambert, M., Maier, W., Meyer-Lindenberg, A., Pützfeld, V., Rausch, F., Schneider, F., … Klosterkötter, J. (2023). Prevention of First-Episode Psychosis in People at Clinical High Risk: A Randomized Controlled, Multicentre Trial Comparing Cognitive-Behavioral Therapy and Clinical Management Plus Low-Dose Aripiprazole or Placebo (PREVENT). *Schizophrenia Bulletin, 49*(4), 1055–1066. https://doi.org/10.1093/schbul/sbad029

Bechdolf, A., Nikolaidis, K., Von Peter, S., Längle, G., Brieger, P., Timm, J., Killian, R., Fischer, L., Raschmann, S., Schwarz, J., Holzke, M., Rout, S., Hirschmeier, C., Hamann, J., Herwig, U., Richter, J., Baumgardt, J., & Weinmann, S. (2024). Utilization of Psychiatric Hospital Services Following Intensive Home Treatment: A Nonrandomized Clinical Trial. *JAMA Network Open, 7*(11), e2445042. https://doi.org/10.1001/jamanetworkopen.2024.45042

BfArM. (2026). *DiGA-Verzeichnis* (Bundesinstitut für Arzneimittel und Medizinprodukte). https://diga.bfarm.de/de/verzeichnis

Bommhardt, T., Peschl, J., Schultze-Lutter, F., Koutsouleris, N., Meisenzahl, E., & Köberlein-Neu, J. (2025). Enhancing early detection and treatment of psychosis in Germany: A protocol for the health economic evaluation of an artificial intelligence-guided complex intervention. *BMJ Open, 15*(6), e103151. https://doi.org/10.1136/bmjopen-2025-103151

BPtK. (2018). *Ein Jahr nach der Reform der Psychotherapie-Richtlinie: Wartezeiten 2018*. Bundestherapeutenkammer. https://api.bptk.de/uploads/20180411_bptk_studie_wartezeiten_2018_c0ab16b390.pdf

Brehm, K., Dallmann, P., Freyer, T., Winter, K., Malchow, B., Wedekind, D., Diller, I.-M., Henkel, K., Sieberer, M., Bär, K.-J., Schneider, F., & Ströhle, A. (2020). Angebot und Inanspruchnahme von Sporttherapie in psychiatrischen Kliniken in Deutschland. *Der Nervenarzt, 91*(7), 642–650. https://doi.org/10.1007/s00115-019-0782-7

Bschor, T. (2022). Behandlung von Negativsymptomatik und kognitiven Beeinträchtigungen bei Erwachsenen mit Schizophrenie. *Arzneiverordnung in Der Praxis, 3*.

Bundesbank. (2025, April 10). *Wealth in Germany grows in nominal terms but declines in real terms, with no change in inequality*. https://www.bundesbank.de/en/tasks/topics/bundesbank-study-wealth-in-germany-grows-in-nominal-terms-but-declines-in-real-terms-with-no-change-in-inequality-955716

Bundes-Psychotherapeuten-Kammer. (2026). *Schizophrenie*. BPtK. https://www.bptk.de/psychische-krankheiten/schizophrenie

Destatis. (2025, May 19). *Indicator 10.2—Gini coefficient of income after social transfers—German Sustainable Development Strategy*. https://dns-indikatoren.de/en/10-2/

Deutschland in English. (2025, October 30). *Calls Grow for National Strategy to Combat Yout...* Deutschland in English. https://deutschlandinenglish.com/p/calls-grow-for-national-strategy-to-combat-youth-mental-health-crisis-in-germany

DGPPN. (2025). *S3-Leitlinie Schizophrenie (Version 4.1, Stand 30.06.2025)* (Version 4.1). https://register.awmf.org/de/leitlinien/detail/038-009

Fässler, L., Ersöz, B., Hahne, I., Koop, S., & Böge, K. (2026). Development of a supportive mHealth device for persons with schizophrenia spectrum disorders (KisoLightApp): A usability study within a participant-involvement principle. *Frontiers in Psychology, 16*, 1727156. https://doi.org/10.3389/fpsyg.2025.1727156

FDZ Gesundheit. (2026). *Forschungsdatenzentrum Gesundheit – Arbeitskreis Versorgungsdaten*. Forschungsdatenzentrum Gesundheit Projekte. https://www.forschungsdatenzentrum-gesundheit.de/projekte/arbeitskreis-versorgungsdaten

Federal Ministry of Health. (2024). *Gesetz zur Verbesserung der Versorgungsqualität im Krankenhaus und zur Reform der Vergütungsstrukturen—Bundesgesetzblatt*. *400*. https://www.recht.bund.de/bgbl/1/2024/400/VO.html

Frey, S. (2014). The economic burden of schizophrenia in Germany: A population-based retrospective cohort study using genetic matching. *European Psychiatry, 29*(8), 479–489. https://doi.org/10.1016/j.eurpsy.2014.04.003

Gaebel, W., Zäske, H., Baumann, A. E., Klosterkötter, J., Maier, W., Decker, P., & Möller, H.-J. (2008). Evaluation of the German WPA "Program against stigma and discrimination because of schizophrenia — Open the Doors": Results from representative telephone surveys before and after three years of antistigma interventions. Schizophrenia Research, 98(1–3), 184–193. https://doi.org/10.1016/j.schres.2007.09.013

References

Garety, P. A., Edwards, C. J., Jafari, H., Emsley, R., Huckvale, M., Rus-Calafell, M., Fornells-Ambrojo, M., Gumley, A., Haddock, G., Bucci, S., McLeod, H. J., McDonnell, J., Clancy, M., Fitzsimmons, M., Ball, H., Montague, A., Xanidis, N., Hardy, A., Craig, T. K. J., & Ward, T. (2024). Digital AVATAR therapy for distressing voices in psychosis: The phase 2/3 AVATAR2 trial. Nature Medicine, 30(12), 3658–3668. https://doi.org/10.1038/s41591-024-03252-8

Garrett, L., Trümbach, D., Lee, D., Mandillo, S., Samaco, R., Flenniken, A. M., Stewart, M., Aguilar-Pimental, J. A., Amarie, O. V., Becker, L., Calzada-Wack, J., Da Silva-Buttkus, P., Dragano, N., Kraiger, M., Lengger, C., Leuchtenberger, S., Marschall, S., Oestereicher, M. A., Rathkolb, B., … Hölter, S. M. (2024). Co-expression of prepulse inhibition and Schizophrenia genes in the mouse and human brain. Neuroscience Applied, 3, 104075. https://doi.org/10.1016/j.nsa.2024.104075

G-BA. (2025). Personalausstattung Psychiatrie und Psychosomatik- Richtlinie (PPP-RL) (Version 2).

Halms, T., Gaebel, W., Leucht, S., Falkai, P., Lincoln, T., Bechdolf, A., Correll, C. U., Schmidt, S. J., Lambert, M., Wobrock, T., & Hasan, A. (2026). Die neue S3-Leitlinie Schizophrenie (living) 2025 (The new S3 guideline on schizophrenia (living) 2025). Der Nervenarzt, 10.1007/s00115-026-01946-7. Advance online publication. https://doi.org/10.1007/s00115-026-01946-7

Heimkes, F. (2024). Psychotherapie für Menschen mit Störungen aus dem schizophrenen Formenkreis—Behandlungsbereitschaft und subjektive Barrieren von in Bayern ambulant tätigen Psychotherapeut*innen (Ludwig-Maximilians-University Munich). https://edoc.ub.uni-muenchen.de/33100/6/Heimkes_Fides.pdf

Hiller, S., Emde, L., Jais, D., Sikorová, S. N., Bakstein, E., Španiel, F., Urbanová, K., Hahn, E., Zierhut, M., Fürstenau, D., Bühner, M., Junker, L., Maurus, I., Pogarell, O., Falkai, P., Strube, W., Bauer, I., Skuban-Eiseler, T., Priller, J., … Leucht, S. (2025). The ILIA study: Protocol for a randomized-controlled multicenter clinical trial on smartphone- and web-based relapse monitoring for patients with schizophrenia or schizoaffective disorder. European Archives of Psychiatry and Clinical Neuroscience. https://doi.org/10.1007/s00406-025-02089-7

IGES Institut. (2024, October 9). Weißbuch Schizophrenie – Versorgungssituation in Deutschland. https://www.iges.com/sites/igesgroup/iges.de/myzms/content/e6666/e76249/e76256/e76257/e76259/attr_objs76296/IGES_Factsheet_Schizophrenie_09102024_ger.pdf

Jäckel, D., Leopold, K., & Bechdolf, A. (2024). Individual Placement and Support in der psychiatrischen Versorgung: Evaluation klinischer Routinedaten mittels eines retrospektiven Chart-Reviews. Der Nervenarzt, 95(9), 839–844. https://doi.org/10.1007/s00115-024-01706-5

Jäckel, D., Willert, A., Brose, A., Leopold, K., Nischk, D., Senner, S., Pogarell, O., Sachenbacher, S., Lambert, M., Rohenkohl, A., Kling-Lourenco, P., Rüsch, N., Bermpohl, F., Schouler-Ocak, M., Disselhoff, V., Skorupa, U., & Bechdolf, A. (2023). Enhancing educational and vocational recovery in adolescents and young adults with early psychosis through Supported Employment and Education (SEEearly): Study protocol for a multicenter randomized controlled trial. Trials, 24(1), 440. https://doi.org/10.1186/s13063-023-07462-2

Khorikian-Ghazari, N., Lorenz, C., Güler, D., Halms, T., Röh, A., Flick, M., Burschinski, A., Pielenz, C., Salveridou-Hof, E., Schneider-Axmann, T., Schneider, M., Wagner, E., Falkai, P., Gaebel, W., Leucht, S., Hasan, A., & Gaigl, G. (2023). Guideline for schizophrenia: Implementation status and attitude toward an upcoming living guideline. European Archives of Psychiatry and Clinical Neuroscience, 273(7), 1587–1598. https://doi.org/10.1007/s00406-023-01568-z

Klein, J. P. (2025, November 27). Digitale Interventionen in der Behandlung Psychischer Störungen (Conference). DGPPN Congress. https://www.researchgate.net/publication/397205312_Digitale_Interventionen_in_der_Behandlung_Psychischer_Storungen

Klosterkötter, J., Hellmich, M., Steinmeyer, E. M., & Schultze-Lutter, F. (2001). Diagnosing Schizophrenia in the Initial Prodromal Phase. Archives of General Psychiatry, 58(2), 158–164. https://doi.org/10.1001/archpsyc.58.2.158

König, H.-H., Heinrich, S., Heider, D., Deister, A., Zeichner, D., Birker, T., Hierholzer, C., Angermeyer, M., & Roick, C. (2010). Das Regionale Psychiatriebudget (RPB): Ein Modell für das neue pauschalierende Entgeltsystem psychiatrischer Krankenhausleistungen? Psychiatrische Praxis, 37(01), 34–42. https://doi.org/10.1055/s-0029-1223418

Lambert, M., König, H., Karow, A., König, H.-H., Rohenkohl, A., Luedecke, D., Schröter, R., Finter, C., Tlach, L., Schindler, A., Peter, H., Scherer, M., Mews, C., Härter, M., Bindt, C., Löwe, B., Briken, P., Peper, H., Schweiger, M., … Schulz, H. (2024). Stepped, evidence-based and integrated care service model vs. usual care for mental disorders: A randomized controlled trial (RECOVER). Psychiatry Research, 339, 116007. https://doi.org/10.1016/j.psychres.2024.116007

Lambert, M., Schöttle, D., Ruppelt, F., Rohenkohl, A., Sengutta, M., Luedecke, D., Nawara, L. A., Galling, B., Falk, A. -L., Wittmann, L., Niehaus, V., Sarikaya, G., Rietschel, L., Gagern, C., Schulte-Markwort, M., Unger, H. -P., Ott, S., Romer, G., Daubmann, A., … Karow, A. (2017). Early detection and integrated care for adolescents and young adults with psychotic disorders: The ACCESS III study. Acta Psychiatrica Scandinavica, 136(2), 188–200. https://doi.org/10.1111/acps.12762

Leimer, T. (2025, July 4). Germany Healthcare Statistics, Trends & Facts (2025). https://feather-insurance.com/blog/germany-healthcare-statistics

References

Leopold, K., Nikolaides, A., Bauer, M., Bechdolf, A., Correll, C. U., Jessen, F., Juckel, G., Karow, A., Lambert, M., Klosterkötter, J., Ruhrmann, S., Pfeiffer, S., & Pfennig, A. (2015). Angebote zur Früherkennung von Psychosen und bipolaren Störungen in Deutschland: Bestandsaufnahme. Der Nervenarzt, 86(3), 352–358. https://doi.org/10.1007/s00115-014-4119-2

Maurus, I., Wagner, S., Spaeth, J., Vogel, A., Muenz, S., Seitz, V., Von Philipsborn, P., Solmi, M., Firth, J., Stubbs, B., Vancampfort, D., Hallgren, M., Kurimay, T., Gerber, M., Correll, C. U., Gaebel, W., Möller, H.-J., Schmitt, A., Hasan, A., & Falkai, P. (2024). EPA guidance on lifestyle interventions for adults with severe mental illness: A meta-review of the evidence. European Psychiatry, 67(1), e80. https://doi.org/10.1192/j.eurpsy.2024.1766

McGorry, P. D., Mei, C., Dalal, N., Alvarez-Jimenez, M., Blakemore, S.-J., Browne, V., Dooley, B., Hickie, I. B., Jones, P. B., McDaid, D., Mihalopoulos, C., Wood, S. J., El Azzouzi, F. A., Fazio, J., Gow, E., Hanjabam, S., Hayes, A., Morris, A., Pang, E., … Killackey, E. (2024). The Lancet Psychiatry Commission on youth mental health. The Lancet Psychiatry, 11(9), 731–774. https://doi.org/10.1016/S2215-0366(24)00163-9

Meisenzahl, E., Walger, P., Schmidt, S. J., Koutsouleris, N., & Schultze-Lutter, F. (2020). Früherkennung und Prävention von Schizophrenie und anderen Psychosen. Der Nervenarzt, 91(1), 10–17. https://doi.org/10.1007/s00115-019-00836-5

Mench, P., Koppius, T., Ewen, J., Rippe, W., Radecke, J. O., Tari, B., Heath, M., Borgwardt, S., Wilms, B., Sprenger, A., & Lencer, R. (2025). Cognitive control in schizophrenia spectrum disorders is associated with long-term movement activity rather than single-bout exercise. European Archives of Psychiatry and Clinical Neuroscience. https://doi.org/10.1007/s00406-025-02101-0

Moetteli, S., & Mueller-Stierlin, A. S. (2024). Ernährungsinterventionen in der Psychiatrie – ein vernachlässigter Baustein für einen gesünderen Lebensstil. *Psychiatrische Praxis, 51*(05), 235–237. https://doi.org/10.1055/a-2315-2739

Mohr, P., Dom, G., Falkai, P., Arango, C., Bitter, I., Beezhold, J., Boyer, P., Catalan, A., Chaumette, B., Dollfus, S., Duarte, C., Fusar-Poli, P., Gaebel, W., Galderisi, S., Howes, O., Keri, P., Meyer-Lindenberg, A., Nordentoft, M., Rybakowski, J., … Quoidbach, V. (2026). Rethinking Schizophrenia: Optimizing Care Pathways in Europe from the First Episode of Psychosis to Long-Term Care. European Psychiatry, 1–27. Cambridge Core. https://doi.org/10.1192/j.eurpsy.2026.10172

National Institute for Health and Care Excellence. (2014). Psychosis and schizophrenia in adults – The NICE guideline on treatment and management (Guideline 178).

OECD. (2025). Health at a Glance 2025: OECD Indicators. OECD Publishing. https://doi.org/10.1787/8f9e3f98-en

Rippe, W., Weisner, L., Ewen, J., Mench, P., Koppius, T., Borgwardt, S., Tari, B., Heath, M., Sprenger, A., Wilms, B., & Lencer, R. (2025). We like to move it – patients with schizophrenia spectrum disorders are impaired in estimating their physical fitness levels and benefit from individualized exercise. European Archives of Psychiatry and Clinical Neuroscience, 275(3), 629–640. https://doi.org/10.1007/s00406-024-01844-6

Robert Koch Institute. (2026). Mental Health Surveillance Dashboard – Beobachtung der psychischen Gesundheit der erwachsenen Bevölkerung in Deutschland (Dashboard). Mental Health Surveillance. https://public.data.rki.de/t/public/views/hf-MHS_Dashboard/Dashboard

Ruhrmann, S., Schulze-Lutter, F., & Klosterkötter, J. (2003). Early Detection and Intervention in the Initial Prodromal Phase of Schizophrenia. Pharmacopsychiatry, 36, 162–167. https://doi.org/10.1055/s-2003-45125

Rummel-Kluge, C., Kissling, W., & Leucht, S. (2006). Antidepressants for the negative symptoms of schizophrenia. Cochrane Database of Systematic Reviews, 2012(6). https://doi.org/10.1002/14651858.CD005581.pub2

Salazar De Pablo, G., Almeida, J., Camacho, J., Suárez Campayo, J., Catalan, A., Pop, M., Aymerich, C., Rogdaki, M., Robinson, D. G., Schooler, N., McGuire, P., Chang, W., Chen, E. Y., Nordentoft, M., Hjorthøj, C., Albert, N., Starzer, M., Srihari, V., Valencia, M., … Correll, C. U. (2026). Do early intervention services for psychosis maintain their effects after transition to usual/modular care? A systematic review and meta-analysis. World Psychiatry, 25(1), 95–104. https://doi.org/10.1002/wps.70012

Schröpfer, F., Greif, E., Dudko, J., Göbel, L., Kühl, R., Lipp, M., Röse, K., Olbeser, J., Borgwardt, S., Göpel, W., & Franzen, L. (2026). Serving the first PASTA plate: Initial evidence for a link between visual-motor integration and mental health. Neuroscience Applied, 5, 106350. https://doi.org/10.1016/j.nsa.2025.106350

Schröpfer, F., Greif, E., Eickhoff, S., Schewe, H., Wiese, J., Derner, N., Heller, L., Andreou, C., Röse, K., Obleser, J., Göpel, W., Borgwardt, S., & Franzen, L. (2026). The impact of premature birth and low birth weight on motor, visual, and cognitive skills and mental health in adolescence: A systematic review and meta-analysis. European Child & Adolescent Psychiatry. https://doi.org/10.1007/s00787-025-02937-w

Schultze-Lutter, F., Michel, C., Schmidt, S. J., Schimmelmann, B. G., Maric, N. P., Salokangas, R. K. R., Riecher-Rössler, A., Van Der Gaag, M., Nordentoft, M., Raballo, A., Meneghelli, A., Marshall, M., Morrison, A., Ruhrmann, S., & Klosterkötter, J. (2015). EPA guidance on the early detection of clinical high risk states of psychoses. European Psychiatry, 30(3), 405–416. https://doi.org/10.1016/j.eurpsy.2015.01.010

References

Schultze-Lutter, F., Rahman, J., Ruhrmann, S., Michel, C., Schimmelmann, B. G., Maier, W., & Klosterkötter, J. (2015). Duration of unspecific prodromal and clinical high risk states, and early help-seeking in first-admission psychosis patients. Social Psychiatry and Psychiatric Epidemiology, 50(12), 1831–1841. https://doi.org/10.1007/s00127-015-1093-3

Singh, T., Poterba, T., Curtis, D., Akil, H., Al Eissa, M., Barchas, J. D., Bass, N., Bigdeli, T. B., Breen, G., Bromet, E. J., Buckley, P. F., Bunney, W. E., Bybjerg-Grauholm, J., Byerley, W. F., Chapman, S. B., Chen, W. J., Churchhouse, C., Craddock, N., Cusick, C. M., … Daly, M. J. (2022). Rare coding variants in ten genes confer substantial risk for schizophrenia. Nature, 604(7906), 509–516. https://doi.org/10.1038/s41586-022-04556-w

Stubbs, B., Ma, R., Teychenne, M., Kinnafick, F., Mossaheb, N., Korman, N., Trott, M., Rosenbaum, S., Schuch, F., Firth, J., & Vancampfort, D. (2026). Integrating Physical Activity Into Routine Psychiatric Care: A Review. JAMA Psychiatry. https://doi.org/10.1001/jamapsychiatry.2026.0026

Stüble, M., Schultze-Lutter, F., Kaess, M., Franscini, M., Traber-Walker, N., Walger, P., Schimmelmann, B. G., Vogeley, K., Kambeitz, J., Kindler, J., & Michel, C. (2024). Clinical and neurocognitive profiles of a combined clinical high risk for psychosis and clinical control sample: Latent class analysis. BJPsych Open, 10(6), e226. https://doi.org/10.1192/bjo.2024.815

Theodor-Wenzel-Werk e.V. (2026). Schizophrenie. Theodor-Wenzel-Werk e.V. https://www.tww-berlin.de/kliniken/krankheitsbilder/schizophrenie/

Trubetskoy, V., Pardiñas, A. F., Qi, T., Panagiotaropoulou, G., Awasthi, S., Bigdeli, T. B., Bryois, J., Chen, C.-Y., Dennison, C. A., Hall, L. S., Lam, M., Watanabe, K., Frei, O., Ge, T., Harwood, J. C., Koopmans, F., Magnusson, S., Richards, A. L., Sidorenko, J., … Van Os, J. (2022). Mapping genomic loci implicates genes and synaptic biology in schizophrenia. Nature, 604(7906), 502–508. https://doi.org/10.1038/s41586-022-04434-5

Uhlhaas, P. J., Davey, C. G., Mehta, U. M., Shah, J., Torous, J., Allen, N. B., Avenevoli, S., Bella-Awusah, T., Chanen, A., Chen, E. Y. H., Correll, C. U., Do, K. Q., Fisher, H. L., Frangou, S., Hickie, I. B., Keshavan, M. S., Konrad, K., Lee, F. S., Liu, C. H., … Wood, S. J. (2023). Towards a youth mental health paradigm: A perspective and roadmap. Molecular Psychiatry, 28(8), 3171–3181. https://doi.org/10.1038/s41380-023-02202-z

Vita, A., Gaebel, W., Mucci, A., Sachs, G., Erfurth, A., Barlati, S., Zanca, F., Giordano, G. M., Birkedal Glenthøj, L., Nordentoft, M., & Galderisi, S. (2022). European Psychiatric Association guidance on assessment of cognitive impairment in schizophrenia. European Psychiatry, 65(1), e58. https://doi.org/10.1192/j.eurpsy.2022.2316

Weinmann, S., Bechdolf, A., & Greve, N. (2021). Psychiatrische Krisenintervention zu Hause: Das Praxisbuch zu StäB & Co. (1st ed.). Psychiatrie Verlag.

Weinmann, S., Borgwardt, S., & Huber, C. G. (2025). Home Treatment in Deutschland und der Schweiz – Entwicklungslinien. Fortschritte der Neurologie · Psychiatrie, 93(04), 124–126. https://doi.org/10.1055/a-2531-4301

Weinmann, S., Spiegel, J., Baumgardt, J., Bühling-Schindowski, F., Pfeiffer, J., Kleinschmidt, M., & Bechdolf, A. (2022). Comparison of Inpatient Equivalent Home Treatment (IEHT) with Standard Inpatient Treatment: A Matched Cohort Study. Psychiatrische Praxis, 49(08), 405–410. https://doi.org/10.1055/a-1615-8763

Weitzel, E. C., Schwenke, M., Schomerus, G., Schönknecht, P., Bleckwenn, M., Mehnert-Theuerkauf, A., Riedel-Heller, S. G., & Löbner, M. (2023). E-mental health in Germany—What is the current use and what are experiences of different types of health care providers for patients with mental illnesses? *Archives of Public Health*, *81*(1), 133. https://doi.org/10.1186/s13690-023-01150-y

Wiegand, H. F., Hölzel, L., Tüscher, O., Lieb, K., Falkai, P., & Adorjan, K. (2025). Mental health services in Germany – Structures, outcomes and future challenges. International Review of Psychiatry, 37(3–4), 253–270. https://doi.org/10.1080/09540261.2025.2479601

Wolf, S., Seiffer, B., Zeibig, J.-M., Frei, A. K., Studnitz, T., Welkerling, J., Meinzinger, E., Bauer, L. L., Baur, J., Rosenstiel, S., Fiedler, D. V., Helmhold, F., Ray, A., Herzog, E., Takano, K., Nakagawa, T., Günak, M. M., Kropp, S., Peters, S., … Ehring, T. (2024). A transdiagnostic group exercise intervention for mental health outpatients in Germany (ImPuls): Results of a pragmatic, multisite, block-randomised, phase 3 controlled trial. The Lancet Psychiatry, 11(6), 417–430. https://doi.org/10.1016/S2215-0366(24)00069-5

Wölwer, W., Baumann, A., Bechdolf, A., Buchkremer, G., Häfner, H., Janssen, B., Klosterkötter, J., Maier, W., Möller, J., Ruhrmann, S., & Gaebel, W. (2006). The German Research Network on Schizophrenia-impact on the management of schizophrenia. Dialogues in Clinical Neuroscience, 8(1), 115–121. https://doi.org/10.31887/DCNS.2006.8.1/wwoelwer

Wölwer, W., Buchkremer, G., Häfner, H., Klosterkötter, J., Maier, W., Möller, H.-J., & Gaebel, W. (2018). Concept and Results of the German Research Network on Schizophrenia. Journal of Mental Health and Clinical Psychology, 2(4), 15–20. https://doi.org/10.29245/2578-2959/2018/4.1152

YOUTHreach. (2026). YOUTHreach. https://youth-reach.eu/

Zielasek, J., & Gaebel, W. (2015). Mental health law in Germany. BJPsych International, 12(1).

Funding

This project was supported with a grant from Boehringer Ingelheim. The company was not involved in the research nor the drafting of the report. All outputs are non-promotional and non-specific to any treatment or therapy.

RETHINKING SCHIZOPHRENIA

Phase III: Country Profiles

Rethinking Schizophrenia in Germany:
Schizophrenia and Brain Health

European Brain Council
Rue d'Egmont 11
1000 Brussels
Belgium

Tel: + 32 (0) 2 513 27 57
info@braincouncil.eu

European Psychiatric Association
Rue d'Egmont 11
1000 Brussels
Belgium

Tel: +32 2 511 02 30
Contact form