

Schizophrenia Between Evidence, Human Rights and Practice: The S3 Guideline 2025 as a Legal and Psychiatric Challenge*

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Abstract

The paper examines the S3 Guideline Schizophrenia 2025 of the German Society for Psychiatry, Psychotherapy, Psychosomatics, and Neurology (DGPPN) as a turning point in modern psychiatry. The paper aims to explore how this living guideline integrates evidence-based medicine, legal regulations, and human rights standards into a unified framework of psychiatric care. Using a qualitative analysis of the guideline's structure, legal references, and participatory development process, the study identifies its methodological innovations and practical challenges. The results highlight that the guideline promotes shared and supported decision-making, empowerment, and recovery-oriented care while defining coercion as a measure of last resort. It establishes psychiatry as a legally constituted field where autonomy, protection, and professional responsibility must be continuously balanced. However, discrepancies persist between the normative standards of the guideline and institutional practice, mainly due to structural and resource limitations. The paper concludes that the S3 Guideline Schizophrenia 2025 represents both a medical and legal policy instrument, setting the foundation for human rights-based psychiatry in Germany and beyond.

Keywords: Schizophrenia; Human Rights; Guideline; Psychiatry; Coercion

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A. INTRODUCTION

Few other medical fields interact as closely with legal and ethical issues as psychiatry. The treatment of people with mental illness is not only a medical act, but also a legal and human rights act: it affects fundamental rights, self-determination, physical integrity and personal freedom. Psychiatry is thus a "legal space" within the healthcare system – characterised by legal requirements, judicial control and ethical tensions between care and autonomy. The S3 guideline on schizophrenia, published in September 2025 by the German Society for Psychiatry, Psychotherapy, Psychosomatics, and Neurology (DGPPN), marks a milestone in this area of tension. It formulates evidence- and consensus-based recommendations for the diagnosis, treatment and rehabilitation of people with schizophrenia, while also focusing on ethical and legal standards: patient rights, participatory decision-making, humane care and protection against abuse or discrimination. The guideline thus serves not only as a medical guide, but also as a normative reference document for dealing with mentally ill people in healthcare facilities and in forensic practice.

In recent decades, medical guidelines have become a central control instrument in clinical practice. They are not laws, but they do have a de facto normative effect. In the field of psychiatry, in particular, they serve a dual function: on the one hand, they are intended to ensure the quality of treatment, and on the other hand, they provide a frame of reference for legal, ethical, and political assessments. In this sense, the S3 guideline on schizophrenia (DGPPN 2025) is not merely a collection of medical recommendations, but an expression of the profession's normative self-understanding. It combines evidence-based research with consensus decisions involving various professional groups, affected individuals and their relatives. This participatory process reflects the aspiration to translate scientific knowledge into social and legal responsibility (Maker, 2024). However, evidence-based medicine in a psychiatric context means more than just the application of empirically tested procedures. It requires a reflexive practice that recognises that scientific data is always embedded in normative interpretative frameworks. In the treatment of schizophrenia, this particularly concerns questions of autonomy, capacity to consent and freedom. The statement "what works is also right" falls short here; in the field of psychiatry, the following must also apply: "What is right must first be allowed to work." Guidelines in psychiatry are thus caught in a particular tension between clinical evidence, legal legitimacy and ethical justifiability (Gkintoni, Skokou & Gourzis, 2024). They have the task of combining scientific effectiveness with respect for human rights. This challenge is particularly evident in the case of coercive measures or the treatment of people with severe mental illness.

Literature Review

Psychiatry differs from other medical disciplines in that its practice regularly interferes with fundamental rights. Hospitalisation, medication, restraint, or care are not only therapeutic acts, but also legally regulated restrictions on freedom. Psychiatry is therefore not a purely medical field of activity, but a "legally constituted space."

This space is defined by three basic principles: care, freedom and responsibility.

- *Care* obliges the profession to alleviate suffering and avoid danger.
- *Freedom* limits this action by protecting the individual's self-determination.
- Finally, *responsibility* requires that medical decisions be transparent, verifiable and legally justifiable.

The history of psychiatry shows that the balance of these principles has never been a given. Abuse, coercive treatment and paternalistic structures have had a lasting impact on trust in the institution. It was only with the reform of psychiatry in the 1970s and the integration of human rights standards – for example, through the UN Convention on the Rights of Persons with Disabilities (2006) – that a paradigm shift was initiated: away from custodial care and towards participatory treatment. The S3 guideline Schizophrenia 2025 follows in this tradition. It attempts to codify the achievements of reform psychiatry while simultaneously creating an evidence-based foundation for modern treatment practices. In doing so, it recognises that medical effectiveness without legal legitimacy is not sustainable. The demand to minimise coercion, promote autonomy, and reflect institutional power is therefore not merely an ethical accessory, but an integral part of guideline-compliant treatment. As a result, psychiatry today is a field where the major fundamental questions of the modern constitutional state converge: How much protection do people need from themselves, and how much freedom from protection?

Schizophrenia is a serious mental illness characterised by disturbances in thinking, perception, and affectivity (ICD-10 classification F20-F29 BfArM 2024). In Germany, approximately 41.3 people per 100,000 inhabitants develop schizophrenia each year (Riedel et al., 2025). The prevalence of diagnosis is approximately 0.9% (Thom et al., 2024), corresponding to around 660,000 people with statutory health insurance. This makes schizophrenia one of the most cost-intensive chronic illnesses in the psychiatric care system (Federal Institute for Drugs and Medical Devices, 2024). In addition to the high individual burden caused by cognitive, emotional, and social limitations, there are also considerable economic costs resulting from the incapacity to work, early retirement, and the

need for care. In terms of health policy, this requires coordinated, cross-sectoral care with early detection, multi-professional case management, and community-based support structures to reduce hospitalisations, chronicity, and coercive measures. The S3 Guideline Schizophrenia 2025 provides a normative and evidence-based framework for this: it translates clinical effectiveness into care pathways that are legally and human rights-compliant – and makes the treatment of schizophrenia a task for society as a whole, balancing autonomy, care, and responsibility.

B. METHODS

This paper aims to critically examine how the S3 Guideline Schizophrenia 2025 of the German Society for Psychiatry, Psychotherapy, Psychosomatics, and Neurology (DGPPN) integrates evidence-based medicine, legal frameworks, and human rights principles into modern psychiatric practice. Specifically, the paper aims to:

- Analyse the methodological and normative innovations introduced by the 2025 living guideline.
- Evaluate how the guideline operationalises concepts such as shared decision-making, supported decision-making, and empowerment in line with the UN Convention on the Rights of Persons with Disabilities (UN CRPD).
- Explore the legal, ethical, and institutional implications of translating human rights obligations into everyday psychiatric treatment.
- Highlight the tensions between clinical evidence, patient autonomy, and coercive interventions, proposing psychiatry as a legally constituted space where care, freedom, and responsibility must be balanced.

Living Guideline Concept

The S3 guideline on schizophrenia, published on 15 October 2025 by the German Society for Psychiatry, Psychotherapy, Psychosomatics, and Neurology (DGPPN), marks a methodological turning point in the development of psychiatric guidelines. For the first time, it was designed as a so-called *living guideline* – a continuously updated document that integrates new scientific findings on an ongoing basis. This dynamic model addresses the challenge that psychiatric research is developing at a rapid pace, while static guidelines often become outdated by the time they are published. The living guideline strategy enables recommendations to be adapted flexibly without requiring the entire consensus process to be restarted. This makes the guideline a living set of rules

that can reflect both medical evidence and social change in real-time. In a legal context, this procedure is remarkable: a guideline that regularly updates itself also gains legitimacy. This is because it can always refer to the current state of scientific knowledge – a prerequisite for being considered "recognised expertise" within the meaning of Section 630a of the German Civil Code (BGB) in the event of a dispute. The S3 guideline thus becomes a binding reference point for medical duties of care, as well as for legal assessments of psychiatric treatment.

Participation of Those Affected and their Relatives

A central methodological feature of the guideline is the systematic involvement of those affected and their relatives. This participation is more than symbolic inclusion; it is an expression of a new understanding of scientific legitimacy. For a long time, psychiatric guidelines were the product of a professional world dominated exclusively by doctors. It was only through the influence of the self-help and human rights movement since the 1990s that it became clear that those affected are not only objects of psychiatric practice, but experts in their own right. The DGPPN has taken this change into account by involving those affected in all phases of guideline development, from prioritising topics to commenting on individual recommendations (Elleuch et al., 2024). This openness not only has ethical significance, but also methodological consequences. It changes the understanding of evidence: no longer are only randomised studies included in the evaluation, but also experiential knowledge and subjective perspectives. This brings the guideline closer to the idea of "patient-centred evidence", i.e., evidence-based practice that is oriented towards the values and living environments of those affected. However, the question remains as to how permanently and bindingly this participation is institutionally secured. As long as those affected do not have equal voting rights in guideline committees, participation remains a well-intentioned but asymmetrical process.

Evidence-based medicine and the consensus principle

The S3 guideline adheres to the so-called consensus principle of evidence-based medicine, which combines scientific data and collective medical expertise. On the AWMF guideline scale (S1–S3), the S3 level represents the highest methodological standard, encompassing systematic literature reviews, structured evidence assessment, and moderated consensus among experts (Association of Scientific Medical Societies, 2024). For the treatment of schizophrenia, this means that each recommendation is based on a weighted combination of study findings, clinical experience, and ethical evaluation. This methodology reflects the complexity of the disorder – schizophrenia is not a homogeneous disease, but a syndrome that integrates biological, psychological

and social dimensions. The guideline deliberately distances itself from a purely biological paradigm. It emphasises psychotherapy, social support, rehabilitation and recovery concepts as well as pharmacological therapy.

This integrative model represents an expanded understanding of evidence, where scientific effectiveness is only recognised as relevant if it leads to actual participation, self-determination, and quality of life. At the same time, this reveals a central challenge: evidence is not value-free. It arises in social and institutional contexts that reflect power relations and the distribution of resources. A guideline that claims to be evidence-based and compliant with human rights must therefore critically reflect on its own normative assumptions. In conclusion, the S3 guideline Schizophrenia 2025 is not only a scientific document, but also a political statement: it represents a form of psychiatry that values transparency, participation, and human rights as essential qualities of medical evidence.

C. RESULTS

1. Cross-Sector Care (Outpatient, Inpatient, Rehabilitative)

The S3 guideline Schizophrenia 2025 emphasises that the treatment of schizophrenic disorders must not be reduced to individual segments of care. It calls for cross-sector, integrated care that encompasses all phases of the disease course – from acute treatment to rehabilitation and outpatient aftercare. This principle reflects the recognition that schizophrenia is a chronic but, in many cases, treatable illness. Fragmented care structures lead to gaps in care, frequent relapses, and unnecessary hospital readmissions. Guideline-based treatment, therefore, means systematically linking interfaces between clinics, community psychiatry, registered specialists and social services. From a legal perspective, this idea is highly relevant: incomplete aftercare can be problematic not only clinically, but also in terms of liability law. According to Section 630a of the German Civil Code (BGB), the treating physician owes a duty of "professional" therapy; in a psychiatric context, this also includes ensuring continuity. If patients are left to their own devices after discharge without adequate support structures, this can be considered a violation of the physician's duty of care. The care system faces a structural dilemma here: on the one hand, the law requires the care and protection of vulnerable persons; on the other hand, these obligations conflict with limited resources and institutional responsibilities. The guideline, therefore, explicitly refers to the need for cooperative care models – such as integrated care contracts (Section 140a of the German Social Code, Book V) or regional networks for community psychiatric coordination. Cross-sector

care thus becomes a legal and ethical touchstone, determining whether psychiatry can be understood as a socially responsible system that complies with human rights or as a patchwork quilt of responsibilities.

2. Participation and Shared Decision-Making

The guideline emphasises shared decision-making as a central principle. Psychiatric treatment should not be an authoritarian process, but rather a collaborative dialogue between patient and practitioner, based on a partnership. The concept of shared decision-making (SDM) was initially developed in somatic medicine. Still, it holds particular significance in psychiatry, as it operationalises the human right to self-determination (Article 12, UN CRPD) and the requirement for informed consent enshrined in Section 630d of the German Civil Code (BGB). However, SDM does not mean that patients are free to choose in every situation (German Civil Code, 2023b). In acute psychotic phases, judgment may be impaired. The guideline, therefore, emphasises the role of supported decision-making – a concept that mediates between paternalistic care and formal autonomy. The aim is to promote the ability to make self-determined decisions through appropriate support, rather than replacing it altogether. In practice, this is done through treatment agreements, advance directives and recovery-oriented therapy planning. These instruments document patients' wishes and create legal certainty, particularly in times of crisis. However, they are still rarely used in everyday clinical practice, often due to lack of time or scepticism about the effectiveness of such agreements (Agudelo-Hernández & Urrego-García, 2024).

From a legal perspective, however, they are of central importance, as they can serve as an expression of presumed will in the event of a dispute and must be taken into account in cases of compulsory treatment (Section 1832 of the German Civil Code). This means that autonomy is also legally enshrined in times of crisis. The guideline recognises SDM not only as a therapeutic method, but also as a human rights foundation of modern psychiatry. Autonomy is not a luxury, but a prerequisite for professional legitimacy.

3. Challenges in the Practice of Psychiatric Clinics

As clearly as the guideline formulates the theoretical standards, it also clearly identifies the obstacles to its practical implementation. Psychiatric clinics are under considerable structural pressure: staff shortages, high occupancy rates, economic constraints, and legal uncertainties make it difficult to implement participatory forms of treatment. The logic of many clinics remains one of risk: safety and hazard prevention take precedence over self-determination and

recovery. In this climate, coercion is often perceived as an unavoidable means of crisis management. The guideline indirectly criticises this attitude by calling for a culture of empowerment – i.e., the systematic promotion of self-efficacy and shared responsibility (Saha et al., 2024).

However, empowerment requires structural prerequisites, including time, effective communication, personnel continuity, and institutional openness. These conditions are not met in many psychiatric institutions. From a legal perspective, there is therefore a discrepancy between the normative claim of the guideline and the actual organisational reality. The Patient Rights Act obliges respect for the will of patients; however, the implementation of this will is often neutralised by institutional routines. The DGPPN therefore calls for psychosocial care to be recognised as a societal responsibility. Only if the federal government, the states and health insurance companies provide sufficient resources for person-centred care can the guideline be more than an ethical ideal. Overall, this chapter of the guideline makes it clear that psychiatric care today is more than just the art of healing: it is a social contract between medicine, law and society, the fulfilment of which is the responsibility not only of clinics, but of the entire healthcare system.

4. Reference to the UN Convention on the Rights of Persons with Disabilities (UN CRPD, Articles 12, 14, 25)

The UN Convention on the Rights of Persons with Disabilities (UN CRPD), which has been binding in Germany since 2009, has fundamentally changed the human rights perspective on mental illness (Federal Republic of Germany, 2009). It no longer regards people with mental illness as objects of state care, but as bearers of equal rights and obligations. Articles 12, 14, and 25 explicitly guarantee self-determination, freedom, and equal access to healthcare. Art. 12 UNCRPD ("Equal recognition before the law") obliges States Parties to recognise and support the legal capacity of persons with disabilities, including those with mental illness. Article 14 prohibits deprivation of liberty solely based on disability, and Article 25 establishes the right to healthcare without discrimination. For psychiatry, this represents a fundamental normative shift: the guiding principle is no longer extended protection through incapacitation, but self-determination through support.

The S3 Guideline on Schizophrenia 2025 explicitly addresses these requirements by emphasising the importance of participatory decision-making processes and supported decision-making in several chapters. The guideline does not see this as a mere ethical addition, but as a prerequisite for guideline-

compliant treatment. At the same time, it recognises the tension between international human rights law and national coercive law. While the UN Convention on the Rights of Persons with Disabilities (UN CRPD) fundamentally rejects deprivation of liberty on the grounds of mental illness and emphasises the principle of self-determination and inclusion (Art. 14 UN CRPD), German guardianship law continues to provide for the possibility of involuntary hospitalisation and compulsory treatment measures even after the reform on 1 January 2023. These interventions are regulated in Sections 1831 et seq. of the German Civil Code (BGB) and Section 312 of the German Family Proceedings Act (FamFG) and are only permissible under strict substantive and procedural conditions. This discrepancy marks one of the most significant unresolved areas of tension in psychiatric practice (German Civil Code, 2023c).

5. Protection Against Discrimination and Coercion

The human rights of people with mental illness are threatened not only by restrictions on their freedom, but also by structural discrimination. Stigmatisation, exclusion and paternalistic attitudes towards treatment are still part of everyday life in psychiatric institutions. The guideline, therefore, explicitly calls for a culture of anti-discrimination and inclusion. This applies to both institutional structures and linguistic and communicative practices. In healthcare practice, a hierarchy is often unconsciously reproduced in which professional authority is placed above the "delusions" or "lack of insight" of patients. From a human rights perspective, this attitude is problematic as it undermines the principle of equality.

Furthermore, discrimination is not only socially relevant but also legally relevant. According to Article 3(3), sentence 2 of the German Basic Law, no one may be disadvantaged because of their disability. A psychiatric practice that systematically grants mentally ill people less freedom of choice than somatically ill people runs the risk of violating this constitutional principle. In this context, coercive measures represent the most intense form of discrimination because they interfere not only with physical integrity (Article 2(2) of the Basic Law), but also with human dignity (Article 1(1) of the Basic Law). The guideline therefore emphasises that coercion may only be used after all alternative means have been exhausted and within the framework of a transparent, documented decision-making process. De-escalation strategies, peer support, open doors and treatment agreements are highlighted as preventive instruments (Basic Law for the Federal Republic of Germany, 1950).

Figure 1. Hierarchy of Legal and Ethical Frameworks in Psychiatric Practice



However, the implementation of these measures is overtaken by the reality of many clinics: a lack of resources, overcrowding, and insufficient training mean that coercion continues to be used as a pragmatic crisis instrument. This suggests that human rights in psychiatry cannot be guaranteed solely by laws, but instead require institutional and cultural work. Human rights must be embedded in training, supervision, and organisational development to be effective in practice.

6. The Importance of Empowerment and Recovery

Closely linked to the human rights perspective is the guiding principle of empowerment, which is central to the recovery movement and plays a key role in the guidelines. Both concepts originated in the self-help movement and were developed by those affected as an alternative to passive, deficit-oriented psychiatry. *Empowerment* means enabling patients to take responsibility for their lives and their recovery. *Recovery*, on the other hand, describes an individual process of regaining meaning in life, social participation and identity – regardless of whether symptoms are present or not. The S3 guideline explicitly recognises this perspective and integrates it into its treatment principles. In doing so, it aligns with the WHO's call to view mental health as a social and human rights issue (World Health Organisation, 2013 & 2021).

However, empowerment and recovery are more than therapeutic ideals; they have legal and ethical significance. They provide a concrete expression of the human right to self-determination and participation. Psychiatric treatment that does not aim at empowerment thus misses the core of patient rights. In practice, this means not only informing patients about treatments but also actively involving them in shaping the therapeutic process. Recovery-oriented psychiatry requires multi-professional teams, peer counselling, open communication cultures and participatory decision-making structures.

However, there is a danger that empowerment will degenerate into rhetoric if structural resources do not support it. Without sufficient staffing, time and institutional support, the ideal of self-empowerment remains a mere postulate. The guideline, therefore, formulates a dual obligation: empowerment is both a clinical method and a human rights obligation. Psychiatry thus becomes a setting where medical evidence and legal responsibility must be demonstrated in everyday practice.

7. Sections 1831, 1832 BGB and Section 312 FamFG – current legal situation (as of 2023)

Since the 2023 reform of guardianship law, the legal basis for compulsory psychiatric measures in Germany is no longer found in Section 1906a of the BGB, but in Sections 1831 and 1832 of the BGB. Accompanying procedural regulations are still contained in Section 312 FamFG. The reform took effect on 1 January 2023 and replaced the previous Sections 1906 ff. BGB. The background to this was the comprehensive restructuring of guardianship law, which placed greater emphasis on self-determination and supported decision-making. In terms of content, the previous regulations on accommodation and compulsory treatment were retained in the main, but modernised in terms of language and structure (Family Proceedings Act, 2023).

In its landmark decisions (BVerfGE 2 BvR 882/09), the Federal Constitutional Court had already emphasised that compulsory treatment constitutes a severe infringement of fundamental rights and is therefore only permissible under strict conditions (Gronholm et al., 2023). These principles also characterise the new legal situation:

The conditions for the admissibility of compulsory treatment (Section 1832 of the German Civil Code) are, in particular (Federal Constitutional Court, 2011):

1. The existence of a mental illness or mental or psychological disability

2. The necessity of treatment to avert imminent significant damage to health,
3. Prospect of success of the treatment,
4. failure of less severe measures, in particular the attempt to obtain voluntary consent after comprehensive information has been provided,
5. judicial approval (Section 312 FamFG), and
6. Medical information about the purpose, nature, duration and risks of the measure.

Placement against the will of a person under care is regulated in Section 1831 of the German Civil Code (BGB) and also requires court approval. It is only permissible if it is necessary for the welfare of the person under care, in particular to avert a significant danger to themselves or others. This means that the protective concept of self-determination remains at the heart of the new law: coercive measures are a last resort, i.e. they are only permissible if voluntary treatment cannot be achieved and the intervention remains proportionate. The Schizophrenia 2025 guideline refers explicitly to this legal situation and emphasises that coercive measures must remain a last resort. It calls for the prior use of de-escalation measures and documented efforts to find consensual solutions (Riedel et al, 2025).

The guideline thus serves as a bridge between medical practice and the constitutional requirements of the Convention on the Rights of Persons with Disabilities (Anwar et al., 2025). At the same time, it is apparent that judicial approval is often perceived as a formal act in practice. Family courts usually follow the medical assessment without independently reviewing the proportionality. This leads to a devaluation of the judicial control mechanism. There is a structural deficit in the legal protection of mentally ill people, which contradicts the human rights perspective of the UN CRPD. Consistent implementation of the guideline would require courts and clinics to jointly develop ethical standards to avoid coercion rather than merely legitimising it.

D. DISCUSSION

The guideline formulates a series of ethical and practical requirements that go beyond mere legal compliance. It understands coercion as clinical failure – as an indication that communication, relationships or structures were not sufficiently robust.

A multi-stage approach is recommended:

- Early detection and prevention through crisis plans and treatment agreements,
- de-escalation through communication, trained teams and spatial design,
- debriefing and documentation to enable learning processes within the team.

This approach shifts the focus: the emphasis is no longer on legal justification, but on institutional self-reflection. Coercion becomes an indicator of systemic weaknesses, not individual guilt. The guideline also calls for the recording and evaluation of coercive measures as a quality indicator. This creates the first opportunity to evaluate clinics according to human rights criteria. In combination with Section 137 of the German Social Code, Book V (quality assurance), this could lead to the development of a legally binding evaluation system in the future (Social Security Code, 2023).

The challenge lies in the fact that coercion is often considered unavoidable in psychiatric practice. However, empirical research shows that clinics with more open concepts, a high staff presence and flat hierarchies use significantly less coercion – without increasing safety risks. This highlights the cultural dimension of coercion: it is not a natural law of medicine, but rather an expression of institutionalised habits. The guideline, therefore, calls for a cultural change that must be supported by the institutions themselves – backed up by further training, supervision and institutional accountability.

1. Forensic Psychiatric Perspectives

The legal tensions are particularly evident in forensic psychiatry, where restrictions on freedom are not the exception but a structural condition. The German Criminal Code (Mahdanian et al., 2023), Section 63, allows for the indefinite detention of mentally ill offenders if their culpability was significantly reduced or eliminated and they continue to pose a danger to the general public (Criminal Code of the Federal Republic of Germany, 2023). Guideline 2025 places particular emphasis on this area. It emphasises that therapeutic and security objectives must be clearly separated. Forensic detention must not become a de facto form of internment.

The European Court of Human Rights (2012 & 2019) has ruled in several decisions – such as *Stanev v. Bulgaria* (2012) and *Rooman v. Belgium* (2019) – that detention without therapeutic prospects constitutes a violation of Article 5 of the ECHR (right to liberty). This also creates an obligation under international law for Germany to ensure that forensic psychiatric institutions are regularly

reviewed, adequately staffed and geared towards release. However, the reality paints a different picture: overcrowded facilities, long periods of detention and a lack of prospects for release characterise everyday life. The guideline, therefore, urges that a recovery-oriented approach also be implemented in forensic psychiatric institutions. This means that every inmate must have an individual treatment goal and a realistic prospect of release. From a human rights perspective, forensic psychiatry represents one of the most significant challenges of modern psychiatry. It exemplifies the conflict between security and freedom, as well as care and autonomy. The guideline reminds us that even where the state restricts freedom, human dignity remains inviolable (Thoma, 2019).

2. Quality Indicators, Guideline Implementation, and Evaluation

The effectiveness of a guideline is not determined by its content, but by its implementation and adherence. The S3 guideline Schizophrenia 2025, therefore, contains not only recommendations for clinical practice, but also guidelines for implementation and quality assurance. In doing so, it emphasises institutional responsibility: psychiatry that complies with human rights is not achieved solely through individual attitudes, but through verifiable structures. The guideline proposes various quality indicators designed to create transparency and comparability between institutions. These include:

- the frequency and duration of coercive measures,
- the proportion of patients with treatment agreements,
- the participation of those affected in quality circles,
- and the assessment of patient satisfaction and subjective well-being.

These indicators serve as the foundation for human rights-oriented quality management. They make it possible not only to sanction violations retrospectively, but also to identify them preventively. Ideally, this will make human rights monitoring part of the clinical routine – a shift from a legal exception to an institutional standard. From a legal perspective, this opens up a new field: the guideline can become a frame of reference for interpreting the "specialist standard" within the meaning of Section 630a of the German Civil Code (BGB). Institutions that violate key guideline recommendations thus risk not only professional criticism, but also liability consequences (German Civil Code, 2023a). Guideline implementation is therefore not a voluntary quality feature, but an expression of legally required diligence. However, practice shows that implementation rarely happens automatically. Between normative requirements and real practice lies the so-called *implementation gap*. The causes are staff shortages, institutional inertia, economic pressure and the lack of

binding guidelines. Many clinics lack clear strategies for systematically integrating guidelines into their training, documentation, and decision-making processes. The DGPPN therefore emphasises that implementation is not only the responsibility of medical specialists, but of the entire organisation – from clinic management to nursing staff. Only when guidelines become part of the institutional DNA can a form of psychiatry emerge that is oriented towards the law and human dignity (German Society for Psychiatry and Psychotherapy, Psychosomatics and Neurology, 2021 & 2025).

3. Role of Ethics Committees, Patient Advocates and Ombudsmen

Psychiatry is a field in which ethical conflicts are structurally frequent. Decisions about coercion, consent, or placement inevitably involve moral dilemmas. The guideline recognises this and explicitly calls for the establishment of institutional control and reflection structures that systematically address these conflicts. These include ethics committees, patient advocates and ombudspersons. On the one hand, they are intended to strengthen patients' rights and, on the other hand, to relieve the burden on staff by basing difficult decisions on a transparent procedure. Ethics committees in psychiatric institutions have the task of reviewing treatment decisions when there are doubts about proportionality or consent. They are not a substitute for judicial review, but an essential forum for interdisciplinary reflection. Their work professionalises and documents ethical considerations – a necessary prerequisite for legally compliant practice. Patient advocates and ombudsperson services, on the other hand, serve to enforce patient rights in a low-threshold manner. They facilitate complaint procedures, mediate conflicts, and create transparency regarding institutional grievances. Some federal states have made their establishment a legal requirement, while others rely on voluntary models.

However, their effectiveness depends crucially on their independence. Ombudsman services that are organisationally subordinate to the clinic management lose their credibility. The guideline, therefore, explicitly requires that complaint structures be organisationally separate, staffed by trained personnel and publicly visible. Human rights in psychiatry are not abstract principles, but practical routines. They arise where those affected are aware of their rights, where employees take ethical responsibility, and where institutions are accountable. The guideline clearly states that human rights are not protected by laws or guidelines alone, but by daily actions within specific institutions. A psychiatric clinic that understands coercion as an exception, participation as a

principle and transparency as a duty becomes a microcosm of the constitutional state.

4. Opportunities of the Living Guideline for Psychiatry based on the Rule of Law

The introduction of the living guideline structure in the S3 guideline Schizophrenia 2025 is a milestone in the development of a dynamic, self-reflective psychiatry. It embodies the aspiration to continuously adapt clinical practice to new scientific, social and legal findings. This makes the guideline an instrument that focuses not only on stability but also on the ability to change – a decisive step forward in a field that static power relations have historically characterised. From a constitutional perspective, this concept creates a transparent link between medical knowledge and legal control. Guidelines are increasingly taking on the character of *de facto* standards. Although they are not legally binding, they define the "recognised state of science", which in turn is the benchmark for duties of care, liability issues and judicial assessments. In this respect, the guideline is a hybrid document – scientifically legitimate, ethically sound and legally relevant.

The living guideline also opens up the possibility of adaptively integrating human rights standards. It can thus respond to future developments in international law – such as discussions on the stronger implementation of the UN CRPD in national law or the Council of Europe's recommendations on avoiding coercion – without first having to undergo a lengthy revision process. This makes it an instrument for progressive norm-setting at the interface between medicine and law. Nevertheless, structural hurdles remain: updating the guideline is resource-intensive, requires interdisciplinary cooperation, and depends on the willingness of institutions to actually implement the recommendations. A guideline alone does not create practice. It requires political support, financial resources, and institutional commitment.

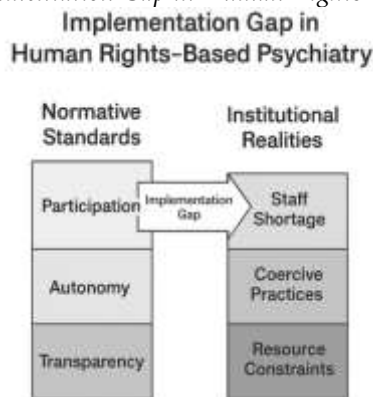
5. Tension Between Evidence and Individual Freedom

The central challenge of modern psychiatry lies in striking a balance between scientific evidence and individual freedom. The S3 guideline formulates clear, empirically based recommendations – for example, on pharmacotherapy, psychotherapy or relapse prevention – but their implementation often conflicts with individual values, subjective experiences and legal boundaries. The tension between "objective" evidence and "subjective" autonomy cannot be resolved, but must be professionally endured. Medical decisions must not be based solely on

effectiveness, but must always consider both legal and ethical dimensions. This means that treatment is only guideline-compliant if it is both legally legitimate and ethically justifiable. The guideline itself is ambivalent in this regard. On the one hand, it is committed to self-determination and participatory decision-making processes.

On the other hand, it remains committed to the medical paradigm that views illness as a deficit that requires treatment – even against the declared will of the person affected. This ambivalence reflects the dilemma of psychiatry as a whole: it is both help and intervention, a protective space and an apparatus of power. A truly human rights-based psychiatry would have to adhere more consistently to the idea of support rather than substitution. The new guardianship law (Gebreegziabhere et al., 2022; Millgate et al., 2022) points in this direction; however, its practical implementation in clinics remains pending. In this respect, the guideline remains an intermediate step – an attempt to tame psychiatry in accordance with the rule of law without paralysing its therapeutic effectiveness.

Figure 2. Implementation Gap in Human Rights-Based Psychiatry



Furthermore, it is necessary to determine whether the current legal framework is entirely in line with the provisions of the UN CRPD. The Convention prohibits deprivation of liberty solely on the grounds of disability; German law expressly permits it under certain circumstances. This opens up a legal policy debate that goes far beyond the guidelines: does psychiatry need a new right of intervention that complies with human rights? The answer to this question can only be found through an interdisciplinary approach. Lawyers, doctors, ethicists, and those affected must work together to clarify how duties of protection and civil liberties can be brought into a symmetrical relationship (Council of Europe, 1950).

6. Psychiatry Between Profession and Politics

The S3 Guideline 2025 is not only a medical document, but also a political one. It defines what constitutes "good psychiatry" – and thus also which forms of dealing with mentally ill people are socially legitimate. In this respect, it shapes the public discourse on normality, responsibility and risk. A critical assessment must therefore also address the power of the guideline itself. Guidelines are never neutral. They reflect the priorities of the profession, the availability of research funding and the social power relations in which they are created. Those who decide what is considered evidence-based also determine which forms of knowledge and experience are recognised and accepted. In recent years, organisations representing those affected have repeatedly pointed out that their perspectives are taken into account in the development of guidelines, but are not given equal weight. The living guideline offers an opportunity to correct this deficiency – provided that participation is not understood as a formal act, but as shared authorship of psychiatric knowledge. Psychiatry is therefore inevitably political. It is at the centre of social negotiations about security, normality and freedom. A legally controlled, human rights-based and evidence-based psychiatry can only succeed if it is prepared to share power with those affected, their families and civil society.

E. CONCLUSION

The S3 guideline Schizophrenia 2025 is exemplary for psychiatry in transition – from a medically dominated discipline to an interdisciplinary field in which law, ethics and human rights play an equal role. It marks an attempt to strike a balance between scientific evidence, clinical experience and normative orientation. From a medical perspective, the guideline offers highly differentiated, evidence-based guidance for diagnosis and therapy. It integrates pharmacological, psychotherapeutic and psychosocial procedures and takes into account the entire course of schizophrenic disorders. In doing so, it creates a comprehensive set of tools for healthcare practice. However, its real significance lies in the legal and ethical repositioning of psychiatry. For the first time, a German guideline systematically refers to human rights obligations. Autonomy, participation and support decisions are no longer considered desirable additions, but rather constitutive elements of professional treatment. Psychiatry thus becomes a space bound by the rule of law, in which medical responsibility is directly linked to fundamental rights. However, the implementation of these principles is by no means a straightforward matter. There are still considerable discrepancies between the guidelines and institutional reality. Coercive

measures are used more frequently than the guidelines stipulate; patient participation often remains symbolic; and the integration of human rights standards into training and practice is still in its infancy. The conclusion is therefore ambivalent: the guideline is a step forward, but not a destination. It serves as a normative compass that points the way to human rights-based psychiatry – but the actual transformation must occur within the institutions themselves.

Modern psychiatry, based on the rule of law, rests on three pillars:

1. Legal transparency – every decision must be verifiable and justifiable;
2. Ethical reflexivity – every measure must be measured against respect for autonomy;
3. Evidence-based practice – scientific knowledge remains the basis, but not the sole criterion.

Only when these three dimensions are integrated can psychiatry fulfil its dual mission: protecting the individual and preserving their freedom.

In this sense, the S3 Guideline Schizophrenia 2025 is not only a medical document but also a legal policy manifesto. It calls for a rethinking of psychiatry – as a space in which healing, law and human dignity are not in competition with each other, but are interdependent.

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