

Clinical Practice Guideline

The Diagnosis and Treatment of Unipolar Depression

National Disease Management Guideline

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Summary

Background: Depression is one of the most common mental disorders worldwide. The German National Disease Management Guideline on Unipolar Depression (NDGM), (Nationale Versorgungsleitlinie, NVL), updated in 2022, contains recommendations on the diagnosis and treatment of acute and chronic depressive disorders.

Methods: The update was based on the findings of a systematic review of the evidence (2013–2022) and was issued by a multidisciplinary panel after a formalized consensus process.

Results: The structure of the guideline was fundamentally revised and is now based on the phases of depression and/or its treatment, as well as on the severity of the disease. There is newly added material with recommendations on Internet- and mobile-device based treatments, esketamine, repetitive magnetic stimulation, psychosocial therapies, rehabilitation, social participation, and complex forms of care. The guideline also emphasizes better coordination of all services in the care of patients with depression. This article covers the most important changes and additions among the 156 recommendations in the guideline. More information and accompanying materials are available at www.leitlinien.de/depression.

Conclusion: There are effective treatments for depression and a variety of supportive measures that can be applied with great benefit by primary care physicians, psychiatrists, psychotherapists, and complementary care providers. The updated guideline aims to further improve the early detection, definitive diagnosis, treatment, and interdisciplinary care of people with depression.

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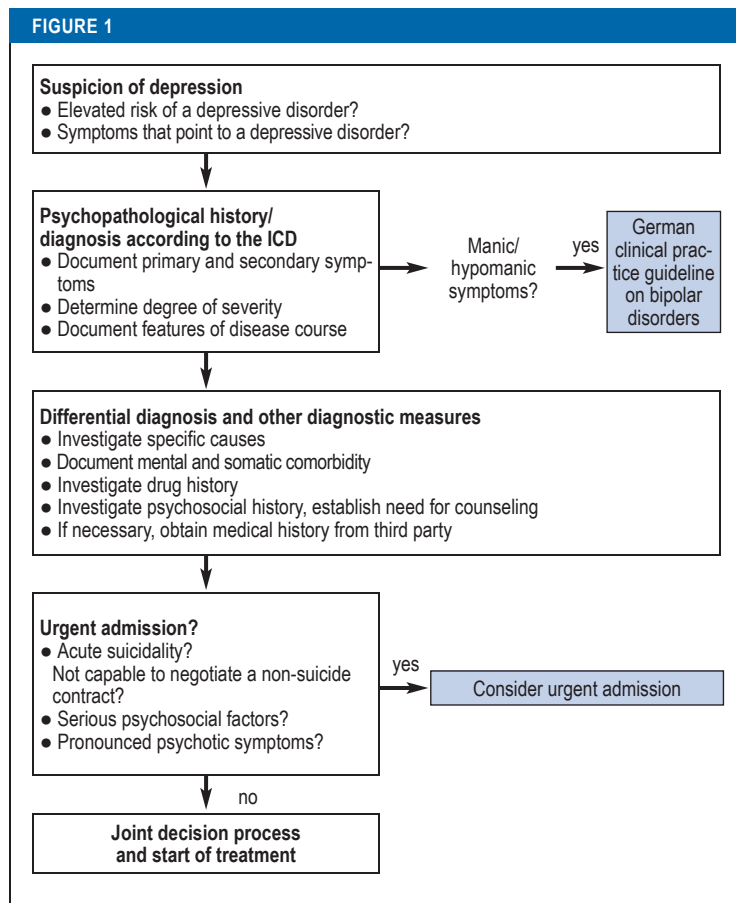
Mortality among depressive patients is around double the rate in the general population, and their mean life expectancy is 7–14 years lower (1, 2). Episodes of depression are among the most common individual diagnoses, as shown by the number of days of inability to work due to this diagnosis (3, 4) and by the fact that depressive disorders are the most frequent reason for early retirement due to reduced capacity for work (5).

The German National Disease Management Guideline (NDMG; in German: *Nationale Versorgungsleitlinie*, NVL) on Unipolar Depression meets all of the requirements for clinical practice guidelines embodied in the rules for guidelines laid out by the Association of the Scientific Medical Societies in Germany (*Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V.*; AWMF) (6). These requirements include a multidisciplinary panel with members from 28 professional scientific associations and three organizations representing patients

(*eTable 1*), transparent management of conflicts of interest, systematic research, and assessment of the evidence according to the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) criteria (7, 8), as well as a structured, formalized consensus process. The formulation of the recommendations and their strength also took account of clinical considerations and practical aspects of care provision, together with issues raised by the patient representatives (9).

A draft of the guideline was made available for public scrutiny. Over 200 comments were received; these were discussed by the guideline group and led to incorporation of several revisions in the final version. A detailed account of the methods can be found in the guideline report (10).

The current version (11) does not yet include recommendations on the topics of comorbidity, peripartum depression, and other specific clinical scenarios. These will be dealt with in 2023.



The diagnostic process for depressive disorders (11)

Diagnosis and monitoring

The care offered by primary care physicians and in general hospitals to patients at risk should include screening for depressive disorders (e.g., questioning about previous episodes and particular somatic illnesses, detection of substance abuse) (↑↑). If depression is suspected, a standard ICD diagnostic work-up should ensue, with documentation of symptoms, severity, and features of the disease course (↑↑) (Figure 1). The new NDMG is aligned not only with ICD-10 but also with ICD-11, which received WHO approval in 2018 and will come into force in Germany at the end of a transitional period (eFigure 1).

A new feature is the recommendation for diagnosis according to the criteria of the International Classification of Functioning, Disability and Health (ICF) (↑↑). In this connection, examples of questions were developed for the outpatient setting. Experience shows that this has not yet been sufficiently implemented in practice, although documentation of the negative effects of depression on function, psychosocial status, and participation is crucial for individual treatment planning.

The recommendations on monitoring of the disease course have been made more specific with regard to

the intervals between visits and the parameters to be captured (symptoms including suicidality, adverse effects, psychosocial status, need for participation, and adherence). To enable assessment of the response to therapy, the initial findings before the start of treatment should be documented, preferably with validated instruments (↑↑), e.g., the PHQ-9 questionnaire for patients (12).

Treatment planning and treatment options

The new NDMG recommends joint agreement, prioritization, and regular evaluation of treatment goals (↑↑). Decisions affecting diagnosis, treatment, and care should be reached according to the concept of shared decision-making (↑↑).

Psychoeducation and low-intensity interventions

Low-intensity interventions are treatments that are readily accessible and usually of a brief nature. They embrace a large number of different options that essentially aim at strengthening patients' capacity for self-management ("guided self-help"). Psychoeducational measures form a basic element of treatment for all patients (eBox 1).

Digitally supported interventions

With regard to Internet- and mobile device-based interventions (IMI), the NDMG recommends that they should be employed only after a thorough diagnostic work-up, due consideration of differential diagnoses, clarification of the indication, discussion with the patient, and prescription (↑↑). Moreover, it recommends therapeutic supervision of IMI and regular verification of their efficacy (↑↑). As for the choice of the most appropriate IMI for users in Germany, orientation is provided by the Index for Digital Health Applications at www.diga.bfarm.de/de (in German).

Drug treatment

As in the preceding version, the NDMG supplies recommendations not only on the indications for drug treatment, but also on how to proceed. The specific choice of antidepressants should be based on the safety and interaction profile, the comorbidity, and the individual patient's preference (eTable 2). A new section is devoted to discontinuation of antidepressants: depending on the clinical situation, e.g., discontinuation after remission or in the case of inefficacy, specific recommendations are given for tapering of the medication and for monitoring. For example, antidepressants should be tapered for at least 8–12 weeks at the end of continuation or maintenance therapy (↑↑). Should symptoms occur in association with discontinuation, switching to an antidepressant that is available in the form of drops and can thus be reduced in particularly small increments may be considered (↔). Because symptoms may first occur after complete withdrawal of the drug concerned, regular follow-up appointments should be arranged for at least the next 6 months (↑↑).

Psychotherapy

The NDMG focuses on the four psychotherapeutic techniques that are available in the outpatient setting in Germany, eligible for reimbursement, and classified as accredited by the psychotherapy guideline of the German Federal Joint Committee (G-BA): psychodynamic psychotherapy (psychoanalysis, depth psychotherapy), behavioral therapy, and systemic therapy. For the first time, there are recommendations on how to proceed in the event of psychotherapy. If there is no improvement after 8–12 weeks, for instance, the possible cause should be investigated and modification of the psychotherapeutic approach considered (↑↑). Furthermore, particularly in patients with a complex disease constellation and/or complicated treatment processes, validated instruments should be considered to document the patient's symptoms and general wellbeing as well as the therapeutic process at regular intervals (↑). Finally, an extensive section is devoted to the long-neglected potential adverse effects of psychotherapy (13, 14).

Acute treatment according to degree of severity

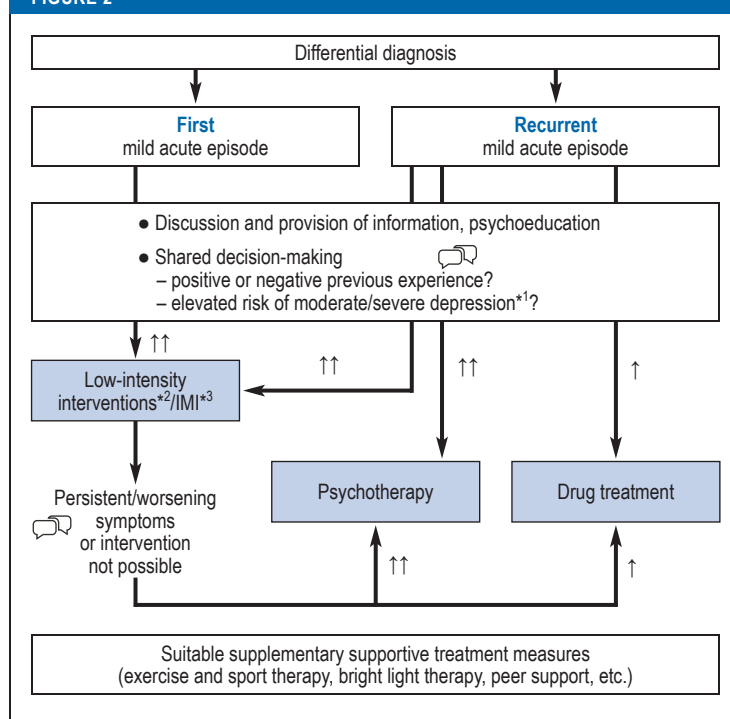
Two algorithms for the severity-dependent treatment of acute depressive episodes were developed for the revised version (Figures 2, 3). The respective roles of drug treatment and psychotherapy for the various degrees of severity were discussed on the basis of recent meta-analyses. In a meta-analysis of 369 studies, the effect size of psychotherapeutic treatments with regard to depressive symptoms after adjustment for various risks of bias was 0.31 (95% confidence interval [0.24; 0.38]) (15). The effect size of antidepressants compared with placebo in a meta-analysis of 522 studies was 0.3 [0.26; 0.34] (16). Meta-analyses on the direct comparison of psychotherapy with antidepressants found no significant differences in effectiveness, so the choice between the two forms of treatment rests ultimately on clinical considerations.

Acute mild depressive episode

In an acute mild depressive episode, low-intensity measures (guided self-help, talk-based interventions using psychotherapeutic techniques) or IMI should be offered (↑↑). Apart from the evidence that has emerged, this new recommendation is motivated by the low-threshold access and the avoidance of long waiting times. Moreover, this frees consultations for patients in whom low-intensity approaches or IMI alone are inadequate.

In mild depressive episodes, the presence of risk factors for worsening or chronification of the depressive symptoms, e.g., previous episodes of depression, extended duration, or comorbidity, justifies treatment with psychotherapy or antidepressants. On the grounds of safety considerations (adverse drug reactions, discontinuation syndrome), antidepressants are not explicitly recommended but should be considered (↑). Noting a persisting tendency towards excessively rapid treatment with antidepressants alone, the guide-

FIGURE 2



Acute treatment of mild depressive disorders (11)

*1 For example previous moderate/severe episodes; psychosocial risk factors; comorbidity

*2 Guided self-help, basic (psychosomatic) management by primary care physicians, or basic psychiatric, psychosomatic, or psychotherapeutic treatment (talk-based services beyond genuine psychotherapies, which have to be applied for with the health insurance fund)

*3 Internet- and mobile device-based interventions (IMI) should be offered in mild depressive episodes, embedded in an overall therapeutic concept.

↑↑ Recommended; ↑ should be considered; ↔ may be considered; ↔ shared decision-making

line group emphasizes that drug treatment should be embedded in an overall therapeutic concept that embraces psychoeducational elements (↑↑). These include, for example, sleep hygiene and, when indicated, supportive options such as sport therapy (Figure 2).

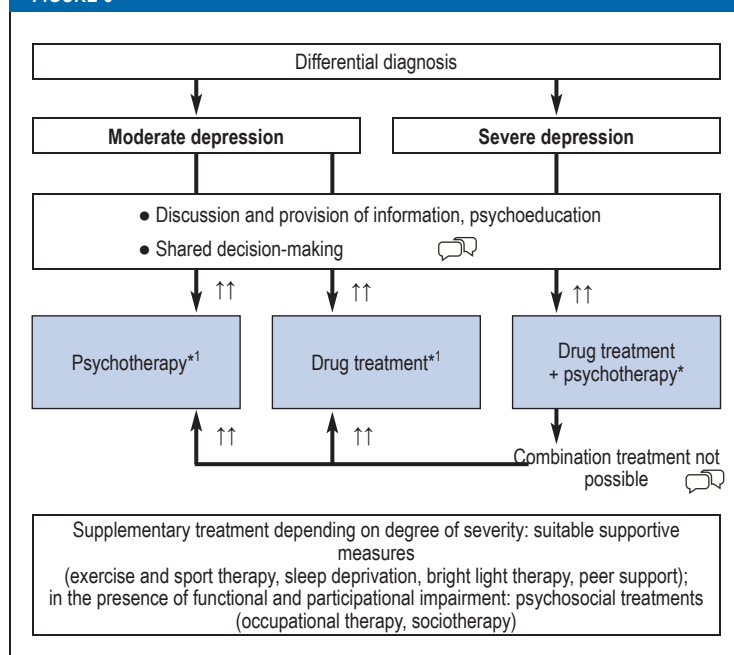
Acute moderate depressive episode

Patients with acute moderate depressive episodes should continue to be offered psychotherapy or drug treatment as equally effective alternatives (↑↑). Additional IMI may be offered (↔). Benzodiazepines and Z-drugs are not recommended in mild depressive episodes (↓↓) and should be considered only exceptionally in moderate depression, e.g., in the presence of debilitating sleep disorders or marked agitation (↓).

Acute severe depressive episode

The recommendations in favor of combined drug treatment and psychotherapy for the treatment of patients with acute severe depressive episodes remain unchanged (↑↑). Patients who refuse combined treatment should be offered one of the two forms of therapy (↑↑) (Figure 3).

FIGURE 3



Acute treatment of moderate and severe depressive disorders (11)

*Internet- and mobile device-based interventions:

- May be offered to patients with moderate depressive episodes in addition to treatment with antidepressants or psychotherapy, embedded in an overall therapeutic concept.
- Should be offered as an alternative treatment option to patients with moderate depressive episodes who refuse both psychotherapy and antidepressants.
- May be offered to patients with severe depressive episodes in addition to treatment with antidepressants and/or psychotherapy.

↑↑ Recommended; ↑ should be considered; ↔ may be considered; ☞ shared decision-making

Continuation and maintenance therapy

An antidepressant should be continued at the same dosage as in the acute phase for 6–12 months during remission and beyond (↑↑). Provided there is no indication for longer maintenance treatment, the antidepressant should then be tapered (↑↑). Long-term maintenance therapy should be considered only in patients with 2–3 or more episodes of depression and significant functional impairment in the recent past (i.e., during the previous 5 years) (↑).

Continuation of psychotherapy in an appropriate form should also be offered to patients receiving acute psychotherapeutic care, with the aim of stabilization after successful treatment as well as prevention of recurrence (↑↑). Following pharmacological continuation treatment, tapering in combination with psychotherapy may be considered as an alternative to pharmacological maintenance therapy (↔), and after successful acute drug treatment a combined pharmacological and psychotherapeutic continuation or maintenance therapy should be considered (↑).

Non-response and treatment resistance

In the case of non-response to drug treatment it is important to be thorough in seeking the cause, e.g.,

poor adherence, comorbidity, comedication, or a low serum concentration (Figure 4). New in the revised guideline is a recommendation for the addition of psychotherapy to drug treatment (↑↑). Alternatively augmentation with low-dose antipsychotics (↑) or with lithium (↑) should be considered, as should a combination of two antidepressants (selective serotonin reuptake inhibitors [SSRI] or serotonin and norepinephrine reuptake inhibitors [SSRI] or tricyclic antidepressants [TCA] with mianserin or mirtazapine or trazodone) (↑). Repetitive transcranial magnetic stimulation (rTMS) may also be considered for augmentation of drug treatment (↔).

It is also important to identify the reason for non-response to psychotherapy (eFigure 2, eTable 3). Intervention and supervision may be helpful in this regard and also facilitate the development of potential solutions (↑). If there is no therapeutic fit between the person giving and the person receiving the treatment, or if the type of psychotherapy does not seem appropriate, the patient concerned should be referred elsewhere (↑↑). If, however, the therapeutic working relationship is stable, the frequency of sessions should be increased (↑↑).

In the case of repeated non-response to drug treatment (Figure 4), trial tapering of the medication should be considered (↑). Another option is augmentation of the antidepressant with administration of esketamine, but because esketamine is available exclusively from hospital pharmacies this may only be considered in the (part-time) inpatient setting (↔). On the basis of consolidation of the evidence, repetitive transcranial magnetic stimulation (rTMS) should now be considered in this scenario too (↑) (Figure 4).

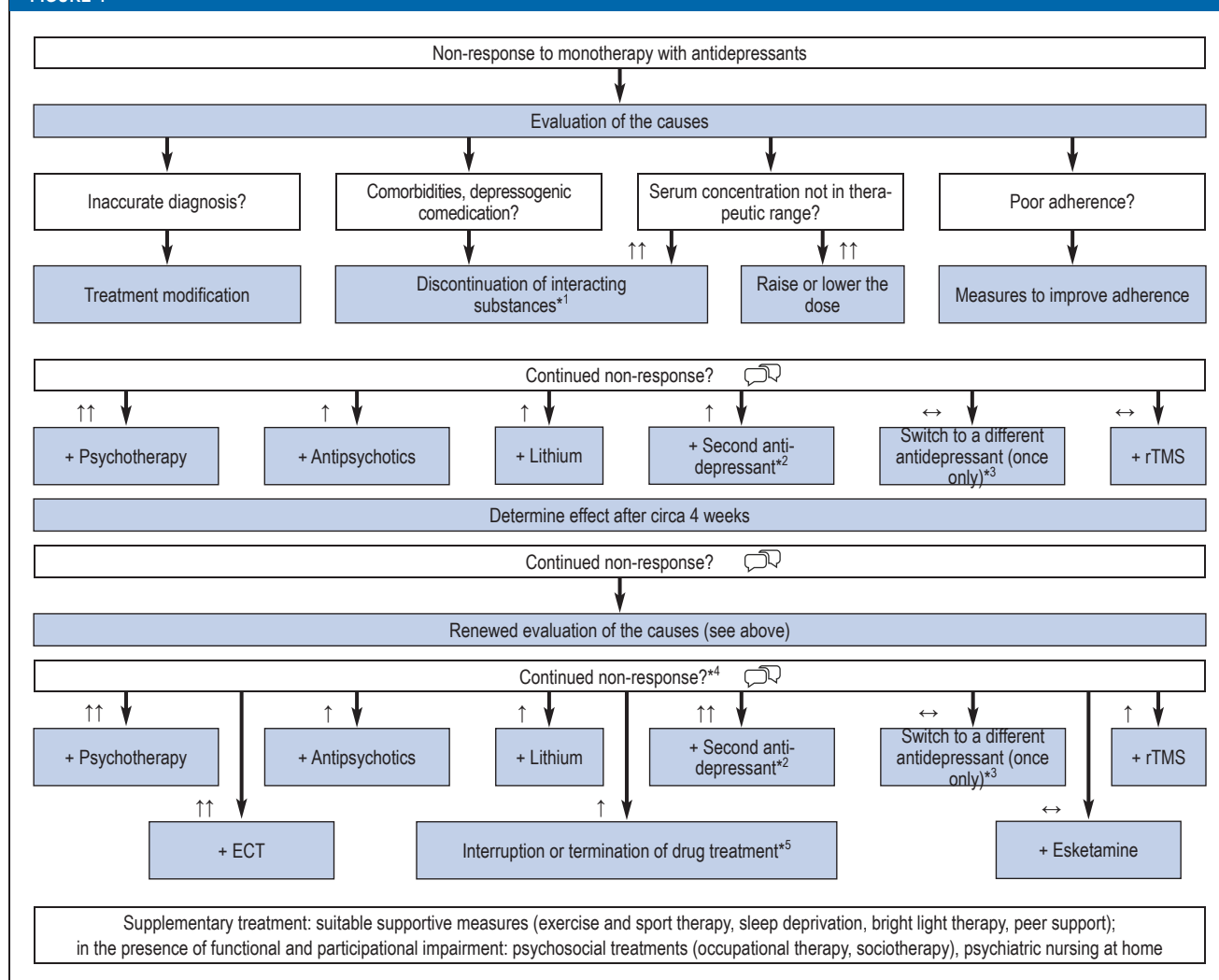
Chronic depression

Chronic (ICD-11: persisting) depressive disorder means that the episode of depression has continued without interruption for more than 2 years. Because the studies on chronic forms of depression have analyzed extremely heterogeneous groups, the certainty of evidence is limited; therefore, the new recommendations in the NDMG are based on clinical considerations: The management of therapy-naïve chronic depression should be oriented on the severity-dependent treatment for acute or recurrent episodes (↑↑). If a depressive disorder becomes chronic although the patient has been treated according to the guidelines, the recommendations on how to proceed in cases of non-response or treatment resistance should be followed (↑↑).

Psychosocial therapy and supportive measures

Psychosocial treatments are, in the view of the guideline group, often used too late or not at all—especially in the outpatient setting. The new NDMG therefore explicitly recommends assessing whether occupational therapy and sociotherapy are indicated (↑) and whether self-help options, advice to relatives, peer support, or recovery support might be helpful (↑↑), as well as

FIGURE 4



Procedure in the event of non-response to drug treatment (11)

*1 If discontinuation does not come into question because a coexisting illness requires priority treatment, consider switching to an antidepressant from a non-interacting class of substances

*2 Combination of SSRI or SNRI or TCA with mianserin, mirtazapine, or trazodone

*3 No more than one change to an antidepressant with the same mechanism of action within the same episode of depression

*4 In the case of repeated non-response, i.e., failure to respond to the initial monotherapy and at least one further treatment strategy, the same six options as before can be considered again (but avoiding a second change of antidepressant), together with three further options.

*5 The number of treatment lines before this option can vary widely among individual cases. In treatment according to the guidelines, all other strategies in the case of non-response can be tried but do not have to be, including augmentation with lithium and antipsychotics.

↑↑ Recommended; ↑ should be considered; ↔ may be considered; ☞ shared decision-making

ECT, electroconvulsive therapy; rTMS, repetitive transcranial magnetic stimulation; SSRI, selective serotonin reuptake inhibitors; SNRI, serotonin and norepinephrine reuptake inhibitors; TCA, tricyclic antidepressants

providing practical information regarding the prescription of psychosocial therapy.

The NDMG recommends that patients should be encouraged to take part in sporting activity or in structured and supervised exercise, ideally in a group context (↑↑). The evidence in favor of bright light therapy has also become stronger, so the NDMG now recommends its use in cases of depression that show a seasonal pattern (↑↑). The certainty of evidence for depression with no seasonal pattern is still very low; because bright light

therapy is such a simple procedure, however, the guideline group believes it is worth trying (↔).

The revised NDMG features detailed recommendations with regard to work incapacity. The guideline group identified a tendency towards too early “knee-jerk” issuing of sickness certificates by primary care physicians. Staying home from work may help to reduce the burden, but can also contribute to worsening and chronification of depressive disorders—particularly in the case of lengthy absence from the

workplace. The NDMG recommends that the potential advantages and disadvantages (*eTable 4*) should be discussed with the patient (↑↑) and that a sickness certificate, particularly if renewed, should be accompanied by therapeutic interventions (↑↑).

Suicidality and other emergencies

The recommendations regarding the management of suicidality were essentially confirmed or, in some cases, modified slightly. A new feature is the explicit recommendation that suicidal patients, too, should be clearly informed about all aspects of treatment and that decisions on the type and setting of the treatment should, whenever possible, be made jointly (↑↑). Furthermore, the guideline group believes that wider availability of outpatient crisis teams would be desirable so that patients can be cared for locally and with less delay. An emergency plan focussing on individual warning signs, coping strategies, social support, and contact addresses should be drawn up (↑↑) (*eBox 2*).

Nasal administration of esketamine may be considered in addition to an antidepressant in the case of suicidality in the (part-time) inpatient setting (↔), and electroconvulsive therapy may also be an option (↔). All drug treatments should be given during and/or after a psychotherapeutic crisis intervention, not alone. In this regard, the revised NDMG contains new recommendations for other emergency scenarios in the context of depressive disorders (depressive stupor, psychomotor agitation, and psychoses, among others).

Medical rehabilitation and services to support participation

A new section gives details of the rehabilitation and support services available for the mentally ill in Germany (*eFigure 3*; in German). One recommendation addresses the indications for inpatient rehabilitation (*eBox 3*). Given that employment has a positive effect on the health of persons with mental illness and that unemployment is a negative prognostic factor (23, 24), the NDMG recommends early counseling of those affected (↑↑). If necessary, they should be assisted in applying for these return-to-work interventions (↑↑).

Coordination of care

Gaps in care provision are common, especially in the transition from inpatient to outpatient setting—a time when patients are especially vulnerable to relapses and suicidality. The overview presented (in German) in *eFigure 4* gives details of the services available, the care providers, and the cost units. The structures for provision of mental health care vary widely from region to region, so all those involved should inform themselves accordingly (↑↑) in order to be able to form individual networks for regional cooperation. The NDMG defines the indications for interdisciplinary cooperation or referral (*eTable 5*) and specifies concrete measures around discharge management (↑↑) (*eBox 4*). Also addressed is the role of pharmacies, both

in the detection of depression and suicidality and in motivating those concerned to undergo treatment.

Especially patients with moderate or severe symptoms who have been ill for ≥ 1 year should be offered multiprofessional, structured, coordinated care (↑↑). Approaches with different intensities can be considered, starting with the as yet unimplemented Disease Management Program (DMP) for depression via multiprofessional networks for community-based complex care (§ 92 Sect. 6b, German Social Code [GSC] V) and psychiatric/psychosomatic outpatient clinics (§ 118, GSC V), as well as home-based forms of care such as inpatient-equivalent psychiatric treatment (§ 115d, GSC V).

Dissemination and patient materials

All materials related to the NDMG on Unipolar Depression are available (in German) free of charge at www.leitlinien.de and at www.awmf.org. The complete version of the NDMG can be downloaded as a PDF or used directly as HTML text on a computer or mobile device. The short version includes all of the recommendations and algorithms together with the principal tables. Decision aids and information material for patients relating to more than 20 prioritized clinical situations are available in language understandable to lay persons. The patient guideline (currently being compiled) presents the entirety of the NDMG's contents in plain language.

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Conflict of interest statement

MH has received payment for one lecture each from the TK health insurance fund (Techniker Krankenkasse) and Münsterlingen Psychiatric Hospital (Switzerland) and for the compilation of two brochures for patients from the Confederation of Occupational Health Insurance Funds (BKK Dachverband). He receives an expense allowance for his activity as chair of the Scientific Advisory Board and Scientific Director of the Agency for Quality in Medicine (AZQ).

PP has received payment from the publisher MBO-Verlag for the compilation of two brochures for patients on behalf of the Confederation of Occupational Health Insurance Funds (BKK Dachverband). PP is a scientific adviser at the Agency for Quality in Medicine (AZQ).

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As with many other professional journals, clinical guidelines in the German Medical Journal are not subject to the peer review process, as S3 guidelines are already texts that have been assessed and discussed by experts (peers) and have a broad consensus.

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► Supplementary material

eReferences, eTables, eFigures, eBox:
www.aerzteblatt-international.de/m2023.0074

Supplementary material to:

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eTABLE 1

Authors of the German National Disease Management Guideline (NDMG) on Unipolar Depression, version 3.0 (2022) (collaborators)

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Prof. Dr. Christian Otte Prof. Dr. Thomas Frodl	German Association for Biological Psychiatry, reg. assoc. (DGBP)
Prof. Dr. Hans Gutzmann	German Association for Geriatric Psychiatry and Psychotherapy, reg. assoc. (DGGPP)
Dr. Sigrud Krause Prof. Dr. Volker Köllner	German Association for Clinical Psychotherapy, Prevention, and Psychosomatic Rehabilitation, reg. assoc. (DGPPR)
Prof. Dr. Dr. Martin Härter Prof. Dr. Harald Baumeister	German Association for Medical Psychology, reg. assoc. (DGMP)
Dr. Petra Klose	German Association for Naturopathic Medicine, reg. assoc. (DGNHK)
Prof. i. K. Dr. Brigitte Anderl-Doliwa Gerlinde Strunk-Richter	German Association for Nursing Science, reg. assoc. (DGP)
Prof. Dr. Andreas Reif Prof. Dr. Dr. Michael Bauer Prof. Dr. Christian Otte	German Association for Psychiatry, Psychotherapy, and Psychosomatics, reg. assoc. (DGPPN)
Christa Leiendecker Dr. Christian Holzapfel	German Association for Psychoanalysis, Psychotherapy, Psychosomatics, and Depth Psychology, reg. assoc. (DGPT)
Prof. Dr. Martin Hautzinger Prof. Dr. Christine Kühner	German Psychological Society, reg. assoc. (DGPs)
Prof. Dr. Henning Schauenburg Univ.-Prof. Ulrike Dinger-Ehrenthal	German Association for Psychosomatic Medicine and Medical Psychotherapy, reg. assoc. (DGPM); German College of Psychosomatic Medicine, reg. assoc. (DKPM)
Prof. Dr. Christoph Nissen	German Sleep Society, reg. assoc. (DGSM)
Reiner Ott	German Association for Social Psychiatry, reg. assoc. (DGSP)
Prof. Dr. Claus Reinsberger	German Association for Sports Medicine and Prevention (DGSP)
Prof. Dr. Matthias Ochs Dr. Filip Caby	German Association for Systemic Therapy, Counseling, and Family Therapy, reg. assoc. (DGSF)
Prof. Dr. Holger Schulz	German Association for Rehabilitation Science, reg. assoc. (DGRW)
Prof. Dr. Thomas Heidenreich PD Dr. Tobias Teismann	German Association for Behavioral Therapy, reg. assoc. (DGVt)
Prof. Silke Wiegand-Greife	German Psychoanalytical Society, reg. assoc. (DPG)
Prof. Dr. Heinz Böker Prof. Dr. Cornelia Albani, MBA	German Psychoanalytical Association, reg. assoc. (DPV)
Azize Kasberg Frank Zamath	German Occupational Therapy Federation, reg. assoc. (DVE)
Dr. Petra Klose Prof. Dr. Jost Langhorst	Society for Phytotherapy, reg. assoc. (GPT)
Patient representative(s)	
Jürgen Matzat	German Federation of Self-Help Groups, reg. assoc. (DAG SHG)
Thomas Voigt † Jürgen Leuther	German Self-Help Association for the Disabled, the Chronically Ill, and Their Relatives, reg. assoc.; German Depression League, reg. assoc.
Karl Heinz Möhrmann	Federal Association of Families of People with Mental Illness, reg. assoc. (BApK)
Methodological monitoring, coordination, and moderation	
Dr. Monika Nothacker, MPH	Association of the Scientific Medical Societies in Germany (AWMF)
Peggy Prien Corinna Schaefer	German Agency for Quality in Medicine (ÄZQ)
Prof. Dr. Dr. Martin Härter	Chair, Scientific Advisory Board of the ÄZQ

eFIGURE 1

Determination of the severity of depressive episodes according to ICD-11 criteria (essential features) (11)

Affective cluster • Depressive mood • Markedly diminished interest or pleasure in activities		≥ 1	
		+	
Cognitive-behavioral cluster • Reduced ability to concentrate and sustain attention to tasks, or marked indecisiveness • Beliefs of low self-worth or excessive and inappropriate guilt and worthlessness • Hopelessness about the future • Recurring thoughts of death, recurrent suicidal ideation, or evidence of attempted suicide		≥ 3	
Neurovegetative cluster • Significantly disrupted sleep or excessive sleep • Significant change in appetite or significant weight change • Psychomotor agitation or retardation • Reduced energy, fatigue, or marked tiredness			
Symptoms almost every day for ≥ 2 weeks		≥ 5	
Number and severity of the symptoms	None of the symptoms are present to an intense degree	Several symptoms are present to a marked degree, or a large number of lesser severity are present overall	Many/most symptoms are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree
Impact on functioning (personal, family, social, educational, occupational...)	Some difficulty in continuing to function in one of more domains	Considerable difficulty functioning in multiple domains	Serious difficulty continuing to function in most domains
Severity according to ICD-11	Mild	Moderate	Severe
Without psychotic symptoms	6A70/71.0	6A70/71.1	6A70/71.3
With psychotic symptoms	–	6A70/71.2	6A70/71.4

eBOX 1

Possible elements of psychoeducational training for patients with depressive disorders (11)

Information about the illness

- Symptoms, diagnosis, cause, course; biological, psychological and psychosocial aspects
- Treatability and prognosis
- Development of a bio-psycho-social model of illness to relieve the patients of feelings of guilt, failure, and self-reproach

Information about self-management

- Links between thoughts, behavior, and feelings
- Sleep hygiene, anxiety management, coping with stress
- Ability to communicate and manage conflict
- Structuring of daily routine and lifestyle (e.g., increasing enjoyable activities)
- Learning relaxation techniques
- Coping with the illness in the work context

Information about the treatment

- Mechanism of action, likely effects, potential interactions and adverse effects of antidepressants, latency of action, need for maintenance therapy, symptoms after discontinuation, and rebound phenomena
- Psychotherapy procedures, latency of action, need to continue treatment after regression of the symptoms, possible positive and negative side effects of psychotherapy
- Supportive measures (sport and exercise therapy, bright light therapy, sleep deprivation therapy, etc.)
- Structured/complex forms of care
- Options in the event of non-response to the treatment
- Neurostimulation
- Psychosocial treatments
- Benefits and potential harmful effects of self-help groups
- Benefits of the inclusion of informal caregivers (i.e., relatives or friends) and their involvement in relatives' self-help groups

Information about rehabilitation measures, assistance with participation, and other services

- Medical rehabilitation
- Assistance with participation in work and education, assistance with social participation
- Services to support children, adolescents, and families (home help, assistance with child rearing, etc.)
- Information on counseling options in this regard

Prevention of recurrence and crisis management

- Recognition of relapses and crises
- Coping with suicidality

This box presents a selection of options based on (e1, e2), supplemented with further topics from the clinical practice of guideline group members.

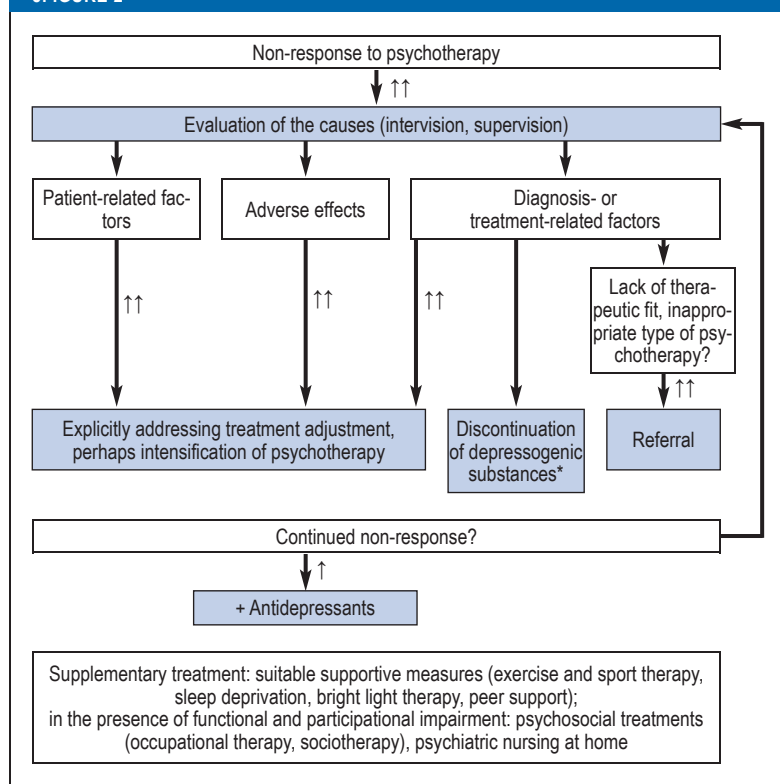
eTABLE 2

Selection criteria for antidepressants (11)

Criteria	Details and examples
Availability	● Approval in Germany ● Availability and eligibility for SHI reimbursement in Germany (not the case for all approved antidepressants)
Patient preference	● Type of administration: oral, oral liquid, orodispersible tablet, i.v., intranasal ● Acceptability of ADR profile, e.g., younger patients may be unhappy about the negative effect of SSRI/SNRI on sexual function ● Acceptability of the need for monitoring (frequency of blood sampling, ECG) ● Experience of previous antidepressant treatments
Safety	● Adverse effect profile ● Suicide risk: e.g., danger of overdose with TCA (intake of tablets for 1 week can be fatal; therefore only small packs are prescribed in the outpatient setting); danger of initially increased suicidality, especially with SSRI and SNRI ● Elevated risk of adverse effects and more potentially serious complications in elderly patients with somatic comorbidities, e.g., TCA delirium, development of heart block/arrhythmia, urinary retention ● Depending on the substance concerned, a variable risk of the occurrence of discontinuation-related symptoms
Comorbidity and comedication	● Contraindications ● Risk of drug interactions ● Potential (negative or positive) effects on comorbidity
Response	● Efficacy and tolerance of previous antidepressant treatment ● In the case of a positive family history: response in first-degree relatives
Manageability, experience of use	● Titration and monitoring requirements vary in complexity: blood count, ECG, etc. ● Treating physicians' experience with individual antidepressants
Biological parameters	● Currently no sufficient evidence that the decision-making process is facilitated by biological parameters

ADR, Adverse drug reaction; ECG, electrocardiography; i.v., intravenous; SHI, statutory health insurance; SNRI, serotonin and norepinephrine reuptake inhibitors; SSRI, selective serotonin reuptake inhibitors; TCA, tricyclic antidepressants

eFIGURE 2



Procedure in the event of non-response to psychotherapy

* If alternative medication is possible and/or a coexisting illness does not take priority

↑↑ Recommended; ↑ should be considered; ↔ may be considered

eTABLE 3

Possible reasons for non-response to psychotherapy (11)

Patient-related factors	Diagnosis- or treatment-related factors	Adverse effects
● Personality factors (perfectionist, hostile-dominant, self-critical) ● Premorbid stress and life history (sexual abuse, traumatization, loss) ● Stressful living conditions (domestic violence, poverty, housing problems, unemployment) ● Cultural background ● Lack of psychosocial competence ● Chronification, resignation ● Low motivation, poor adherence ● Excessively high expectations ● Degree of severity, comorbidity ● Potential secondary gain	● Misdiagnosis of a depressive disorder ● Somatic and mental comorbidity ● Depressogenic comedication ● Inadequate case formulation and selection of treatment elements ● Inappropriate conduct of the therapy ● Lack of fit between psychotherapist and patient ● Other treatment-related factors	● (Transient) worsening of symptoms ● Intensified perception of negative thoughts and dysfunctional behavior due to problem orientation ● Demoralization due to perception of complexity of problem ● Intensified interpersonal conflicts in social context (partnership, family, friends, workplace) ● Stigmatization, self-stigmatization ● Disruption of the cooperative working relationship by unfavorable expectations

eTABLE 4

Criteria for and against the issuing of sickness certificates in unipolar depression (11)

	Factors to be considered
Depressive symptoms*	● The severity of the symptoms ● The degree of somatic symptoms ● The disease burden ● The presence of psychotic symptoms or comorbid mental disorders (e.g., anxiety disorder, PTSD) ● The impact of the social context on the symptoms
Psychosocial factors	● The stress of daily life as a possible reason for not taking up offers of intervention ● Possible deactivation ● Possible loss of daily rhythm ● Possible reduction of social contacts, isolation
Workplace-related factors	● The extent to which ability to work is impacted ● The possible loss of fulfillment and positive confirmation from working ● The possible reinforcement of avoidance behavior in the event of problems in the workplace (mobbing, overwork, lack of support) ● The threat of unemployment due to (repeated) inability to work

* In patients who are clearly unfit for work owing to pronounced symptoms or severe functional impairment, the determination of inability to work is largely independent of psychosocial and workplace-related factors. PTSD, Post-traumatic stress disorder

eBOX 2

Component elements of emergency plans (1)

An essential feature of emergency plans for suicidal patients is that they are drawn up jointly. The following elements may be included:

- A list of individual warning signs for acute self-harming behavior
- A list of possible coping strategies
- Encouragement not to remain alone, but to take advantage of social support for purposes of distraction
- Contact data of family members and friends
- Contact data of psychosocial services, emergency telephone numbers
- Agreement to avoid availability of potential means of harm (e.g., stockpiling of medications, access to guns)

Furthermore, an antisuicide pact can be a very effective instrument for short-term agreements with patients—provided the interpersonal obligation occupies the center ground and the process comprises more than just routinely filling out a form designed above all to avoid legal consequences.

eBOX 3

Indications and exclusion criteria for inpatient rehabilitation in depressive disorders (11)

Indications

- (Impending) high risk of loss or reduction of ability to work
- (Impending) loss of ability to live autonomously and independently
- (Impending) reduction in participation

In the presence of capacity for rehabilitation (motivation/motivatability, resilience) and positive rehabilitation prognosis

Exclusion criteria

- Acute danger of self-harm or harming others
- Insufficient resilience for rehabilitation treatment due to, for example:
 - Pronounced incapacity for self-regulation
 - Primarily substance-related and addictive disorders (possibly with indication for qualified withdrawal treatment)
 - Severe cognitive impairment (e.g., dementia)
 - Serious acute somatic illness
 - Marked psychopathology, e.g., psychotic symptoms

eTABLE 5

Indications for interdisciplinary cooperation or referral to other disciplines for consultation, cotreatment or continuation of treatment in connection with depressive disorders (11)

Clinical situation	Referral ^{*1}
Previous care provided exclusively by primary care physician and: - Severe/recurring/chronic symptoms - Comorbid mental disorder of another kind - Lack of improvement with low-intensity talk-based interventions and/or antidepressants (after 6 weeks at the most)	Psychiatry ^{*2} /psychotherapy ^{*3} / ^{*4} /psychosomatics ^{*2}
Previous care provided exclusively by primary care physician and/or psychotherapist and poor tolerance of the antidepressants	Psychiatry ^{*2} /psychotherapy ^{*2} /psychosomatics ^{*2}
Previous care provided exclusively by primary care physician and/or psychotherapist and treatment with antidepressants and planned existing pregnancy	Psychiatry ^{*2} /psychotherapy ^{*2} /psychosomatics ^{*2} ; gynecology/obstetrics
Previous care provided exclusively by primary care physician and/or psychotherapist and psychotic symptoms	Psychiatry ^{*2}
Clinical situation	Referral ^{*2} /interdisciplinary cooperation
Previous care provided exclusively by primary care physician and: - Presence of risk factors for chronification or worsening - Extended certification of inability to work considered (> 6 weeks) - Need for supplementary psychodiagnostic assessment or psychological testing, unclear differential diagnosis (particularly bipolar or comorbid mental disorders)	Psychiatry ^{*2} /psychotherapy ^{*2,3} /psychosomatics ^{*2} ; if appropriate, sociotherapy
Drug treatment and failure to improve	If appropriate, psychiatry ^{*2} /psychotherapy ^{*2} /psychosomatics ^{*2} ; if appropriate, clinical pharmaceuticals ^{*4} ; if appropriate, sociotherapy
Psychotherapeutic treatment and failure to improve	If appropriate, psychiatry ^{*2} /other psychotherapy ^{*2,3} /psychosomatics ^{*2} ; if appropriate, sociotherapy
Severe somatic comorbidity (e.g., prioritization or coordination of medication)	Appropriate discipline: psychiatry ^{*2} /psychotherapy ^{*2} /psychosomatics ^{*2}
Multimorbidity, multimедication	Corresponding disciplines: geriatrics, gerontopsychiatry/psychiatry; if appropriate, pharmacy/clinical pharmaceuticals ^{*4}
Existing indication for low-intensity measures, e.g., behavioral activation	If appropriate, occupational therapy, sociotherapy
Testing and implementation of workplace-based measures (e.g., trial of resilience)	Occupational therapy
Impending reduction of income, restricted participation	Counseling facilities for services relating to participation
For patients in nursing care	
- Agreement on drug treatment safety - Agreement with regard to monitoring - Specification of contact persons - Agreement of an emergency plan	Psychiatric nursing, community care services, inpatient facilities for care of the elderly

^{*1} Referral for consultation, cotreatment or continuation of treatment. The table refers to the outpatient setting, taking into account the structures of the German mental health care system and the German professional regulations, especially with regard to the authority to prescribe certain treatments.

^{*2} Specialists for psychiatry and psychotherapy, for psychosomatic medicine and psychotherapy, for neurology, for neurology and psychiatry, for psychotherapeutic medicine, and for psychiatry

^{*3} Psychological psychotherapists and child/adolescent psychotherapists (for treatment of patients ≥ 18 years)

^{*4} For analysis of medication to identify the reason for non-response and/or for purposes of drug treatment safety

eBOX 4

Actions to be taken on the discharge of patients with depressive disorders from acute inpatient treatment (11)

For all patients:

- Early involvement of informal caregivers and, as appropriate, the care facility, subject to approval by the patient
- Provision of an exhaustive report including detailed recommendations as to the dosage (increase, tapering) of the drugs prescribed, if possible following the nationwide medication plan template; if appropriate, reference to off-label treatment, including reasons, and to possible consequences of this for the outpatient prescribers
- Communication with the primary care physicians and/or psychiatrists who will be continuing the treatment; agreement within a week of fixed dates for outpatient follow-up and for repeat prescriptions and, if needed, continued certification of inability to work
- Communication with the psychotherapists who will be providing continuing treatment with regard to the transition to outpatient psychotherapy; if appropriate, trial sessions can be held before discharge
- Agreement and handing over of a concrete action and emergency plan for the patient (see Section 12, Management in the Case of Suicidality and Other Emergency Situations [11]; in German); provision of information about regional self-help structures or local self-help contact centers

If required:

- Prescription and/or provision of medication for a transitional period*¹
- Prescription of supplementary treatments (e.g., occupational therapy) or sociotherapy for a transitional period*²
- Prescription of (psychiatric) nursing care in the patient's home for a transitional period*²
- Declaration of inability to work for a transitional period*²
- Consideration of the patient's inclusion in a structured program or in complex forms of care, with initiation of enrollment if necessary
- Planning forms of care involving hospital visits, if the patient is not able to take part in outpatient treatment
- Initiation of measures to promote rehabilitation and participation (e.g., reintegration measures)

The measures listed here substantiate and supplement the legally mandatory discharge management in Germany (§ 39 of the Federal Joint Committee [G-BA] sub-legislative legal standards) for patients with depressive disorders.

*¹ Provision of the smallest pack size; provision before weekends/public holidays; for detailed regulations see the German sub-legislative legal standards (Medicinal Products Directive)

*² As a rule, up to 7 calendar days; for detailed regulations see the respective German sub-legislative legal standards



Medizinische Rehabilitation

- medizinische Leistungen (ärztliche Versorgung, Psychotherapie)
- psychosoziale Angebote
- Belastungserprobung und Arbeitstherapie
- stufenweise Wiedereingliederung („Hamburger Modell“)

Anbieter: Psychosomatisch-psychotherapeutische Rehabilitationseinrichtungen, Rehabilitationseinrichtungen für psychisch kranke und behinderte Menschen (RPK), ambulante Ergotherapie

Antragstellung über GKV/PKV, GRV, GUV, JH, EH, SEr ...



Teilhabe Arbeit und Bildung

- berufs- und arbeitsplatzbezogene Maßnahmen (Arbeits-erprobung, Berufsvorbereitung, berufliche Anpassung und Weiterbildung, berufliche Ausbildung, Arbeitsplatzanpassung, Unterstützte Beschäftigung, Arbeitsassistent, Hilfsmittel ...)
- psychosoziale Angebote (Aktivierung, Förderung der sozialen Kompetenz, Training lebenspraktischer und motorischer Fähigkeiten ...)
- Hilfen zur Schulbildung bzw. schulischen Aus- und Weiterbildung

Anbieter: ambulante Ergotherapie, Rehabilitationseinrichtungen für psychisch kranke und behinderte Menschen (RPK), medizinisch-beruflich orientierte Rehabilitation (MBOR), Berufsbildungswerk (BBW), Berufsförderungswerke (BFW), Berufliche Trainingszentren (BTZ), Integrationsfachdienste, Inklusionsbetriebe, Werkstätten für behinderte Menschen (WfbM), Zuverdienstprojekte (in therapeutischen Tagesstätten), arbeitsbezogene Dienstleistungsunternehmen¹

Antragstellung über GRV, GUV, BA, JH, EH, SEr, IÄ



Soziale Teilhabe

- Leistungen für Wohnraum (z. B. Hilfen bei der Beschaffung einer Wohnung)
- niedrigschwellige Beschäftigungsangebote, Begegnungsmöglichkeiten
- Assistenzleistungen (Haushaltsführung, Gestaltung sozialer Beziehungen, Teilhabe am gemeinschaftlichen und kulturellen Leben ...)
- Leistungen zur Förderung der Verständigung
- Leistungen zur Mobilität

Anbieter: ambulante Soziotherapie, Tagesstätten, ambulantes betreutes Wohnen, Wohngemeinschaften, Wohnformen mit Heimcharakter (z. B. Übergangseinrichtungen, sozio-therapeutische Wohnheime), Psychosoziale Kontakt- und Beratungsstellen, Zuverdienste

Antragstellung über GUV, JH, EH, SEr



Ergänzende Leistungen

- unterhaltssichernde Leistungen (Krankengeld, Erwerbsminderungsrente, Übergangsgeld, Grundsicherung ...)
- begleitende Hilfen im Lebensumfeld (Pflegedienste, Haushalts- und Betriebshilfe, Kinderbetreuung, Mahlzeitendienst ...)
- Rehabilitationssport, Funktionstraining
- Angebote der Selbsthilfe für Betroffene und/oder Angehörige

Anbieter: Sozialleistungsträger, Freie Wohlfahrtspflege, Kommunale Einrichtungen, Vereine ...

Antragstellung über GKV/PKV, GRV, GUV, BA, SEr, JH, GPV ...



Information und Beratung

- Information über und Beratung zur Auswahl von Angeboten und Anbietern
- Ermittlung der zuständigen Kostenträger
- Unterstützung bei der Antragstellung

Anbieter: regional verschieden, z. B. Ergänzende unabhängige Teilhabeberatung (EUTB) www.teilhabeberatung.de; Rehabilitationsberatungsdienst www.deutsche-rentenversicherung.de; Ansprechstellen für Rehabilitation und Teilhabe www.ansprechstellen.de; Kliniksozialdienste; Sozial-psychiatrische Dienste; Psychosoziale Kontakt- und Beratungsstellen; Beratungsstellen von Verbänden der Freien Wohlfahrtspflege (AWO, Caritas, DRK, Diakonie, Deutscher Paritätischer Wohlfahrtsverband u. a.); Rehabilitationseinrichtungen für psychisch kranke und behinderte Menschen (RPK), Inklusionsämter; Integrationsfachdienste

keine Antragsstellung nötig, in der Regel kostenfreie Nutzung durch Patient*innen, Angehörige und Versorgende möglich

Die Abbildung dient der grundsätzlichen Orientierung und bietet keine vollständige Darstellung aller Angebote, Anbieter und Kostenträger. BA Bundesagentur für Arbeit (SGB III); EH Träger der Eingliederungshilfe; GKV/PKV Gesetzliche/Private Krankenversicherung (SGB V); GPV Gesetzliche Pflegeversicherung; GRV Gesetzliche Rentenversicherung (SGB VI); GUV Gesetzliche Unfallversicherung; IÄ Integrationsämter (SGB IX); JH Träger der öffentlichen Jugendhilfe; SEr Träger des Sozialen Entschädigungsrechts (z. B. Kriegssopfer, Soldaten*innen)

¹ Unternehmen, die im Auftrag des Inklusionsamtes z. B. ein Jobcoaching durchführen.



Behandlung

- Hausärztliche Versorgung¹
- Spezialfachärztliche psychiatrisch-psychotherapeutische Versorgung²
- Psychotherapeutische Versorgung durch Psychotherapeut*innen
- Ergotherapie, Belastungserprobung und Arbeitstherapie
- Soziotherapie
- Physiotherapie, Bewegungs- und Sporttherapie
- Kunst- und Musiktherapie³
- Strukturierte, komplexe und aufsuchende Versorgungsformen (Psychiatrische/Psychosomatische Institutsambulanzen; Psychiatrische häusliche Krankenpflege; integrierte Versorgung⁴; multiprofessionelle gemeindepsychiatrische Teams⁴; stationsäquivalente psychiatrische Behandlung⁵; DMP Depression⁶; Ambulante Komplexbehandlung in multiprofessionellen Netzverbünden^{6,7})

Anbieter:

- ambulante Versorgung: Praxen, Psychiatrische/Psychosomatische Instituts- und Hochschulambulanzen
- (teil-)stationäre Versorgung: Fachkliniken, Fachabteilungen von Allgemeinkrankenhäusern



Beratung und Begleitung

- Information über und Unterstützung bei der Beantragung und Vermittlung von Leistungen
- niedrigintensive Leistungen (Psychoedukation, Aktivierung, Beratung, Peer-Counseling ...)

Anbieter: Sozialpsychiatrische Dienste, Psychosoziale Kontakt- und Beratungsstellen, Beratungsstellen für Rehabilitation und Teilhabe, Angebote der Selbsthilfe für Betroffene und/oder Angehörige, Genesungsbegleiter*innen, Apotheken



Rehabilitation und Teilhabe

- Medizinische Rehabilitation
- Leistungen zur Teilhabe am Arbeitsleben
- Leistungen zur Teilhabe an Bildung
- Leistungen zur sozialen Teilhabe
- Leistungen zur Unterstützung von Kindern, Jugendlichen und Familien
- Spezielle Leistungen der Suchthilfe

Details siehe Abbildung „Strukturen von Rehabilitation und Teilhabe“

Die Abbildung dient der grundsätzlichen Orientierung und stellt keine vollständige Darstellung aller Angebote, Anbieter und Kostenträger dar.

¹ FÄ für Allgemeinmedizin (mit obligatorischer Qualifikation in psychosomatischer Grundversorgung);

FÄ für Innere Medizin sowie weitere historische Fachbezeichnungen;

² FÄ für Psychiatrie und Psychotherapie, FÄ für Psychosomatische Medizin und Psychotherapie, Ärzt*innen mit Zusatzbezeichnung Psychotherapie und Psychoanalyse sowie weitere historische Fachbezeichnungen;

³ nur im stationären Kontext verfügbar;

⁴ nicht in allen Regionen und/oder bei allen Krankenkassen verfügbar;

⁵ nach § 115d, SGB V;

⁶ zum Zeitpunkt der Veröffentlichung der NVL noch nicht umgesetzt/verfügbar;

⁷ KSV-Psych-RiLi nach § 92 Abs. 6b SGB V