QUALITY STANDARDS

Major Depression

Care for Adults and Adolescents

2024 UPDATE

Ontario Health

Scope of This Quality Standard

This quality standard addresses care for people who have major depression or who are suspected to have major depression. The quality standard applies to adults and adolescents aged 13 years and older, and it considers all care settings. It does not apply to people with postpartum depression or to children under 13 years of age.

This quality standard focuses on unipolar major depression. Some statements refer specifically to people with major depression that is classified as mild, moderate, or severe. A range of scientifically validated measurement scales enable clinicians to determine this classification based on factors such as the number, duration, and intensity of symptoms; the presence or absence of psychotic symptoms; and the person's degree of functional impairment.

Where relevant, the quality statements align with the Ontario Health *Clinically Appropriate Use of Virtual Care for Depression and Anxiety-Related Conditions* guidance document.[1] This guidance aims to provide support for primary care clinicians who use virtual modalities as part of a hybrid model of care (i.e., care that involves a combination of virtual and in-person visits as appropriate) for the management of depression and anxiety-related conditions.

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and care partners know what to ask for in their care
- Help clinicians know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards and their accompanying patient guides are developed by Ontario Health, in collaboration with clinicians, patients, and care partners across Ontario.

For more information, contact QualityStandards@OntarioHealth.ca.

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care looks like for people with major depression.

Quality Statement 1: Comprehensive Assessment

People suspected to have major depression have timely access to a comprehensive assessment.

Quality Statement 2: Suicide Risk Assessment and Intervention

People with major depression who are at considerable risk to themselves or others, including those who experience psychotic symptoms, receive immediate access to suicide risk assessment and preventive intervention.

Quality Statement 3: Shared Decision-Making

People with major depression jointly decide with clinicians on the most appropriate treatment for them, based on their values, preferences, and goals for recovery. They have access to a decision aid in a language they understand that provides information on the expected treatment effects, side effects, risks, costs, and anticipated waiting times for treatment options.

Quality Statement 4: Treatment After Initial Diagnosis

People with major depression have timely access to either pharmacotherapy or evidence-based psychotherapy based on their preference, the severity of symptoms, and their ability to tolerate treatment. People with moderate to severe or persistent depression are offered a combination of both treatments.

Quality Statement 5: Adjunct Therapies and Self-Management

People with major depression are advised about adjunct therapies and self-management strategies that can complement pharmacotherapy or psychotherapy.

Quality Statement 6: Monitoring for Treatment Adherence and Response

People with major depression are monitored for the onset of, or an increase in, suicidal thinking following initiation of any treatment. People with major depression have a follow-up appointment with their clinician at least every 2 weeks for at least 6 weeks or until treatment adherence and response have been achieved. After this, they have a follow-up appointment at least every 4 weeks until they enter remission.

Quality Statement 7: Optimizing, Switching, or Adding Therapies

People with major depression who are prescribed medication are monitored for 2 weeks for the onset of effects; after this time, dosage adjustment or switching medications may be considered. People with major depression who do not experience a response to their medication after 8 weeks are offered a different or additional medication, psychotherapy, or a combination of both.

Quality Statement 8: Continuation of Medication

People taking medication who enter into remission from their first episode of major depression are advised to continue their medication for at least 6 months after remission. People with recurrent episodes of major depression who are taking medication and enter into remission are advised to continue their medication for at least 2 years after remission.

Quality Statement 9: Electroconvulsive Therapy

People with severe major depression and those with difficult-to-treat depression have access to electroconvulsive therapy.

Quality Statement 10: Assessment and Treatment for Recurrent Episodes

People with major depression who have reached full remission but are experiencing recurrent episodes have timely access to reassessment and treatment.

Quality Statement 11: Education and Support

People with major depression and their family members and care partners are offered education on major depression and information regarding community supports and crisis services.

Quality Statement 12: Transitions in Care

People with major depression who transition from one clinician to another have a documented care plan that is made available to them and their receiving clinician within 7 days of the transition, with a specific timeline for follow-up. People with major depression who are discharged from acute care have a scheduled follow-up appointment with a clinician within 7 days.

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2024 Summary of Updates

In 2023, we completed an evidence review to capture new or updated clinical practice guidelines and health technology assessments published since the original release of this quality standard in 2016. This update aligns the quality standard with the most recent clinical evidence and current practice in Ontario.

Below is a summary of changes to the overall quality standard:

- Updated links, secondary references, and data sources where applicable
- Updated formatting to align with current Ontario Health design and branding
- Revised the accompanying resources (i.e., patient guide, placemat, case for improvement slide deck, technical specifications) to reflect changes to the quality standard and align with current Ontario Health design and branding
- Updated data in the case for improvement slide deck, in the "Why This Quality Standard Is Needed" section, and in quality statement rationales where applicable
- Replaced the terms *antidepressant medication* and *antidepressants* with *medication* or *pharmacotherapy*, where appropriate
- Added a guiding principle on intersectionality to align with content added on providing culturally appropriate and trauma-informed care to equity-deserving populations

Below is a summary of changes to specific quality statements:

- Quality statement 1:
  - Modified the definition of *comprehensive assessment* to include ruling out depression secondary to other causes
  - Updated the rationale with indications for when people can be suspected to have major depression and added considerations for equity-deserving populations
  - Updated the "For Clinicians" audience statement to include the use of direct interviews and considerations for adolescents in alignment with the updated *Guidelines for Adolescent Depression in Primary Care*,[2] as well the need for clinicians to have the education, knowledge, and skills to provide care in a culturally appropriate, trauma-informed, anti-racist, and anti-oppressive way
  - Updated the "For Organizations and Health Services Planners" audience statement to include provisions for health care team members to receive ongoing education and training in culturally appropriate and trauma-informed care
- Quality statement 2: Modified the rationale to highlight that an assessment for suicide risk should be done at every clinical encounter and added suicide risk factors for the health care team, family members, and care partners to be aware of

- Quality statement 3: Updated the rationale to include collaborative models emphasizing the interprofessional involvement of 2 or more clinicians as part of the shared decision-making process in alignment with the updated Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 guidelines[3]
- Quality statement 4:
  - Added "severity of symptoms" and "ability to tolerate treatment" to the quality statement
  - Added a definition for *pharmacotherapy*
  - Updated the definition for *evidence-based psychotherapy* to include interpersonal psychotherapy adapted for adolescents and clinician-guided internet-delivered cognitive behavioural therapy (based on the 2019 health technology assessment by Health Quality Ontario[4]) as examples and modified session frequency based on the updated CANMAT 2023 guidelines[3]
  - Modified the rationale to include details on the effectiveness of pharmacotherapy and psychotherapy as initial treatments
  - Incorporated person-centred language by replacing "treatment resistant" with "those for whom previous adequate trials of treatment have not been effective"
- Quality statement 5: Added cultural adaptations and guided digital health interventions as adjunct therapies in alignment with the updated CANMAT 2023 guidelines[3] and added associated definitions
- Quality statement 6:
  - Modified the definition of *response* to include "validated rating scale for measurement-based care" and added a reference to quality statement 1
  - Modified the rationale to emphasize the importance of closely monitoring people with suicide risk and added a reference to quality statement 2
  - Added suicide risk to the list of risk factors in the "For Clinicians" audience statement
- Quality statement 7:
  - Updated the definition of *onset of effects* to align with the updated CANMAT 2023 guidelines[3] and added a reference to quality statement 1
  - Modified the rationale to include the use of sequential treatment to prevent recurrence
  - Added references in the "For Clinicians" audience statement to online tools to assist with medication titration and schedule switching, and medication classification by pharmacology and mechanism of action
- Quality statement 8: Modified the rationale to include other risk factors for remission requiring long-term maintenance treatment with medication and to acknowledge the potential risks of long-term pharmacotherapy

- Quality statement 9: Modified the quality statement to incorporate person-centred language by replacing “treatment resistant” with “people with severe major depression or those with difficult-to-treat depression.” Added definitions for *severe major depression* and *difficult-to-treat depression* and aligned the definition of *electroconvulsive therapy*, the rationale, and the quality indicators with the updated terminology
- Quality statement 10: Replaced “symptoms of relapse” with “recurrent episodes” in the quality statement to align with previously included definition
- Quality statement 12: Added references to the *Transitions From Youth to Adult Health Care Services*[5] and *Transitions Between Hospital and Home*[6] quality standards to the rationale

Why This Quality Standard Is Needed

Major depression is one of the most common mental illnesses, imposing a substantial human and economic burden on people and society. Each year, about 7% of people meet the diagnostic criteria for major depression, and about 13% to 15% of these people will experience major depression for the rest of their lives.[7,8] In 2020, about 15% of Canadians screened positive for major depression, which is twice the prevalence observed between 2015 and 2019, before the COVID-19 (coronavirus) pandemic.[9,10]

Major depression affects people of all ages, including older people, although it is most common in people who are in their early 20s to early 30s. Studies show higher rates of depression in women than in men. People with major depression may feel persistently sad and irritable and may lose interest in pleasurable activities. They may also exhibit changes in sleeping patterns and eating habits and have difficulty concentrating or thinking clearly. These symptoms often have a negative impact on personal relationships as well as work performance and attendance. People with major depression often feel guilty and suffer from significant distress, potentially leading them to think about self-harm or suicide.

There are significant gaps in the quality of care that people with major depression receive in Ontario. For example, since 2010/11, only about 1 in 3 people discharged from hospital for a primary diagnosis of major depression or other mood disorders receives the recommended follow-up visit with a clinician within 7 days (major depression cohort, ICES, 2022/23).[11]

There are also inequities in the care people receive for major depression. For example, people living in lower-income areas are more likely than those living in higher-income areas to revisit the emergency department for a mental health and addictions condition within 30 days of an initial emergency department visit for major depression (major depression cohort, ICES, 2022/23). And a study found that, between 2016 and 2019, about 29% of people 66 years of age and older living in rural communities in Ontario received follow-up with their prescribing primary care clinician within 30 days of first medication prescription for major depression, compared with 36% among those living in urban communities.[12]

Measurement to Support Improvement

The Major Depression Quality Standard Advisory Committee identified 9 overarching indicators to monitor the progress being made toward improving care for people with major depression in Ontario.

Indicators That Can Be Measured Using Provincial Data

- Number of inpatient deaths by suicide among people with a primary diagnosis of major depression
- Percentage of people with major depression discharged from a hospital inpatient stay who die by suicide within 30 days, 3 months, 6 months, and 1 year of discharge
- Percentage of emergency department visits for major depression that are a person's first contact with health care services for a diagnosis of major depression
- Percentage of people with major depression who show an improvement in depressive symptoms during an inpatient stay
- Percentage of readmissions to any hospital within 7 days and within 30 days of discharge from an inpatient hospital stay for major depression, stratified by the reason for readmission:
  - Any reason
  - Reason related to mental health and addictions
  - Major depression
- Percentage of unscheduled emergency department visits within 7 days and within 30 days of discharge from an inpatient hospital stay for major depression, stratified by the reason for the visit:
  - Any reason
  - Reason related to mental health and addictions
  - Major depression
  - Self-harm

Indicators That Can Be Measured Using Only Local Data

- Percentage of people with major depression, or family members of people with major depression, whose overall ratings of services received are good or very good
- Percentage of people with major depression who rate the care they receive in the hospital as excellent, very good, or good
- Percentage of people with major depression who show a decrease in their unmet needs over time

Quality Statement 1: Comprehensive Assessment

People suspected to have major depression have timely access to a comprehensive assessment.

Sources: American Psychological Association, 2019[13] | Australia's National Depression Initiative, 2011[14]| Canadian Network for Mood and Anxiety Treatments, 2023[3]| Department of Veterans Affairs and Department of Defense, 2022[15] | Guidelines for Adolescent Depression in Primary Care, 2018[2] | National Institute for Health and Care Excellence, 2022[16]| Registered Nurses' Association of Ontario, 2016[17]

Definitions

Timely access: For suspected severe major depression, within 7 days of initial contact. For suspected mild to moderate major depression, within 4 weeks of initial contact (advisory committee consensus).

Comprehensive assessment: This includes the following:

- Physical examination
- Mental status examination
- Relevant laboratory tests
- Psychosocial history (including socioeconomic factors, past personal and family history of depression,[15] and trauma)
- In older people, cognitive assessment
- Diagnosis of major depression using the criteria from the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)
- Use of validated tools to assess the severity of symptoms and degree of functional impairment, such as[3]:
    - Beck Depression Inventory (BDI-I or BDI-II)
    - Center for Epidemiologic Studies Depression Scale (CES-D)
    - Patient Health Questionnaire (PHQ-9)
    - Quick Inventory of Depressive Symptomatology – Self-Rated (QIDS-SR)
    - Zung Self-Rating Depression Scale

- Assessment of potential medical and psychiatric comorbidities (especially bipolarity and psychosis)
    - Assessment should rule out depression secondary to other causes (e.g., hypothyroidism, vitamin B-12 deficiency, syphilis, or pain),[15] account for symptom severity, and account for the existence of any chronic physical health problems with associated functional impairment, duration, and course of illness[2,16,18]
- Past treatment history and complete medication history, including self-medication
- Current and past substance use and addiction issues
- Assessment of suicide risk by a trained professional using a validated suicide risk assessment scale
    - Note: Suicide risk assessment of adolescents and young adults should involve the person's parents or care partners (see quality statement 2)

The comprehensive assessment should be culturally sensitive, that is, respectful of diverse cultural, ethnic, and spiritual backgrounds. Information from the family and relevant third parties should be obtained when appropriate.

Rationale

People can be suspected of having major depression through the presence of any emotional problem as the main complaint, a positive screen on a validated screening tool, or the presence of other signs and symptoms despite a negative screen result.[2] A comprehensive assessment allows for an accurate diagnosis of major depression and the collection of baseline measurements. It also allows for the identification of potential underlying conditions or issues (e.g., physical, cognitive, psychiatric, functional, or psychosocial factors) that may cause symptoms, and it informs their subsequent treatment. In addition, the assessment enables early identification of suicide risk.

Racialized, Indigenous, Two-Spirit, trans, nonbinary, and gender-diverse people and certain religious populations experience a higher prevalence of depression, as well as a lack of access and underuse of mental health services because of barriers such as treatment costs, cultural beliefs, stigma, language barriers, fear of being judged by the clinician, unequal geographic distribution of services, and fragmented health services.[3] Providing culturally appropriate and trauma-informed care, in which the sociocultural and language needs of these equity-deserving populations and the influence of transgenerational and other traumas on assessment and management are explicitly addressed, improves psychiatric care and patient outcomes.[3]

What This Quality Statement Means

For People With Suspected Major Depression

You should receive a comprehensive assessment. During an assessment, your clinician will want to learn more about you to understand how best to help you. The assessment should include questions about your physical health, your medical history, what medications you're taking, how you spend your time, and how you're feeling.

For Clinicians

If you suspect a person has major depression, complete and document a timely comprehensive assessment (i.e., within 7 days of initial contact for suspected severe major depression or within 4 weeks of initial contact for suspected of mild to moderate major depression). The assessment should include direct interviews with the person (and their families or care partners, where appropriate). Adolescents suspected to have major depression should be interviewed separately from families or care partners.[2] Ensure that you have the appropriate education, knowledge, and skills to provide care in a culturally appropriate, trauma-informed, anti-racist, and anti-oppressive way that recognizes people's intersectional identities (see Appendix 3, Guiding Principles, Intersectionality).

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place to assist clinicians with the assessment of people suspected to have major depression. This includes ensuring access to laboratory testing and areas for physical examination, providing the time required for a full assessment, and ensuring access to validated assessment tools and trained professionals competent in suicide risk assessment.

Ensure that all members of health care teams in primary care and home and community care settings receive ongoing education and training in culturally appropriate and trauma-informed care. Ensure that the workforce represents the diversity of the population being served in terms of their racial, ethnic, and cultural backgrounds and that care practices are culturally appropriate, antiracist, and anti-oppressive.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with suspected severe major depression, identified by a clinician, who receive a comprehensive assessment within 7 days of initial contact
- Percentage of people with suspected mild to moderate major depression, identified by a clinician, who receive a comprehensive assessment within 4 weeks of initial contact

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 2: Suicide Risk Assessment and Intervention

People with major depression who are at considerable risk to themselves or others, including those who experience psychotic symptoms, receive immediate access to suicide risk assessment and preventive intervention.

Sources: Canadian Network for Mood and Anxiety Treatments, 2023[3] | Department of Veterans Affairs and Department of Defense, 2022[15] | National Institute for Health and Care Excellence, 2022[16] | Registered Nurses' Association of Ontario, 2016[17]

Definitions

Immediate access: Help is offered at the point of contact.[19]

Suicide risk assessment: This includes questions about[19]:

- Suicidal thoughts, intent, plans, means, and behaviours; feelings of hopelessness
- Specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) and general medical conditions, as well as psychiatric treatment that may increase the likelihood of acting on suicidal ideas
- Past and, particularly, recent suicidal behaviours
- Current stressors and potential protective factors (e.g., positive reasons for living, social support)
- Family history of suicide or mental illness

Suicide risk assessment scales can be used by trained professionals to guide assessment.[19]

Preventive intervention: Interventions to prevent suicide include involuntary admission to hospital, observation every 15 minutes or 1-to-1 constant observation while in hospital, urgent medication treatment, and urgent electroconvulsive therapy.

Rationale

People with major depression have an increased lifetime risk of suicide and should be assessed for suicide risk on initial contact and at every clinical encounter throughout treatment.[3,15,17] The health care team, family members, and care partners should be alert for suicide risk in people with a sad or depressed mood, as well as in people who show signs or experience symptoms of agitation, negativity and hopelessness, or suicidal ideation. The health care team, family members, and care partners

should also be alert to the following risk factors: previous suicide attempts, a family history of suicide, a history of physical or sexual abuse, family violence, and comorbid conditions such as posttraumatic disorder, substance use disorders, personality disorders, sleep disorders, and chronic pain.[3]

What This Quality Statement Means

For People With Major Depression

You should receive immediate help if you or your clinician feels you're at risk of harming yourself or someone else. This help might take place at your clinician's office or in an emergency department.

For Clinicians

If you suspect a person with major depression may be at risk to themselves or others, or if they show signs or report experiencing symptoms of psychosis, complete and document a full suicide risk assessment, as described in the Definitions section of this statement. If the person is deemed to be at risk for suicide, provide urgent preventive intervention as described in the Definitions section.

For Organizations and Health Services Planners

Ensure the availability of suicide risk assessment tools, resources, and trained professionals.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people with major depression identified by a clinician to be at considerable risk to themselves or others, or who show psychotic signs or report experiencing psychotic symptoms, who receive immediate access to suicide risk assessment and, if necessary, preventive intervention

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 3: Shared Decision-Making

People with major depression jointly decide with clinicians on the most appropriate treatment for them, based on their values, preferences, and goals for recovery. They have access to a decision aid in a language they understand that provides information on the expected treatment effects, side effects, risks, costs, and anticipated waiting times for treatment options.

Sources: American Psychological Association, 2019[13] | Canadian Network for Mood and Anxiety Treatments, 2023[3] | Department of Veterans Affairs and Department of Defense, 2022[15] | National Institute for Health and Care Excellence, 2022[16] | Registered Nurses' Association of Ontario 2016[17]

Definition

Decision aid: This is a tool that helps people make decisions about their care by providing evidence-based information on the treatment options available and their effects, side effects, risks, and costs. Decision aids also help people consider their values and preferences and how these relate to their treatment choice. It is vital that decision aids be available in languages that people understand.

Rationale

People with major depression, their families or care partners (if desired), and their health care team should make health care decisions together.[15,16] Treatments are more likely to be effective when they align with people's preferences. People should be informed of the effects, side effects, risks, and costs of all potential treatment options for their condition. A decision aid can provide this information in an accessible way. Collaborative care models emphasizing the interprofessional involvement of 2 or more clinicians can effectively support a reduction in depressive symptoms and suicidal ideation in primary care settings, particularly for people with comorbid medical conditions and those from equity-deserving populations, including those from low socioeconomic backgrounds.[3]

What This Quality Statement Means

For People With Major Depression

You should be given tools and information to help you to discuss your condition with your clinician and to make treatment decisions that are right for you.

For Clinicians

Involve people with major depression in all decisions regarding their treatment. Explain the potential effects, side effects, risks, and costs of all treatment options in an understandable way, and discuss how these may align with people's preferences, values, and goals for recovery. Offer people with major depression and, if desired, their family or care partners a decision aid that provides this information in a language they understand.[20] Examples of decision aids include those provided by Laval University, McMaster University, and McGill University and by the Ottawa Hospital Research Institute.

For Organizations and Health Services Planners

Ensure the availability of up-to-date, evidence-based decision aids for people with major depression in a language they understand. Provide an environment that allows for conversations with people with depression, families, and care partners about treatment options.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with major depression who report making joint decisions about their care with their clinician
- Percentage of people with major depression who have access to a decision aid while making decisions about their care with their clinician

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 4: Treatment After Initial Diagnosis

People with major depression have timely access to either pharmacotherapy or evidence-based psychotherapy based on their preference, the severity of symptoms, and their ability to tolerate treatment. People with moderate to severe or persistent depression are offered a combination of both treatments.

Sources: American Psychological Association, 2019[13] | British Association for Psychopharmacology, 2015[21] | Canadian Network for Mood and Anxiety Treatments, 2023[3] | Department of Veterans Affairs and Department of Defense, 2022[15] | Guidelines for Adolescent Depression in Primary Care, 2018[2] | Health Quality Ontario, 2019[4] | National Institute for Health and Care Excellence, 2022[16] | Registered Nurses' Association of Ontario 2016[17]

Definitions

Timely access: For suspected severe depression, within 7 days of contact; for suspected mild to moderate depression, within 4 weeks of contact (advisory committee consensus).

Pharmacotherapy: Medication with antidepressant activity is the initial treatment option for people experiencing a major depressive episode of low to moderate severity. Where there is a partial response to initial treatment, an atypical antipsychotic medication (i.e., a serotonin-dopamine activity modulator) may be added at a low dose.[3] For people experiencing a severe major depressive episode with psychotic symptoms, a combination of a medication with antidepressant activity and an atypical antipsychotic medication (i.e., a serotonin-dopamine activity modulator) at higher doses should be considered.[3]

Evidence-based psychotherapy: This includes talk-based treatment that clinical research has shown can help a person identify and change troubling emotions, thoughts, and behaviours, such as cognitive behavioural therapy (CBT) and interpersonal psychotherapy, including interpersonal psychotherapy adapted for adolescents (IPT-A).[22,23] Other psychotherapies that may be effective include behavioural activation therapy, clinician-guided internet-delivered CBT, short-term dynamic psychotherapy, and mindfulness-based cognitive therapy.[4,15,22]

Cognitive behavioural therapy and interpersonal therapy for major depression should be:

- Delivered 1 on 1 or in a group setting
- Include at least 12 to 16 sessions delivered twice weekly over 3 to 4 months
- Delivered by an appropriately trained therapist in accordance with a treatment manual

Rationale

Both pharmacotherapy and evidence-based psychotherapy can be effective treatments for major depression. For initial treatment, the choice between the 2 should be based on context, availability, the preference of the person with major depression, the severity of symptoms, and their ability to tolerate treatment.[3] During the acute treatment phase, medications with antidepressant activity reduce symptoms of depressed mood, guilt, suicidal thoughts, anxiety, and somatic symptoms more effectively than psychotherapy, whereas psychotherapy (specifically CBT) may be more effective than medications with antidepressant activity at 6- to 12-month follow-ups.[3] The addition or initiation of CBT can also be effective for reducing suicidal thoughts and suicide attempts for people with a recent history of either. Combining pharmacotherapy and psychotherapy may be effective for people with moderate to severe major depression and for those for whom previous adequate trials of treatment have not been effective.

What This Quality Statement Means

For People With Major Depression

Your clinician should offer you a choice between medication and psychotherapy to treat your depression. If your depression doesn't get better, you should be offered a combination of the 2 treatments.

For Clinicians

Offer people with major depression pharmacotherapy or evidence-based psychotherapy (such as CBT or interpersonal psychotherapy). Offer a combination of the 2 treatments to people with moderate to severe or persistent major depression who have tried medications or psychotherapy without an adequate response. Monitor the risk of suicide at every clinical encounter throughout treatment (see quality statement 2).

For Organizations and Health Services Planners

Ensure pharmacotherapy and evidence-based psychotherapies are available and accessible in a timely manner for all people with major depression.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with severe major depression who receive a combination of medication and psychotherapy within 7 days of their assessment
- Percentage of people with mild to moderate major depression who receive medication or psychotherapy within 4 weeks of their assessment
- Availability of evidence-based psychotherapy

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 5: Adjunct Therapies and Self-Management

People with major depression are advised about adjunct therapies and self-management strategies that can complement pharmacotherapy or psychotherapy.

Sources: American Psychological Association, 2019[13] | Canadian Network for Mood and Anxiety Treatments, 2023[3] | Department of Veterans Affairs and Department of Defense, 2022[15] | National Institute for Health and Care Excellence, 2022[16]

Definitions

Adjunct therapies: These include light therapy, yoga, physical activity, cultural adaptations, and guided digital health interventions[15,16,24]:

- Light therapy: This therapy involves daily exposure to bright light, usually administered at home with a fluorescent light box. The standard "dosage" of light is 10,000 lux (units of illuminance) for 30 minutes a day, given early in the morning
- Yoga: This is a discipline that integrates physical postures, breath control, and meditation. The duration should be at least 4 weeks, with an average frequency of 4 sessions a week, 45 to 60 minutes per session
- Physical activity: Physical activity of any sort should be administered for at least 8 weeks, usually 3 times a week for 30 to 60 minutes per session
- Cultural adaptations: These include evidence-based psychological treatments adapted or modified using culturally appropriate idioms and metaphors, therapist adaptations through cultural matching or training, and the integration of religion and spirituality
- Guided digital health interventions: These interventions are delivered via computer, smartphone, or tablet for 15 to 60 minutes per week and are used to promote depression self-management, drawing on evidence-based psychotherapies such as CBT and behavioural activation, as well as mindfulness; users are guided by a trained therapist, peer supporter, or lay coach

Self-management strategies: These include sleep hygiene and nutrition:

- Sleep hygiene: The habits and practices of maintaining a regular sleep schedule; avoiding excess eating, drinking, or smoking before going to sleep; and establishing a proper sleep environment
- Nutrition: Maintaining a healthy, balanced diet and correcting any nutritional deficiencies

Rationale

Therapies and self-management strategies such as light therapy, yoga, physical activity, cultural adaptations, guided digital health interventions, behavioural activation, sleep hygiene, and good nutrition can be effective complements to pharmacotherapy or psychotherapy for major depression, potentially resulting in faster improvement and fewer residual symptoms.[25] Therapies that are more feasible and pleasurable for people to engage in improve their likelihood of being effective.[26]

What This Quality Statement Means

For People With Major Depression

In addition to medication and psychotherapy, your clinician should offer you or give you information about other things you can do that might improve your depression. Examples include light therapy, yoga, exercise, treatments that incorporate aspects of your culture or religion, and digital programs you can do on a computer, smartphone, or tablet with support from a therapist. Maintaining a regular sleep schedule and eating well are also very important.

For Clinicians

Advise people with major depression about adjunct therapies and self-management strategies that may complement pharmacotherapy or psychotherapy. These include light therapy, yoga, physical activity, cultural adaptations, guided digital health interventions, sleep hygiene, and nutrition.

For Organizations and Health Services Planners

Ensure the availability of relevant educational materials about adjunct therapies and self-management strategies for major depression.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people with major depression who receive information about adjunct therapies and self-management strategies

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 6: Monitoring for Treatment Adherence and Response

People with major depression are monitored for the onset of, or an increase in, suicidal thinking following initiation of any treatment. People with major depression have a follow-up appointment with their clinician at least every 2 weeks for at least 6 weeks or until treatment adherence and response have been achieved. After this, they have a follow-up appointment at least every 4 weeks until they enter remission.

Sources: Australia's National Depression Initiative, 2011[14] | Canadian Network for Mood and Anxiety Treatments, 2023[3] | National Institute for Health and Care Excellence, 2022[16]

Definitions

Response: This is indicated by an improvement in symptoms of at least 50% within 8 weeks of starting treatment.[3] Improvement is determined using the same validated rating scale for measurement-based care used at the initial assessment (see quality statement 1).

Remission: This is defined as a score below the predetermined threshold on the depression symptom rating scale used at the initial assessment and follow-ups or as the absence or near absence of symptoms for at least 8 weeks.[3]

Rationale

Assessing treatment response is critical to optimizing care. Nonadherence to treatment is common and a major reason for inadequate response to treatment and the recurrence of symptoms. As depression is increasingly conceptualized and treated as a recurrent or chronic condition, efforts to enhance treatment adherence should be encouraged. Additional emphasis should be put on closely monitoring adolescents and young adults (i.e., those under 25 years of age) and people with suicide risk (see quality statement 2).

What This Quality Statement Means

For People With Major Depression

Your clinician should monitor you closely to see how you are responding to treatment and to make changes to your treatment if you are not feeling better.

For Clinicians

Follow up at least every 2 weeks with people taking medications for at least 6 weeks or until treatment adherence and response are achieved. Then, follow up every 4 weeks until remission. Provide people with major depression with information on the importance of being consistent and continuing treatment despite improvement or side effects.

Note: People with significant risk factors such as psychotic symptoms, suicide risk, and significant side effects from medications must be followed up more frequently or for a longer duration, according to your discretion.

For Organizations and Health Services Planners

Facilitate the ability of clinicians to schedule follow-up appointments at regular intervals, and ensure clinicians are available to actively monitor adolescents and young adults newly started on medications.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people taking medication for major depression who are monitored for an onset of, or increase in, suicidal ideation for at least 6 weeks following the initiation of the medication

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 7: Optimizing, Switching, or Adding Therapies

People with major depression who are prescribed medication are monitored for 2 weeks for the onset of effects; after this time, dosage adjustment or switching medications may be considered. People with major depression who do not experience a response to their medication after 8 weeks are offered a different or additional medication, psychotherapy, or a combination of both.

Sources: American Psychological Association, 2019[13] | British Association for Psychopharmacology, 2015[21] | Canadian Network for Mood and Anxiety Treatments, 2023[18]| National Institute for Health and Care Excellence, 2022[16]

Definitions

Onset of effects: The point at which an early improvement or a reduction of 20% or more on a symptom rating scale score is observed within 2 to 4 weeks after starting medication.[3] Improvement is determined using the same validated rating scale for measurement-based care used at the initial assessment (see quality statement 1).

Response: This is indicated by an improvement in symptoms of at least 50% within 8 weeks of starting a medication.[3] Improvement is determined using the same validated rating scale for measurement-based care used at the initial assessment (see quality statement 1). While 8 weeks after starting a medication is a typical point at which to consider a change in treatment if response has not been achieved, other time frames may be more appropriate for some subpopulations; for example, older people may require up to 12 weeks to experience a response.

Rationale

Monitoring and assessing treatment response is critical to optimizing treatment with pharmacotherapy. If inadequate response to medication is noted, it is imperative that the clinician explain and offer other treatment options. To prevent recurrence, those with severe major depression should be offered sequential treatment (i.e., adding psychotherapy after stabilizing symptoms with medication; see quality statement 4).[3]

What This Quality Statement Means

For People With Major Depression

If you start taking a new medication, your clinician should monitor you closely to see if it's helping you and to see if you're experiencing any adverse effects. Adverse effects are unwanted effects of a medication. Examples include tiredness, upset stomach, and constipation. If you're not feeling better after 8 weeks on this medication, your clinician should offer you another medication, psychotherapy, or a combination of medication and psychotherapy.

For Clinicians

Assess people for 2 weeks after they start a new medication to determine their response. If needed, adjust the dosage or switch medications at this time. Complete an additional assessment every 2 weeks for 6 to 8 weeks. If they do not respond, offer a different medication, psychotherapy, or both.

SwitchRx.com is an online clinical tool to assist with medication titration and schedule switching.[3] Neuroscience-Based Nomenclature is a publication and digital application that classifies medications by their pharmacology and mechanism of action; it reports on 4 additional dimensions of relevant information for each medication in the nomenclature.[27]

For Organizations and Health Services Planners

Ensure the availability of and access to appropriate pharmacotherapy and psychotherapy for people with major depression.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people who receive medication for major depression and who are monitored for 2 weeks for the onset of effects of therapy
- Percentage of people who do not experience a response to their medication for major depression within 8 weeks and who are offered another or an additional medication or psychotherapy

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications

Quality Statement 8: Continuation of Medication

People taking medication who enter into remission from their first episode of major depression are advised to continue their medication for at least 6 months after remission. People with recurrent episodes of major depression who are taking medication and enter into remission are advised to continue their medication for at least 2 years after remission.

Sources: American Psychological Association, 2019[13] | British Association for Psychopharmacology, 2015[21] | Canadian Network for Mood and Anxiety Treatments, 2023[3] | Department of Veterans Affairs and Department of Defense, 2022[15] | National Institute for Health and Care Excellence, 2022[16]

Definitions

Remission: This is defined as a score below the predetermined threshold on the depression symptom rating scale used at the initial assessment and follow-ups or as the absence or near absence of symptoms for at least 8 weeks.[3]

Recurrent episodes of major depression: This consists of 3 or more episodes, 2 of which are in the past 5 years, with at least 6 months between episodes.

Rationale

People with major depression who recover from their depressive episode with medication can reduce the risk of experiencing residual symptoms, relapse, and recurrence by continuing to take their medication for a period of time afterward.[28] To prevent relapse and recurrence, those with frequent recurrent episodes, severe or chronic episodes, comorbid psychiatric or other medical conditions, residual symptoms, or difficult-to-treat episodes should be advised to take their medication for at least 2 years after achieving symptomatic remission. They should also be advised of the potential risks of long-term maintenance treatment with medication and how these balance against the risks of experiencing a depression relapse.[16,18]

What This Quality Statement Means

For People With Major Depression

To avoid the risk of your depression coming back, when you're feeling better you should keep taking your medication for a period of time recommended by your clinician. Your clinician will work with you to develop this timeline.

For Clinicians

Advise people who enter into remission with medication following their first episode of major depression to continue their medication for at least 6 months. Advise people who enter into remission with medication following a recurrent episode of major depression to continue their medication for at least 2 years.

For Organizations and Health Services Planners

Ensure the continuing availability of medication for people with major depression.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people in remission from their first episode of major depression who are advised to continue their medication for at least 6 months after remission
- Percentage of people in remission from their first episode of major depression who continue their medication for at least 6 months after remission
- Percentage of people with recurrent episodes of major depression in remission with medication who are advised to continue their medication for at least 2 years after remission
- Percentage of people with recurrent episodes of major depression in remission with medication who continue their medication for at least 2 years after remission

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 9: Electroconvulsive Therapy

People with severe major depression and those with difficult-to-treat depression have access to electroconvulsive therapy.

Sources: British Association for Psychopharmacology, 2015[21] | Canadian Network for Mood and Anxiety Treatments, 2023[3] | Department of Veterans Affairs and Department of Defense, 2022[15] | National Institute for Health and Care Excellence, 2022[16]

Definitions

Severe major depression: This is experienced by people who have most of the symptoms of depression and whose symptoms are severe and associated with significant functional impairment (e.g., a score of 16 or more on the Patient Health Questionnaire-9 [PHQ-9] or 24 or more on the Hamilton Depression Rating Scale). It can occur with or without psychotic symptoms.[15,16,29]

Difficult-to treat-depression: This is persistent depression that occurs when standard or adequate trials of treatment have not been effective. The term is used as part of a collaborative patient-centred approach for discussing unsatisfactory treatment response.[3,30]

Electroconvulsive therapy: A therapeutic procedure that involves applying an electrical stimulus to the brain.[31] It is typically provided about 3 times a week for 2 to 4 weeks or over 6 to 12 sessions.[3]

Rationale

Electroconvulsive therapy (ECT) is a safe and effective treatment for severe major depression and difficult-to-treat depression, particularly when chosen by the person based on a past positive experience with ECT, when a rapid response is needed (e.g., the person's condition has become life-threatening because they are not eating or drinking), or when adequate trials of pharmacotherapy or psychotherapy have not been effective.[32] People with major depression should be made aware of the potential effects, side effects, and risks of ECT so they can make an informed decision about this treatment. If ECT is contraindicated or not chosen by the person, repetitive transcranial magnetic stimulation may be considered as an alternative.[3,33]

What This Quality Statement Means

For People With Major Depression

If your depression is severe or if it isn't getting better with medication or psychotherapy, your clinician should offer you or explain how you can get another type of treatment called electroconvulsive therapy, or ECT. ECT is a procedure in which a small electrical current is passed through the brain of a person under general anaesthesia.

For Clinicians

Offer ECT or provide information about ECT to people with severe major depression and to those with difficult-to-treat depression who have not responded to adequate trials of pharmacological and nonpharmacological treatments. Also offer it as maintenance therapy to those who have previously had a positive response to it.

For Organizations and Health Services Planners

Ensure ECT is available to people with severe major depression and those with difficult-to-treat depression.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with severe major depression or difficult-to-treat depression who are offered electroconvulsive therapy
- Percentage of people with severe major depression or difficult-to-treat depression who receive electroconvulsive therapy
- Availability of electroconvulsive therapy

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 10: Assessment and Treatment for Recurrent Episodes

People with major depression who have reached full remission but are experiencing recurrent episodes have timely access to reassessment and treatment.

Source: Advisory committee consensus

Definitions

Recurrent episodes: 3 or more episodes of major depression, 2 of which are in the past 5 years, with at least 6 months between episodes.

Timely access: For suspected severe major depression, within 7 days of the recurrent episode being identified. For suspected mild to moderate major depression, within 4 weeks of the recurrent episode being identified.

Rationale

Recurrent episodes of depression are common among those who have experienced a first episode of major depression.[28] In such situations, it is vital that people have timely access to reassessment and the treatments that were effective for them in the past.

What This Quality Statement Means

For People With Major Depression

If you have recovered from depression but start feeling worse again, you should be assessed and receive treatment again. If a clinician suspects you may have severe major depression, you should have access to assessment and treatment within 7 days. If a clinician suspects you may have mild to moderate major depression, you should have access to assessment and treatment within 4 weeks.

For Clinicians

Assess and treat people with major depression who had reached full remission and who are experiencing recurrent episodes within 7 days for people suspected to have severe major depression or 4 weeks for those suspected to have mild to moderate major depression.

For Organizations and Health Services Planners

Ensure systems, processes, and resources are in place for the appropriate triage and timely treatment of people experiencing recurrent episodes of major depression.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with mild to moderate major depression in full remission who receive a comprehensive assessment within 4 weeks of initial contact for a recurrent episode of major depression
- Percentage of people with severe major depression in full remission who receive a comprehensive assessment within 7 days of initial contact for a recurrent episode of major depression

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 11: Education and Support

People with major depression and their family members and care partners are offered education on major depression and information regarding community supports and crisis services.

Sources: Canadian Network for Mood and Anxiety Treatments, 2023[3] | Department of Veterans Affairs and Department of Defense, 2022[15] | Guidelines for Adolescent Depression in Primary Care, 2018[2] | National Institute for Health and Care Excellence, 2022[16] | Registered Nurses' Association of Ontario, 2016[17]

Definitions

Family members: The people closest to a person in terms of knowledge, care, and affection; this may include biological family or family of origin, family through marriage, or family of choice and friends. The person defines their family and who will be involved in their care.

Care partners: Unpaid people who provide care and support in a nonprofessional capacity, such as parents, other family members, friends, or anyone else identified by the person with major depression.

Education on major depression: Education should be provided on the following topics:

- Signs and symptoms of depression
- Treatment options and their potential effects and side effects
- Self-management strategies such as monitoring symptoms and suicide risk, participating in meaningful activity, eating well, practising sleep hygiene, performing physical activities, and reducing tobacco and alcohol use
- Risk of relapse and early signs and symptoms of relapse to watch for
- Self-care and resilience for family members and care partners
- Information on local resources for education and support

Rationale

People with major depression and their family members and care partners can benefit from education about the condition and information on community supports and crisis services available in their communities. Education should focus on the nature of major depression, signs and symptoms, treatment options, self-management strategies, how to reduce the risk of relapse, and self-care strategies for family members and care partners.

What This Quality Statement Means

For People With Major Depression

Your clinician should offer you and your family members and care partners information about your condition, including signs and symptoms of major depression, treatment options and their potential effects and side effects, and things you can do in addition to treatment that might help (for example, eating well and exercising). They should also tell you about community supports and crisis services that are available to you.

For Clinicians

Offer people with major depression and their families and care partners education on major depression and information on community supports and crisis services available to them.

For Organizations and Health Services Planners

Ensure the availability of appropriate educational materials on major depression and information on community supports and crisis services for people with major depression and their families and care partners.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people with major depression who, along with their families and care partners, are offered education on major depression and information regarding community supports and crisis services

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 12: Transitions in Care

> People with major depression who transition from one clinician to another have a documented care plan that is made available to them and their receiving clinician within 7 days of the transition, with a specific timeline for follow-up. People with major depression who are discharged from acute care have a scheduled follow-up appointment with a clinician within 7 days.
>
> Source: Advisory committee consensus

Definition

Documented care plan: The following information should be documented and provided to people with depression, family members, care partners, and receiving clinicians before all transitions in care:

- Depression symptoms at the time of transition
- Risk for suicide or self-harm, if any
- Treatment history, including treatment options that have failed
- Goals for treatment

Rationale

Transitions between clinicians can increase the risk of errors and miscommunication in a person's care. It is important for people with major depression who are moving from one clinician to another to have a care plan that is shared with them and between clinicians. Optimal communication and coordination of treatment with other clinicians reduces the risk of relapse and can reduce side effects. If the person is being referred to a new clinician, it is important to ensure that the new clinician accepts the person as a patient before transferring them.

A follow-up appointment after hospitalization helps to support the person's transition to the community. It allows for the identification of medication-related issues, helps to maintain clinical and functional stability, and aims to prevent readmission to hospital. It is especially important for people with major depression admitted to hospital with a high risk for suicide to be followed up soon after discharge. If the person's consent is obtained, their family or care partners should be notified of their potential risk for suicide.

For additional information on the transition from youth to adult health care services and the transition between hospital and home, see Ontario Health's *Transitions From Youth to Adult Health Care Services*[5] and *Transitions Between Hospital and Home*[6] quality standards.

What This Quality Statement Means

For People With Major Depression

If you move from one clinician to another, you and your new clinician should each receive a written copy of your care plan from your previous clinician. A care plan is a document that provides information about your symptoms, your treatment history, and your goals for treatment. Your care plan should also specify a timeline for you to see your new clinician. If you have been treated for major depression in the hospital, a follow-up appointment with a new clinician should be scheduled for you before you leave the hospital, and this appointment should be within 7 days of when you go home.

For Clinicians

When handing over a person's care to another clinician, ensure that the new clinician accepts the person as a patient, that the person and the new clinician each receive a documented care plan within 7 days, and that a follow-up appointment is scheduled with the new clinician. When discharging a patient from hospital, ensure they have a scheduled follow-up appointment with a clinician within 7 days of discharge.

For Organizations and Health Services Planners

Ensure systems, processes, and resources are in place to facilitate communication and the sharing of information between clinicians during care transitions. Ensure the system can accommodate the appropriate follow-up timelines.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with major depression who transition from one clinician or care setting to another and have a documented care plan
- Percentage of people with major depression who transition from one clinician or care setting to another whose care plan specifies a timeline for follow-up
- Percentage of people with major depression who transition from one clinician or care setting to another and have their care plan made available to the receiving clinician within 7 days
- Percentage of people with major depression who are discharged from hospital who see a psychiatrist or primary care clinician within 7 days of discharge

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Emerging Practice Statement: Nonpharmacological Interventions

What Is an Emerging Practice Statement?

An emerging practice statement describes an area for quality improvement that has been prioritized by the advisory committee but for which there is insufficient or inconsistent evidence in the guidelines used in the development of the quality statements. An emerging practice statement acknowledges that there is a need for evidence-based guidance to be developed in an area, but the evidence base in this area is still emerging.

Rationale

The advisory committee discussed the following topics to be considered in future work: nonpharmacological treatments such as meditation, wellness recovery action planning, peer support, and spirituality.

Appendix 1: About This Quality Standard

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For People With Major Depression

This quality standard consists of quality statements. These describe what high-quality care looks like for people with major depression.

Within each quality statement, we've included information on what these statements mean for you, as a person with major depression.

In addition, you may want to download this accompanying patient guide on major depression to help you and your family have informed conversations with your clinicians. Inside, you will find information and questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people with major depression or who are suspected to have major depression. They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions, available in the technical specifications. Measurement is key to quality improvement. Collecting and using data when implementing a quality standard can help you assess the quality of care you are delivering and identify gaps in care and areas for improvement.

There are also a number of resources online to help you, including:

- Our patient guide on major depression, which you can share with patients and families to help them have conversations with you and their other clinicians. Please make the patient guide available where you provide care
- Our measurement resources, including the technical specifications for the indicators in this quality standard, the "case for improvement" slide deck to help you to share why this standard

was created and the data behind it, and our measurement guide containing supplementary information to support the data collection and measurement process

- Our placemat, which summarizes the quality standard and includes links to helpful resources and tools
- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of care across Ontario. This is a place where clinicians can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard

How the Health Care System Can Support Implementation

As you work to implement this quality standard, there may be times when you find it challenging to provide the care outlined due to system-level barriers or gaps. These challenges have been identified and documented as part of the development of the quality standard, which included extensive consultation with clinicians and lived experience advisors and a careful review of available evidence and existing programs. Many of the levers for system change fall within the purview of Ontario Health, and as such we will continue to work to address these barriers to support the implementation of quality standards. We will also engage and support other provincial partners, including the Ministry of Health or other relevant ministries, on policy-level initiatives to help bridge system-level gaps.

In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

Appendix 2: Glossary

Term	Definition
Adolescents	People aged 13 to 17 years.
Adults	People aged 18 years and older.
Care partner	An unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person with depression. Other terms commonly used to describe this role include “caregiver,” “informal caregiver,” “family caregiver,” “carer,” and “primary caregiver.”
Clinicians	Regulated professionals who provide care to patients or clients. Examples are nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychiatrists, psychologists, social workers, and speech-language pathologists.
Culturally appropriate care	Care that incorporates cultural or faith traditions, values, and beliefs; is delivered in the person’s preferred language; adapts culture-specific advice; and incorporates the person’s wishes to involve family or community members.[34]
Family	The people closest to a person in terms of knowledge, care, and affection; this may include biological family or family of origin, family through marriage, or family of choice and friends. The person defines their family and who will be involved in their care.
Health care team	Clinicians, as well as people in unregulated professions, such as administrative staff, behavioural support workers, child life specialists, patient transport staff, personal support workers, recreational staff, spiritual care staff, and volunteers.
Home	A person’s usual place of residence. This may include personal residences, retirement residences, assisted-living facilities, long-term care facilities, hospices, and shelters.
Primary care	A setting where people receive general health care (e.g., screening, diagnosis, and management) from a clinician whom the person can access directly without a referral. This is usually the primary care clinician, family physician, nurse practitioner, or other clinician with the ability to make referrals, request laboratory testing, and prescribe medications.
Primary care clinician	A family physician (also called a primary care physician) or nurse practitioner.
Transitions in care	These occur when patients transfer between different care settings (e.g., hospital, primary care, long-term care, home and community care) or between different clinicians during the course of an acute or chronic illness.
Young adults	People aged 18 to 25 years.

Appendix 3: Values and Guiding Principles

Values That Are the Foundation of This Quality Standard

This quality standard was created, and should be implemented, according to the Patient, Family and Caregiver Declaration of Values for Ontario. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients, and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

A quality health system is one that provides good access, experience, and outcomes for all people in Ontario, no matter where they live, what they have, or who they are.

Guiding Principles

In addition to the above values, this quality standard is guided by the principles outlined below.

Acknowledging the Impact of Colonization and Racism

Clinicians should acknowledge and work toward addressing the historical and present-day impacts of colonization and racism in the context of the lives of Indigenous Peoples and racialized people throughout Canada. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous and racialized people, families, and communities, as well as recognizing their strength and resilience. This quality standard uses existing clinical practice guideline sources that may not include culturally appropriate care or acknowledge traditional beliefs, practices, and models of care relevant to Indigenous and racialized people.

French Language Services

In Ontario, the *French Language Services Act* guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 26 designated areas and at government head offices.[35]

Social Determinants of Health

Homelessness and poverty are 2 examples of economic and social conditions that influence people's health, known as the social determinants of health. Other social determinants of health include employment status and working conditions, race and ethnicity, food security and nutrition, gender, housing, immigration status, social exclusion, and residing in a rural or urban area. Social determinants of health can have strong effects on individual and population health; they play an important role in understanding the root causes of poorer health. People with a mental illness or addiction often live under very stressful social and economic conditions that worsen their mental health,[36] including social stigma, discrimination, and a lack of access to education, employment, income, and housing.[37]

Chronic Disease Self-Management

People with major depression and their families and care partners should receive services that are respectful of their rights and dignity and that promote shared decision-making and self-management.[38] Further, people should be empowered to make informed choices about the care and services that best meet their needs.[39,40] People with major depression should engage with their clinicians in informed, shared decision-making about their treatment options. Each person is unique and has the right to determine their own path toward health and well-being.[38]

Integrated Care

People with major depression should receive care through an integrated approach that facilitates access to interprofessional services from multiple clinicians from different professional backgrounds and across health care settings to provide comprehensive services.[41] Clinicians should work with people with major depression, their families and care partners, and communities to deliver the highest quality of care across settings. Interprofessional collaboration, shared decision-making, coordination of care, and continuity of care (including follow-up care) are hallmarks of this patient-centred approach.[41]

Intersectionality

Intersectionality refers to the differences in experiences with discrimination and injustice that people have based on social categorizations such as race or ethnicity, class, age, and gender and the interaction of these experiences with compounding power structures (e.g., the media, education systems). These interconnected categorizations create overlapping and interdependent systems of discrimination or disadvantage.[42-44] For example, the stigma experienced by people with major depression can vary depending on clinical and demographic characteristics such as racial or ethnic background and age, as well as other characteristics such as language barriers or perceived socioeconomic status. Understanding how the various aspects of people's identities intersect can provide insights into the complexities of the processes that cause health inequities and how different people experience stigma and discrimination.[45]

Recovery

This quality standard is underpinned by the principle of recovery, as described in the Mental Health Strategy for Canada. People with major depression can lead meaningful lives. People with major depression have a right to services provided in an environment that promotes hope, empowerment,

self-determination, and optimism, and that are embedded in the values and practices associated with recovery-oriented care. The concept of recovery refers to "living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses."[46] As described in the Mental Health Strategy Canada, "recovery – a process in which people living with mental health problems and mental illnesses are actively engaged in their own journey of well-being – is possible for everyone. Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments."

Mental wellness is defined as a balance of the mental, physical, spiritual, and emotional, which is enriched as individuals have purpose in their daily lives, hope for their future, a sense of belonging, and a sense of meaning.[47] These elements of mental wellness are supported by factors such as culture, language, Elders, families, and creation. The First Nations Mental Wellness Continuum Framework provides an approach that "respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of knowing."[48]

Strengths-Based Practice

A strengths-based practice actively involves the person and the clinician who supports them in working together to achieve the person's intended outcomes in a way that draws on the person's strengths.[49,50] The person is recognized and acknowledged as the expert of their own lived experience, and the clinician is recognized as an expert in their discipline and in facilitating a conversation that reinforces the person's strengths and resources.

Trauma-Informed Care

Trauma-informed care is health care that reflects an understanding of trauma, the impact that traumatic experiences can have on human beings, and the potential to traumatize or retraumatize patients when providing them with care.[51,52] A trauma-informed approach does not necessarily involve addressing the trauma directly. Rather, it involves acknowledging that a person may have experienced a previous traumatic event that may contribute to their current health concerns and takes steps to reduce opportunities for traumatization (e.g., using active strategies around consent, attending to individual patient needs, recognizing the inherent power imbalance in clinician–patient relationships, facilitating greater patient agency and choice in all interactions).[53,54] A trauma-informed approach emphasizes the creation of an environment in which a person can feel comfortable disclosing trauma, and it involves understanding, respecting, and responding to the effects of trauma.[52-54]

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About Us

We are an agency created by the Government of Ontario to connect, coordinate, and modernize our province's health care system. We work with partners, providers, and patients to make the health system more efficient so everyone in Ontario has an opportunity for better health and well-being.

Mental Health and Addictions Centre of Excellence

The Mental Health and Addictions Centre of Excellence was established within Ontario Health and is the foundation on which a mental health and addictions strategy is developed and maintained. This strategy recognizes that mental health and addictions care is a core component of an integrated health care system. The centre's role is to ensure that mental health and addictions care is: The

- Delivered consistently across the province
- Integrated with the broader health system
- More easily accessible
- Responsive to diverse needs of people living in Ontario and their families

The centre will also help implement the Roadmap to Wellness, the province's plan to build a comprehensive and connected mental health and addictions system.

Equity, Inclusion, Diversity, and Anti-Racism

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism in the health care system. As part of this work, Ontario Health has developed an Equity, Inclusion, Diversity and Anti-Racism Framework, which builds on existing legislated commitments and relationships and recognizes the need for an intersectional approach.

Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

For more information about Ontario Health, visit OntarioHealth.ca.

Looking for More Information?

Visit hqontario.ca or contact us at QualityStandards@OntarioHealth.ca if you have any questions or feedback about this quality standard.

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