Quality Standards

Major Depression

Care for Adults and Adolescents

Let's make our health system healthier

Ontario
Health Quality Ontario

Summary

This quality standard addresses care for people who have major depression. The quality standard applies to adults and adolescents who have suspected major depression, and it considers all care settings. It does not apply to women with postpartum depression or to young children.

About Quality Standards

Health Quality Ontario, in collaboration with clinical experts, patients, residents, and caregivers across the province, is developing quality standards for Ontario.

Quality standards are concise sets of statements that will:

- Help patients, residents, families, and caregivers know what to ask for in their care
- Help health care professionals 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

The recommendations in this quality standard do not override the responsibility of health care professionals to make decisions with patients, after considering each patient's unique circumstances.

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How to Use Quality Standards

Quality standards inform clinicians and organizations about what high-quality health care looks like. They are based on the best available evidence.

They also include indicators to help clinicians and organizations assess the quality of care they are delivering, and to identify gaps and areas for improvement. These indicators measure structure, process and outcomes.

In addition, tools and resources to support clinicians and organizations in their quality improvement efforts accompany each quality standard.

For more information on how to use quality standards, contact qualitystandards@hqontario.ca.

About Health Quality Ontario

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by a single-minded purpose: Better health for all Ontarians.

Who We Are

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

What We Do

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voice of patients, caregivers, and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Why It Matters

We recognize that, as a system, we have much to be proud of, but also that it often falls short of being the best it can be. Plus certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent at Health Quality Ontario is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better has no limit.

About This Quality Standard

Scope of This Quality Standard

This quality standard includes 12 quality statements addressing areas that were identified by Health Quality Ontario's Major Depression Quality Standard Advisory Committee as having high potential for quality improvement. It focuses on adults and adolescents 13 years of age or older receiving care for major depression in all settings by a number of providers. This quality standard does not apply to women 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. There is a range of scientifically validated measurement scales that 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.

Why This Quality Standard Is Needed

Major depression is one of the most common mental illnesses, imposing a huge 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.[1,2]

Major depression affects people of all ages, including the elderly, 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 suicide or self-harm.

There are significant gaps in the quality of care that people with major depression receive in Ontario: for example, only one in three people discharged from hospital for a primary diagnosis of depression or other mood disorders receives the recommended follow-up visit with a physician within 7 days.[3] There are also inequities in the care people receive for major depression: for example, although hospitalization rates for major depression are significantly higher for people living in lower-income areas than in higher-income areas, people in lower-income areas starting antidepressant medication are less likely to receive the recommended three or more physician follow-up visits within 12 weeks of starting their medication.[4]

Principles Underpinning This Quality Standard

This quality standard is underpinned by the principles of respect and *recovery,* as described in the Mental Health Strategy for Canada.[5]

People with major depression should receive services that are respectful of their rights and dignity and that promote self-determination. Each person is unique and has the right to determine their path toward mental health and well-being.[5]

People with major depression are capable of leading meaningful lives. They have a right to services provided in an environment that promotes hope, empowerment, and optimism, and that are consistent with the values and practices of recovery-oriented care.

People with major depression should receive services that are respectful of their gender, sexual orientation, socioeconomic status, housing, age, background (including self-identified cultural, ethnic, or religious background), or disability. There are "many intersecting factors (biological, psychological, social, economic, cultural, and spiritual)" that may have an impact on mental health and well-being.[5]

Care for people with major depression should also incorporate what is referred to as recovery. As described in the Mental Health Strategy for Canada, "recovery—a process in which people living with mental health problems and mental illnesses are actively engaged in their own journey of wellbeing—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."[5]

How We Will Measure Our Success

Early in the development of each quality standard, a small number of health outcomes are chosen as the most important measures of success of the entire standard. The outcomes are mapped to indicators that reflect the goals of the standard. These outcomes and the associated indicators guide the development of the quality standard so that every statement within the standard aids in achieving the chosen outcomes. Each statement is accompanied by process, structure, and/or outcome indicators that measure the successful implementation of the statement.

The following set of outcome indicators has been selected to measure the impact of the major depression quality standard as a whole:

- 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
- Overall rating of services received by people with major depression
- 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
- Percentage of people with major depression who show an improvement in depressive symptoms during an inpatient stay
- Readmission to any hospital within 7 days and 30 days of discharge from an inpatient hospital stay, stratified by the reason for readmission:
  - Any reason
  - A reason related to mental health and addictions
  - Major depression
- Unscheduled emergency department visit within 7 days and 30 days after hospital inpatient discharge, stratified by the reason for the visit:
  - Any reason
  - A reason related to mental health and addictions
  - Major depression
  - Self-harm

Quality Statements in Brief

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, or who show 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 antidepressant medication or evidence-based psychotherapy, based on their preference. People with 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 adjunctive therapies and self-management strategies that can complement antidepressant medication 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 health care provider 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 antidepressant 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 respond to their antidepressant medication after 8 weeks are offered a different or additional antidepressant, psychotherapy, or a combination of antidepressants and psychotherapy.

Quality Statement 8: Continuation of Antidepressant Medication

People taking antidepressant 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 antidepressant 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 or treatment-resistant major 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 symptoms of relapse have timely access to reassessment and treatment.

Quality Statement 11: Education and Support

People with major depression and their families and caregivers 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 care provider to another have a documented care plan that is made available to them and their receiving provider 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 health care provider within 7 days.

1

Comprehensive Assessment

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

Background

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.

Sources: American Psychiatric Association, 2010[6] | Canadian Network for Mood and Anxiety Treatments, 2009[1] | Guidelines for Adolescent Depression in Primary Care, 2007[7] | National Institute for Health and Clinical Excellence, 2009[8] | National Depression Initiative, 2011[9] | Veterans Affairs and the Department of Defense, 2009[10]

What This Quality Statement Means

For Patients

You should receive a comprehensive assessment. An assessment means that your care team will want to learn more about you to understand how best to help you. It 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 depression, complete and document a full assessment as described in the Definitions section of this statement.

For Health Services

Ensure systems, processes, and resources are in place to assist clinicians with the assessment of people with suspected 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 to trained professionals competent in suicide risk assessment.

Quality Indicators

Process Indicators

Percentage of people with suspected severe major depression, identified by a health care provider, who receive a comprehensive assessment within 7 days of initial contact

- Denominator: total number of people with suspected severe major depression, identified by a health care provider
- Numerator: number of people in the denominator who receive a comprehensive assessment within 7 days of initial contact
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Timely access

- For suspected severe depression: within 7 days of contact
- For suspected mild to moderate depression: within 4 weeks of contact

Comprehensive assessment

This includes the following:

- Physical examination
- Mental status examination
- Relevant laboratory tests
- Psychosocial history (including socio-economic factors and trauma)
- In elderly people, cognitive assessment
- Diagnosis of major depression using the criteria from DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders,* 5th Edition)
- Use of validated tools for assessing the severity of symptoms and degree of functional impairment, such as:
  - Patient Health Questionnaire (PHQ-9)
  - Quick Inventory of Depressive Symptomatology—Self-Rated (QIDS-SR)
  - Beck Depression Inventory (BDI-I or BDI-II)
  - Zung Self-Rating Depression Scale
  - Center for Epidemiologic Studies Depression Scale (CES-D)

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Process Indicators CONTINUED

Percentage of people with suspected mild to moderate major depression, identified by a health care professional, who receive a comprehensive assessment within 4 weeks of initial contact

- Denominator: total number of people with suspected mild to moderate major depression identified by a health care professional
- Numerator: number of people in the denominator who receive a comprehensive assessment within 4 weeks of initial contact
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Comprehensive assessment

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- Assessment of potential medical and psychiatric comorbidities (especially bipolarity and psychosis)
- 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 suicide risk assessment scales

  Note: Suicide risk assessment of young adults and adolescents should involve the parents or caregivers.

The assessment should be culturally sensitive—respectful of diverse cultural, ethnic, and spiritual backgrounds.

Information from the family and relevant third parties should be obtained when appropriate.

2

Suicide Risk Assessment and Intervention

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

Background

People with major depression have an increased lifetime risk of suicide and should be assessed for suicide risk on initial contact and throughout treatment. Health care providers, family members, and caregivers should be alert for suicide risk in people with a sad or depressed mood, suicidal ideation, and one or more risk factors, including previous suicide attempts, a family history of suicide, physical or sexual abuse, family violence, and chronic pain.

Sources: American Psychiatric Association, 2010[6] | Canadian Network for Mood and Anxiety Treatments, 2009[1] | National Institute for Health and Clinical Excellence, 2009[8] | Veterans Affairs and the Department of Defense, 2009[10]

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What This Quality Statement Means

For Patients

You should receive immediate help if you or your health care professional feels you're at risk of harming yourself or someone else. This help might take place at your health care professional'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 psychotic symptoms, 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 Health Services

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

Quality Indicators

Process Indicator

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

- Denominator: total number of people with major depression identified by a trained professional to be at considerable risk to themselves or others or who show psychotic symptoms
- Numerator: number of people in the denominator who receive immediate access to suicide risk assessment and, if necessary, preventive intervention
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Immediate access

Help is offered at the point of contact.[6]

Suicidal risk assessment

This includes questions about:

- Suicidal thoughts, intent, plans, means, and behaviours (hopelessness)
- Specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or 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.[6]

Suicide preventive interventions

These include involuntary admission to hospital, observation every 15 minutes or one-to-one constant observation, urgent medication treatment, and urgent electroconvulsive therapy.

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.

Background

People with major depression, their families (if desired), and their health care providers should make health care decisions together. 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 patient decision aid can help provide all this information in an accessible way.

Sources: American Psychiatric Association, 2010[6] | Veterans Affairs and the Department of Defense, 2009[10]

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What This Quality Statement Means

For Patients

You should be given tools and information that help you make treatment decisions with your health care professional.

For Clinicians

Involve people with major depression in all decisions regarding their treatment. Explain the effects, side effects, risks, and costs of all potential treatment options for their condition in an understandable way and discuss how these may align with their preferences, values, and goals for recovery. Offer people with major depression and, if desired, their family or caregivers a decision aid that provides this information in a language they understand.

For Health Services

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 patients, families, and caregivers about various treatment options.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Patient decision aid

This is a tool that helps patients 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.

Quality Indicators

Process Indicators

Percentage of people with major depression who report making joint decisions about their care with their health care providers

- Denominator: total number of people with major depression who are receiving care from a health care provider
- Numerator: number of people in the denominator who report making joint decisions about their care with their health care providers
- Data source: local data collection

Process Indicators CONTINUED

Percentage of people with major depression who have access to a decision aid while making decisions about their care with their health care providers

- Denominator: total number of people with major depression who are receiving care from a health care provider
- Numerator: number of people in the denominator who have access to a decision aid while making decisions about their care with their health care providers
- Data source: local data collection

4

Treatment After Initial Diagnosis

People with major depression have timely access to either antidepressant medication or evidence-based psychotherapy, based on their preference. People with severe or persistent depression are offered a combination of both treatments.

Background

Both antidepressant medications and evidence-based psychotherapies (such as cognitive behavioural therapy or interpersonal therapy) can be effective treatments for major depression. Combining antidepressants and psychotherapy may be effective for people with severe or treatment-resistant major depression.

Sources: American Psychiatric Association, 2010[6] | British Association for Psychopharmacology, 2015[11] | Canadian Network for Mood and Anxiety Treatments, 2009[1] | National Institute for Health and Clinical Excellence, 2009[8] | Scottish Intercollegiate Guidelines Network, 2010[12] | Veterans Affairs and the Department of Defense, 2009[10]

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What This Quality Statement Means

For Patients

You should have a choice of psychotherapy or antidepressant drugs. If your depression doesn't get better, you should be offered a combination of the two treatments.

For Clinicians

Offer people with major depression antidepressants or evidence-based psychotherapy (such as cognitive behavioural therapy or interpersonal psychotherapy). Offer a combination of the two treatments to people with severe or persistent major depression who have tried antidepressants or psychotherapy without an adequate response.

For Health Services

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

Quality Indicators

Process Indicators

Percentage of people with severe major depression who receive a combination of medications and psychotherapy within 7 days of their assessment

- Denominator: total number of people with severe major depression who have been assessed
- Numerator: number of people in the denominator who receive medications and psychotherapy within 7 days of their assessment
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Timely access

- **For severe depression:** within 7 days
- **For mild to moderate depression:** within 4 weeks

Evidence-based psychotherapy

This includes cognitive behavioural therapy and interpersonal psychotherapy (see below). Other psychotherapies that may be effective include behavioural activation therapy, short-term dynamic psychotherapy, and mindfulness-based cognitive therapy.[1]

Cognitive behavioural therapy and interpersonal therapy

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

- Delivered on a one-to-one or group basis
- Delivered over 16 to 20 sessions over 3 to 4 months
- Delivered by an appropriately trained therapist in accordance with a treatment manual

Process Indicators CONTINUED

Percentage of people with mild to moderate major depression who receive medications or psychotherapy within 4 weeks of their assessment

- Denominator: total number of people with mild to moderate major depression
- Numerator: number of people in the denominator who receive medications or psychotherapy within 4 weeks of their assessment
- Data source: local data collection

Structural Indicator

Availability of evidence-based psychotherapy

- Data source: local data collection

5

Adjunct Therapies and Self-Management

People with major depression are advised about adjunctive therapies and self-management strategies that can complement antidepressant medication or psychotherapy.

Background

Therapies and self-management strategies such as light therapy, yoga, physical activity, behavioural activation, sleep hygiene, and good nutrition can be effective complements to antidepressant medication or psychotherapy for major depression, potentially resulting in faster improvement and fewer residual symptoms.[13] Therapies that are more feasible and pleasurable for people improve their likelihood of being effective.[14]

Source: Canadian Network for Mood and Anxiety Treatments, 2009[1]

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What This Quality Statement Means

For Patients

In addition to medication and psychotherapy, your health care professional should offer you educational materials about other steps you can take that might improve your depression, such as light therapy, yoga, and exercise.

For Clinicians

Advise people with major depression about adjunct therapies and self-management strategies that can complement antidepressant medication or psychotherapy. These include light therapy, yoga, physical therapy, sleep hygiene, and nutrition.

For Health Services

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

Quality Indicators

Process Indicator

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

- Denominator: total number of people with major depression
- Numerator: number of people in the denominator who receive information about adjunct therapies and self-management techniques
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Adjunct therapies

These include light therapy, yoga, and physical activity.

- **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 (intensity) for 30 minutes per 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, and 45 to 60 minutes per session
- **Physical activity:** Physical activity of any sort administered for at least 8 weeks, usually 3 times a week for 30 to 60 minutes per session

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

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 health care provider 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.

Background

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 (under 25 years of age).

Sources: American Psychiatric Association, 2010[6] | Canadian Network for Mood and Anxiety Treatments, 2009[1] | National Depression Initiative, 2011[9] | National Institute for Health and Clinical Excellence, 2009[8] | Veterans Affairs and the Department of Defense, 2009[10]

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What This Quality Statement Means

For Patients

Your health care professional should monitor you closely.

For Clinicians

Follow up at least every 2 weeks with people taking antidepressants, for at least 6 weeks or until treatment adherence and response are achieved. Then, follow up every 4 weeks until remission. Provide 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 and significant side effects from medications must be followed up more frequently or for a longer duration, according to your discretion.

For Health Services

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

Quality Indicators

Process Indicator

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

- Denominator: total number of people with major depression taking antidepressant medication
- Numerator: number of people in the denominator who are monitored for an onset of, or increase in, suicidal ideation for at least 6 weeks following the initiation of antidepressant medication
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Response

This is indicated by an improvement in symptoms of at least 50%. This improvement is determined using the same scale used in the initial assessment.

Remission

This is defined as a score below the predetermined threshold on the depression symptom rating scale used at the initial assessment and follow-up.

7

Optimizing, Switching, or Adding Therapies

People with major depression who are prescribed antidepressant 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 respond to their antidepressant medication after 8 weeks are offered a different or additional antidepressant, psychotherapy, or a combination of antidepressants and psychotherapy.

Background

Monitoring and assessing treatment response is critical to optimizing treatment with antidepressant medication. If inadequate response to medication is noted, it is imperative that the health care provider explain and offer other treatment options. For some specific subpopulations, different time frames may be more appropriate; for example, the elderly may require up to 12 weeks to respond.

Sources: American Psychiatric Association, 2010[6] | British Association for Psychopharmacology, 2015[11] | Canadian Network for Mood and Anxiety Treatments, 2009[1] | National Institute for Health and Clinical Excellence, 2009[8]

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What This Quality Statement Means

For Patients

If you start on a new antidepressant, your health care professional should closely monitor the therapeutic effects or side effects of the medication. If your dosage is adjusted or your medications switched, and you're still not feeling better, another therapy should be tried.

For Clinicians

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

For Health Services

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

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Onset of effects

This is indicated by an improvement in symptoms of at least 20%. This improvement is determined using the same scale used in the initial assessment.

Response

This is indicated by an improvement in symptoms of at least 50%. This improvement is determined using the same scale used in the initial assessment.

Quality Indicators

Process Indicators

Percentage of people with major depression who receive antidepressant medication who are monitored for 2 weeks for the onset of effects

- Denominator: total number of people with major depression who receive antidepressant medication
- Numerator: number of people in the denominator who are monitored for the onset of effects for 2 weeks after starting the medication
- Data source: local data collection

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Process Indicators CONTINUED

Percentage of people with major depression who do not respond to their antidepressant medication within 8 weeks who are offered another or additional antidepressant or psychotherapy

- Denominator: total number of people with major depression receiving antidepressant medication who have not responded to the medication by 8 weeks of treatment
- Numerator: number of people in the denominator who are offered another or additional antidepressant or psychotherapy
- Data source: local data collection

8

Continuation of Antidepressant Medication

People taking antidepressant 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 antidepressant medication and enter into remission are advised to continue their medication for at least 2 years after remission.

Background

People with major depression who recover from their depressive episode with antidepressant medication can reduce the risk of experiencing residual symptoms, relapse, or recurrence by continuing to take their medication for a period of time afterward.[16]

Sources: American Psychiatric Association, 2010[6] | British Association for Psychopharmacology, 2015[11] | Canadian Network for Mood and Anxiety Treatments, 2009[1] | National Institute for Health and Clinical Excellence, 2009[8] | Veterans Affairs and the Department of Defense, 2009[10]

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What This Quality Statement Means

For Patients

To avoid the risk of your depression coming back, when you're feeling better you should keep taking your antidepressant medication for several months. Your health care professional will work with you to develop this timeline.

For Clinicians

Advise patients who enter remission with antidepressant medication therapy during their first episode of major depression to continue antidepressants for at least 6 months. Advise people who have experienced recurrent episodes of major depression to continue antidepressants for at least 2 years.

For Health Services

Ensure the continuing availability of antidepressant medication for people suffering from major depression.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Recurrent episodes of major depression

This consists of three or more episodes, two of which are in the past 5 years, with at least 6 months between episodes.

Remission

This is defined as a score below the predetermined threshold on the depression symptom rating scale used at the initial assessment and follow-up.

Quality Indicators

Process Indicators

Percentage of people in remission from their first episode of major depression with antidepressant medication therapy who are advised to continue antidepressants for at least 6 months after remission

- Denominator: total number of people in remission from their first episode of major depression with antidepressant medication
- Numerator: number of people in the denominator who are advised to continue antidepressant medication for at least 6 months after remission
- Data source: local data collection

8

Continuation of Antidepressant Medication CONTINUED FROM PAGE 27

Process Indicators CONTINUED

Percentage of people in remission from their first episode of major depression with antidepressant medication therapy who continue antidepressants for at least 6 months after remission

- Denominator: total number of people in remission from their first episode of major depression with antidepressant medication
- Numerator: number of people in the denominator who continue antidepressant medication for at least 6 months after remission
- Data source: local data collection

Percentage of people with recurrent episodes of major depression in remission with antidepressant medication therapy who are advised to continue antidepressants for at least 2 years after remission

- Denominator: total number of people with recurrent episodes of major depression who are in remission with antidepressant medication
- Numerator: number of people in the denominator who are advised to continue antidepressant medication for at least 2 years after remission
- Data source: local data collection

Percentage of people with recurrent episodes of major depression in remission with antidepressant medication therapy who continue antidepressants for at least 2 years after remission

- Denominator: total number of people with recurrent episodes of major depression who are in remission with antidepressant medication
- Numerator: number of people in the denominator who continue antidepressant medication for at least 2 years after remission
- Data source: local data collection

9

Electroconvulsive Therapy

People with severe or treatment-resistant major depression have access to electroconvulsive therapy.

Background

Electroconvulsive therapy is a safe and effective treatment for severe depression, particularly when symptoms have not responded to antidepressant medication and psychotherapy.[17] People with major depression should be made aware of the effects, side effects, and risks of electroconvulsive therapy so they can make an informed decision about this treatment. If electroconvulsive therapy is contraindicated or not chosen by the patient, repetitive transcranial magnetic stimulation may be considered as an alternative treatment.

Sources: American Psychiatric Association, 2010[6] | British Association for Psychopharmacology, 2015[11] | Canadian Network for Mood and Anxiety Treatments, 2009[1] | National Institute for Health and Clinical Excellence, 2009[8] | Veterans Affairs and the Department of Defense, 2009[10]

What This Quality Statement Means

For Patients

If your depression isn't getting better with antidepressants or psychotherapy, you should have access to electroconvulsive therapy.

For Clinicians

Offer and provide information about electroconvulsive therapy to patients who are not responsive to pharmacological and nonpharmacological treatments, or as maintenance therapy for patients who have had a positive response to it.

For Health Services

Ensure electroconvulsive therapy is available.

Quality Indicators

Process Indicators

Percentage of people with severe or treatment-resistant major depression who are offered electroconvulsive therapy

- Denominator: total number of people with severe or treatment-resistant major depression
- Numerator: number of people in the denominator who are offered electroconvulsive therapy
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Electroconvulsive therapy

This is typically provided about 3 times a week for 2 to 4 weeks.

Process Indicators CONTINUED

Percentage of people with severe or treatment-resistant major depression who receive electroconvulsive therapy

- Denominator: total number of people with severe or treatment-resistant major depression
- Numerator: number of people in the denominator who receive electroconvulsive therapy
- Data sources: local data collection, Ontario Health Insurance Plan Claims Database

Structural Indicator

Availability of electroconvulsive therapy

- Data source: local data collection

10

Assessment and Treatment for Recurrent Episodes

People with major depression who have reached full remission but are experiencing symptoms of relapse have timely access to reassessment and treatment.

Background

Recurrent episodes of depression are common among those who have experienced a first episode of major depression.[16] In such situations, it is vital that people have timely access to reassessment and the kinds of treatment that were effective for them in the past.

Source: Expert consensus

 CONTINUED FROM PAGE 32

What This Quality Statement Means

For Patients

You should receive care if you start feeling worse again after treatment.

For Clinicians

Assess and treat people with major depression who had reached full remission and who are experiencing symptoms of relapse, within 7 days or 4 weeks, depending on the severity of their symptoms.

For Health Services

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

Quality Indicators

Process Indicators

Percentage of people with mild to moderate major depression in full remission who receive a comprehensive assessment within 4 weeks after experiencing symptoms of relapse

- Denominator: total number of people with mild to moderate major depression in full remission who are experiencing symptoms of relapse
- Numerator: number of people in the denominator who receive a comprehensive assessment within 4 weeks of identification of relapse symptoms
- Data source: local data collection

Percentage of people with severe major depression in full remission who receive a comprehensive assessment within 7 days after experiencing symptoms of relapse

- Denominator: total number of people with severe major depression in full remission who are experiencing symptoms of relapse
- Numerator: number of people in the denominator who receive a comprehensive assessment within 7 days of identification of relapse symptoms
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Timely access

- **For severe depression:** within 7 days
- **For mild to moderate depression:** within 4 weeks

Recurrent episodes of major depression

This consists of three or more episodes, two of which are in the past 5 years, with at least 6 months between episodes.

11

Education and Support

People with major depression and their families and caregivers are offered education on major depression and information regarding community supports and crisis services.

Background

People with major depression and their family members and caregivers can benefit from education about the condition and information on services and supports available in their communities. Education aims to provide insight into the nature of major depression and the relevant signs and symptoms, as well as potential strategies for family members and caregivers to employ and help reduce the risk of relapse.

Sources: American Psychiatric Association, 2010[6] | Canadian Network for Mood and Anxiety Treatments, 2009[1] | National Institute for Health and Clinical Excellence, 2009[8] | Scottish Intercollegiate Guidelines Network, 2010[12] | Veterans Affairs and the Department of Defense, 2009[10]

What This Quality Statement Means

For Patients

You and your family and caregivers should be offered information about your condition, community supports, and crisis services.

For Clinicians

Offer people with major depression and their families and caregivers education on the nature of depression and information on community supports and crisis services.

For Health Services

Ensure the availability of appropriate education and information for people with major depression and their families and caregivers.

Quality Indicators

Process Indicator

Percentage of people with major depression who, along with their families and caregivers, are offered education about major depression and information regarding community supports and crisis services

- Denominator: total number of people with major depression
- Numerator: number of people in the denominator who, along with their families and caregivers, are offered education about major depression and information regarding community supports and crisis services
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Family members and caregivers

These include members of the person's family, natural supports, and caregivers who live with or are in close contact with the person with depression.

Education

This includes the following topics:

- Signs and symptoms of depression
- Treatment options and their 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
- Family self-care and resilience
- Local resources for support
- Risk of relapse, and early signs and symptoms of relapse

12

Transitions in Care

People with major depression who transition from one care provider to another have a documented care plan that is made available to them and their receiving provider 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 health care provider within 7 days.

Background

Transitions between care providers 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 care provider to another to have a care plan that is shared with them and between providers. Optimal communication and coordination of treatment with other health care professionals lessens the risk of relapse and can reduce side effects. If the person is being referred to a new provider, it is important to ensure that the new provider accepts the patient before transferring them.

A follow-up appointment after hospitalization helps to support the transition to the community. It can allow for the identification of medication-related issues; it also helps to maintain clinical and functional stability and aims to prevent readmission to hospital. It is especially important for people with major depression who are 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 caregivers should be notified of their potential risk for suicide.

Source: Expert consensus

What This Quality Statement Means

For Patients

If you move on to a new health care professional, you should each receive a written copy of your care plan from your previous health care professional and your first appointment should be scheduled within a specific timeline. For example, if you have major depression, you should see your new health care professional within 7 days of being discharged from hospital.

For Clinicians

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

For Health Services

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

Process Indicators

Percentage of people with major depression who transition from one care provider or care setting to another and have a documented care plan

- Denominator: total number of people with major depression who transition from one care provider or care setting to another
- Numerator: number of people in the denominator who have a documented care plan
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Documented care plan

The following information should be communicated to the patient, family, caregivers, and the receiving providers prior to the transition:

- 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

 CONTINUED FROM PAGE 37

Process Indicators CONTINUED

Percentage of people with major depression who transition from one care provider or care setting to another whose care plan specifies a timeline for follow-up

- Denominator: total number of people with major depression who transition from one care provider or care setting to another who have a documented care plan
- Numerator: number of people in the denominator whose care plan specifies a timeline for follow-up
- Data source: local data collection

Percentage of people with major depression who transition from one care provider or care setting to another and have their care plan made available to the receiving provider within 7 days

- Denominator: total number of people with major depression who transition from one care provider or care setting to another who have a documented care plan
- Numerator: number of people in the denominator whose care plan is made available to the receiving provider within 7 days
- Data source: local data collection

Percentage of people with major depression who are discharged from hospital who see a psychiatrist or primary care physician within 7 days of discharge

- Denominator: total number of people with major depression who are discharged from hospital
- Numerator: number of people who within 7 days of discharge of index hospitalization have at least one psychiatrist or primary care physician visit
- Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Ontario Health Insurance Plan Claims Database

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.

Summary

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.

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