Schizophrenia

Care for Adults in Hospitals
2023 Update

Quality Standards

Ontario Health

Scope of This Quality Standard

This quality standard addresses **care for adults aged 18 years and older with a primary diagnosis of schizophrenia** (including related disorders such as schizoaffective disorder) who are seen in an emergency department or admitted to an inpatient setting. This quality standard also includes guidance for the care of people who are transitioning from the inpatient setting to the community. Although this quality standard is focused on hospital care, some of the interventions described are likely to take place outside of the hospital following their initiation or a referral in hospital. All patients should have a follow-up visit after initiating any new treatment.

For a quality standard that addresses care for adults with schizophrenia in the community, please refer to *Schizophrenia: Care in the Community for Adults*.[1]

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 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

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

For more information, contact QualityStandards@OntarioHealth.ca.

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care in the hospital looks like for people with schizophrenia.

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Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia undergo a comprehensive interprofessional assessment that informs their care plan.

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Adults who present to an emergency department or in an inpatient setting with a primary diagnosis of schizophrenia are assessed for substance use and, if appropriate, offered treatment for concurrent disorders.

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Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

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Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered individual cognitive behavioural therapy for psychosis, either in the inpatient setting or as part of a post-discharge care plan.

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Adults with a primary diagnosis of schizophrenia who are discharged from an inpatient setting have a follow-up appointment within 7 days.

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2023 Summary of Updates

We completed a review of evidence in 2022 to capture new or updated clinical practice guidelines and health technology assessments published since the original release of this quality standard in 2016. The present review and update aligns the quality standard with the most recent clinical evidence and current practice in the Ontario landscape.

Below is a summary of general updates to the overall quality standard:

- Added the American Psychiatric Association 2020 practice guideline for the treatment of patients with schizophrenia[2]
- Removed the 2017 Canadian Psychiatric Association clinical practice guidelines for the treatment of schizophrenia, because they no longer met the inclusion criteria for guideline selection (being an original guideline)
- Updated links, secondary references, and data sources where applicable
- Added references to the *Schizophrenia: Care in the Community for Adults*[1] quality standard
- Updated formatting to align with current design and branding
- Updated accompanying quality standard resources to reflect any changes to the quality standard and to align with current design and branding (e.g., patient guide, case for improvement slide deck, measurement guide)
- Updated data in the case for improvement slide deck and data tables

Below is a summary of changes to specific quality statements:

- Quality statement 1: under Definitions, revised bullets for clarity; added assessment for post-traumatic stress disorder and other reactions to trauma
- Quality statement 2: under Background, added references to the *Opioid Use Disorder*[3] and *Problematic Alcohol Use and Alcohol Use Disorder*[4] quality standards
- Quality statement 4: revised the Background section with person-centred language
- Quality statement 5: added a qualifier to the quality statement (i.e., "who smoke tobacco"); under Definitions, updated products for nicotine replacement therapy to reflect availability in Ontario and corrected categorization of non–nicotine replacement drug therapies

- Quality statement 6: in the quality statement, Definitions, and Background, revised wording with person-centred language. Under Background, added potential adverse effects and importance of ongoing physical health monitoring
- Quality statement 7: under Definitions and What This Quality Statement Means, updated the frequency of long-acting injectable antipsychotics to reflect new pharmacological options. Under What This Quality Statement Means, revised wording with person-centred language
- Quality statement 9: under Definitions, revised the definition of Family with person-centred language; under Background, added for clarity that family intervention can start in the inpatient setting or community and added a reference to the *Schizophrenia: Care in the Community for Adults*[1] quality standard
- Quality statement 11: under Definitions, revised for clarity; under Background, added reference to the *Schizophrenia: Care in the Community for Adults*[1] and *Transitions Between Hospital and Home Care*[5] quality standards
- Minor wording changes to other quality statements and indicators where applicable

Why This Quality Standard Is Needed

Schizophrenia is a severe and chronic mental health condition that usually begins when a person is in late adolescence or early adulthood. The symptoms of schizophrenia can be categorized as positive, negative, or cognitive. Positive symptoms include hallucinations, delusions, and disorganized speech and behaviour.[6] Negative symptoms include social withdrawal and a loss of interest.[6] Cognitive features include problems with memory, attention, planning, and organizing.[7]

In Canada, about 1% of the population has schizophrenia.[8] The disorder ranks in the top five conditions that have the highest impact on the life and health of people in Ontario.[9] Schizophrenia is more common in men, in people living in cities, and in families of recent immigrants.[8,10]

People with schizophrenia die at a rate that is three times higher than that of the general population and die up to 15 years earlier; the majority of these premature deaths are the result of cardiovascular disease.[11,12] People with schizophrenia are also much more likely to die by suicide compared to people without

schizophrenia.[13,14] In addition, people with schizophrenia have an increased risk of substance use, homelessness, and unemployment.[15,16] [16]

There are substantial gaps in the quality of care that people with schizophrenia receive in Ontario: only 26.8% of people discharged from a schizophrenia-related hospitalization receive the recommended follow-up visit with a physician within 7 days; people hospitalized for schizophrenia have a high rate (16.6%) of readmission within 30 days of discharge[17]; and rates of emergency department visits for schizophrenia vary widely across the province (ICES, unpublished data, 2023).

People with schizophrenia often also encounter stigma or beliefs and attitudes that lead to negative stereotyping of them and their illness. Stigma, or the perception of stigma, can negatively affect people's ability to tell friends and family about their illness, and to seek help. Stigma may also affect their ability to access health care services.

This quality standard includes 11 quality statements that address areas identified by the Schizophrenia Care in the Hospital Quality Standard Advisory Committee as having high potential to improve care in the hospital for people with schizophrenia in Ontario.

Measurement to Support Improvement

The Schizophrenia Care in the Hospital Quality Standard Advisory Committee identified six overarching indicators to monitor the progress being made toward improving care for people with schizophrenia in Ontario.

Indicators That Can Be Measured Using Provincial Data

- Number of deaths by inpatient suicide among adults with a primary diagnosis of schizophrenia
- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who die by suicide within 30 days of discharge
- Rates of readmission to any facility within 7 days and 30 days of discharge, stratified by the reason for readmission:
    - Any reason
    - A reason related to mental health and addictions
    - Schizophrenia

- Rates of unscheduled emergency department visits after hospital inpatient discharge within 7 days and 30 days, stratified by the reason for the visit:
  - Any reason
  - A reason related to mental health and addictions
  - Schizophrenia
  - Self-harm

Indicators That Can Be Measured Using Only Local Data

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who experience an improvement in behavioural symptoms between admission and discharge, stratified by their length of stay
- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who experience an improvement in positive symptoms between admission and discharge, stratified by their length of stay

Quality Statements to Improve Care

01

Comprehensive Interprofessional Assessment

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia undergo a comprehensive interprofessional assessment that informs their care plan.

Sources: American Psychiatric Association, 2020[2] | National Institute for Health and Care Excellence, 2014[16]

Definition

Comprehensive interprofessional assessment: This should be undertaken by health care professionals with expertise in the care of people with schizophrenia and ideally be informed by communication with the individual's primary care and/or community treatment providers. The assessment should address the following domains:

- Current sources of distress, including psychiatric symptoms and impairments
- Risk of harm to self or others
- Physical health and well-being (see Quality Statement 3)
- Psychological and psychosocial status (including social networks, intimate relationships, and history of trauma or adversity); consider an assessment for post-traumatic stress disorder and other reactions to trauma
- Developmental history (social, cognitive, sensory, and motor development and skills, including coexisting neurodevelopmental conditions)
- Social status (housing, culture and ethnicity, responsibilities for children or as a caregiver, role of family and their involvement in the person's life, leisure activities and recreation, community participation, participation in peer and self-help activities)
- Occupational and educational histories (educational attainment, employment, activities of daily living) and financial status

- Medical history and physical examination to assess medical conditions, nutritional status, and any prescribed drug treatments that may result in psychosis
- History of substance use (see Quality Statement 2)
- Legal history and current legal involvement, if any
- Self-identified goals and aspirations that are aligned with personal recovery
- Treatment history (including medication duration and dosages) and psychosocial interventions
- Activities of daily living, instrumental activities of daily living, and home management
- Capacity to make personal care and financial decisions, as described in the *Ontario Substitute Decisions Act*[5]
- Level of service needs (assessed using a tool or instrument such as the Level of Care Utilization System [LOCUS]) to match resource intensity with care needs

Background

An assessment undertaken by an interprofessional health care team—ideally, informed by family, caregivers, and/or personal supports—provides an opportunity to thoroughly examine biological, psychological, and social factors that may have contributed to the onset, course, and outcome of the illness. An assessment can establish a diagnosis and determine a baseline level of functioning to track potential changes in the person's status. It should identify targets for intervention and treatment, as well as the person's own goals.

What This Quality Statement Means

For Adults With Schizophrenia

You should receive a full assessment every time you are admitted to hospital. 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 medical history, what medications you are taking, your social situation, and your goals for recovery.

For Clinicians

For people admitted with a primary diagnosis of schizophrenia, carry out a comprehensive interprofessional assessment, as described in the Definitions

section of this statement. The results of these assessments will inform people's care plans.

For Health Services

Ensure that systems, processes, and resources are available in inpatient settings for teams to carry out comprehensive assessments of people with schizophrenia. This includes access to standardized assessment tools and protocols, and timely access to relevant sources of information to support comprehensive assessments.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who receive a comprehensive interprofessional assessment
- Ability to generate Clinical Assessment Protocols from the Resident Assessment Instrument–Mental Health (RAI-MH) data collection system for people with schizophrenia
- Access to an interprofessional team, within the hospital, for people with schizophrenia

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

02

Screening for Substance Use

Adults who present to an emergency department or in an inpatient setting with a primary diagnosis of schizophrenia are assessed for substance use and, if appropriate, offered treatment for concurrent disorders.

Sources: American Psychiatric Association, 2020[2] | National Institute for Health and Care Excellence, 2014[16] | Scottish Intercollegiate Guidelines Network, 2013[18]

Definition

Substance use: This is the harmful use of alcohol, prescription or nonprescription medications, or illicit drugs.

Background

Substance use is common among people with schizophrenia and is associated with poor functional recovery. Substance use may exacerbate the symptoms and worsen the course of schizophrenia, and it may interfere with the therapeutic effects of both pharmacological and nonpharmacological treatments. Validated screening tools such as the Dartmouth Assessment of Lifestyle Inventory and the Leeds Dependence Questionnaire can assist with screening for substance use.

Further information is available in the *Opioid Use Disorder*[3] and *Problematic Alcohol Use and Alcohol Use Disorder*[4] quality standards.

What This Quality Statement Means

For Adults With Schizophrenia

When you are in hospital, you should be assessed for the use of alcohol or drugs, because they might make your symptoms worse and interfere with treatment.

For Clinicians

Conduct an assessment for substance use in people with a primary diagnosis of schizophrenia who present to the emergency department or an inpatient setting.

Initiate a referral for treatment of concurrent disorders for people who use substances in a harmful manner.

For Health Services

Ensure that hospitals are able to assess and provide treatment for concurrent disorders for people with schizophrenia who use alcohol, prescription or nonprescription medications, or illicit drugs in a harmful manner.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults presenting to hospital with a primary diagnosis of schizophrenia who are assessed for substance use
- Percentage of adults presenting to hospital with a primary diagnosis of schizophrenia and a substance use disorder who are offered treatment for concurrent disorders

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

03

Physical Health Assessment

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia undergo a physical health assessment focusing on conditions common in people with schizophrenia. This assessment informs their care plan.

Sources: American Psychiatric Association, 2020[2] | National Institute for Health and Care Excellence, 2014[16] | Scottish Intercollegiate Guidelines Network, 2013[18]

Definition

Physical health assessment: This should include:

- Weight, body mass index, and waist circumference
- Pulse and blood pressure
- Fasting blood glucose or glycated hemoglobin (HbA_{1c})
- Lipid panel (total cholesterol, low- and high-density lipoproteins, triglycerides)
- Extrapyramidal signs and symptoms
- Overall physical health (with particular attention to common findings such as cardiovascular disease and lung disease)
- Age-appropriate physical health screening
- Nutritional intake

Background

Adults with schizophrenia have poorer physical health and a shorter life expectancy than the general population: people with schizophrenia die at a rate that is three times higher than that of the general population and die up to 15 years earlier.[11,12] The most common cause of premature death is cardiovascular disease, owing partly to modifiable risk factors such as obesity, smoking, diabetes, hypertension, and dyslipidemia.[19] Antipsychotic medications can be

associated with weight gain and can aggravate other metabolic or cardiovascular risk factors. There is a need to comprehensively assess physical health—with a particular emphasis on cardiovascular risk factors and diabetes—to enable treatment if necessary.

What This Quality Statement Means

For Adults With Schizophrenia

You should have a physical examination every time you are admitted to hospital. It should focus on conditions that are common in schizophrenia (for example, heart disease and diabetes), and it should be used to develop your care plan.

For Clinicians

Complete a physical assessment that focuses on conditions common in people with schizophrenia. The results of these assessments will inform their care plans.

For Health Services

Ensure that systems, processes, and resources are in place for health care teams to carry out comprehensive physical health assessments of people with schizophrenia while they are in the hospital. This includes access to standardized physical assessment protocols and tools.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who received a comprehensive physical health assessment (including a metabolic workup) within the past year
- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who did not receive a comprehensive physical health assessment (including a metabolic workup) within the past year but receive one during the current hospitalization

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

04

Promoting Physical Activity and Healthy Eating

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered interventions that promote both physical activity and healthy eating.

Sources: National Institute for Health and Care Excellence, 2014[16] | Scottish Intercollegiate Guidelines Network, 2013[18]

Definition

Interventions that promote physical activity and healthy eating: These behavioural interventions, offered in hospital, may follow a chronic illness self-management model or an information-based approach. They provide information and support to increase levels of physical activity and healthy eating.

Background

There are many reasons why people with schizophrenia experience a higher incidence of physical health conditions (see Quality Statement 3), but one important group of causes is lifestyle factors, including poor nutrition and a lack of physical activity.[16] Offering interventions that promote both physical activity and healthy eating to people with schizophrenia can help to improve their physical and mental health. As well, several of the medications used to treat schizophrenia may cause weight gain. This side effect should be mitigated as much as possible by encouraging physical activity and healthy eating.

What This Quality Statement Means

For Adults With Schizophrenia

You should be offered services or programs that encourage you to exercise and eat in a healthy way. These steps can help improve your physical and mental health.

For Clinicians

Offer people with schizophrenia combined interventions that promote physical activity and healthy eating.

For Health Services

Ensure that combined interventions are available in hospitals that promote physical activity and healthy eating for people with schizophrenia.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who receive interventions that promote physical activity and/or healthy eating
- Availability of programs that promote physical activity or healthy eating for adults admitted to an inpatient setting with a primary diagnosis of schizophrenia

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

05

Promoting Smoking Cessation

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia and who smoke tobacco are offered behavioural and pharmacological interventions to alleviate nicotine-withdrawal symptoms and to help them reduce or stop smoking tobacco.

Source: National Institute for Health and Care Excellence, 2014[16]

Definition

Interventions to help people reduce or stop smoking tobacco: These interventions may be offered in hospital and include:

- Motivational interviewing
- Behavioural support
- Nicotine replacement therapy products (e.g., transdermal patches, gum, inhalation cartridges, lozenges, or sprays)
- Adequately dosed pharmacotherapy (i.e., varenicline or bupropion)

Background

Rates of cigarette smoking among people with schizophrenia are much higher than in the general population.[20] High tobacco use contributes to the main causes of morbidity and mortality in people with schizophrenia.[21] Tobacco use may also interfere with the effectiveness and mechanisms of action of certain antipsychotic medications.[22] People with schizophrenia should be offered interventions to help them stop or reduce smoking that are aligned with their readiness for change.

What This Quality Statement Means

For Adults With Schizophrenia

You should be offered services or programs that may help you to stop smoking or smoke less. Quitting or cutting down on smoking can help improve your physical and mental health.

For Clinicians

Offer smoking-cessation behavioural interventions, counselling, or medications to people with schizophrenia who smoke tobacco to alleviate their nicotine-withdrawal symptoms and help them reduce or stop smoking.

For Health Services

Ensure that smoking-cessation behavioural interventions and medications are available in hospitals for people with schizophrenia who smoke.

QUALITY INDICATOR: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia who smoke tobacco and who receive smoking cessation behavioural and/or pharmacological interventions

Measurement details for this indicator, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

06

Treatment With Clozapine

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia, and whose symptoms have not responded to previous adequate trials of treatment with two different antipsychotic medications, are offered clozapine.

Sources: American Psychiatric Association, 2020[2] | National Institute for Health and Care Excellence, 2014[16] | Scottish Intercollegiate Guidelines Network, 2013[18]

Definition

Symptoms have not responded: People's symptoms have not responded [to treatment] if they continue to experience prominent positive symptoms (such as hallucinations, delusions, and disorganized thinking or behaviour[23]) after trials of two different antipsychotic medications at adequate dosage and duration, and with reasonable assurance of medication adherence during the trials. The trials may or may not have been initiated in an inpatient setting.

Background

Clozapine is uniquely effective and is the treatment of choice for people with schizophrenia whose symptoms have not responded to other antipsychotic medications, or whose symptoms have responded partially but psychotic symptoms persist.[16] A trial of clozapine should also be considered for people with schizophrenia who experience substantial side effects from other antipsychotic medications,[15] who exhibit persistent symptoms of aggression or violent behaviours, or who have persistent suicidal thoughts or behaviours.[2]

Like other antipsychotic medications, clozapine is associated with a range of adverse effects that can influence physical health, and it requires ongoing physical health assessment and management (see Quality Statement 3).[39] Clozapine is also associated with an increased risk of several severe adverse effects, including agranulocytosis, myocarditis, cardiomyopathy, and bowel obstruction. Protocols to monitor and manage these risks need to be followed rigorously.[24]

What This Quality Statement Means

For Adults With Schizophrenia

If you have tried at least two different antipsychotic medications and your symptoms continue to be distressing, you should be offered clozapine. Clozapine is taken orally.

For Clinicians

Offer people with schizophrenia clozapine if they have tried two antipsychotic medications and their symptoms have not improved or remain distressing.

For Health Services

Through adequately resourced systems and services, ensure that clinicians are able to offer clozapine as a treatment for people with schizophrenia who are admitted to hospital, and monitor and manage the risks associated with clozapine.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia whose symptoms have not responded to adequate trials of treatment with at least two different antipsychotic medications and who are offered clozapine
- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia whose symptoms have not responded to adequate trials of treatment with at least two different antipsychotic medications, and who receive clozapine

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

07

Treatment With Long-Acting Injectable Antipsychotic Medication

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

Sources: American Psychiatric Association, 2020[2] | National Institute for Health and Care Excellence, 2014[16] | Scottish Intercollegiate Guidelines Network, 2013[18] | World Health Organization, 2012[24]

Definition

Long-acting injectable antipsychotic medication: These medications are injected every 2 weeks to every 3 months. The option of treatment with long-acting injectable antipsychotic medications should be offered early in the course of antipsychotic treatment.

Background

Long-acting injectable antipsychotic medications can improve treatment adherence and prevent relapse. Relapse into more active psychosis may affect the overall course of the illness. Unlike treatment with oral antipsychotic medications, treatment with long-acting injectable medications can help clinicians know a person's level of medication adherence. Further potential advantages include a reduced risk of unintentional or deliberate overdose, and the need for regular contact between the person and the health care team.[25] People with schizophrenia who have long-acting injectable medication initiated in the hospital require a scheduled follow-up appointment to continue their treatment.

What This Quality Statement Means

For Adults With Schizophrenia

You may want to take your antipsychotic medication as a long-acting injection so you don't have to remember to take it every day. Your health care professional should talk with you early in your treatment about whether this would be a good option for you. Depending on the medication, you would get an injection every

2 weeks to every 3 months. Not all antipsychotic medications can be given as a long-acting injection.

For Clinicians

Offer the option of long-acting injectable antipsychotic medications to people with schizophrenia. Offer this option early in the course of antipsychotic treatment.

For Health Services

Through adequately resourced systems and services, ensure that clinicians are able to offer long-acting injectable antipsychotic medications to people with schizophrenia.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who are offered a long-acting injectable antipsychotic medication
- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who receive a long-acting injectable antipsychotic medication

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

08

Cognitive Behavioural Therapy for Psychosis

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered individual cognitive behavioural therapy for psychosis, either in the inpatient setting or as part of a post-discharge care plan.

Sources: American Psychiatric Association, 2020[2] | Health Quality Ontario, 2018[26] | National Institute for Health and Care Excellence, 2014[16] | Scottish Intercollegiate Guidelines Network, 2013[18] | World Health Organization, 2012[24]

Definition

Cognitive behavioural therapy for psychosis: This therapy should be:

- Started in the inpatient setting. Alternatively, assessment should occur in hospital, with referral for cognitive behavioural therapy on discharge
- Delivered on a one-to-one basis over at least 16 planned sessions
- Delivered by an appropriately trained health care professional in accordance with a treatment manual

Background

Cognitive behavioural therapy is a form of psychotherapy that helps a person become more conscious of their beliefs and patterns of thinking. It helps them to execute strategies to reshape their beliefs and thoughts to achieve a positive outcome. Cognitive behavioural therapy for psychosis, in addition to antipsychotic medication, can reduce symptom severity and rehospitalization rates in people with schizophrenia.[16]

What This Quality Statement Means

For Adults With Schizophrenia

You should be offered cognitive behavioural therapy. This type of psychotherapy helps you develop skills and strategies to get healthy and stay healthy by

focusing on the problems of day-to-day life and how your perceptions can affect your feelings.

For Clinicians

Offer people with schizophrenia individual cognitive behavioural therapy for psychosis that they can access in hospital or in the community after discharge. Advise them that this therapy is more effective when delivered in conjunction with antipsychotic medication.

For Health Services

Through adequately resourced systems and services, ensure that people with schizophrenia can access individual cognitive behavioural therapy for psychosis, either in hospital or in the community following discharge. Ensure that clinicians are aware of and able to refer people to these services.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who are screened for the appropriateness of cognitive behavioural therapy for psychosis
- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who are screened and referred for cognitive behavioural therapy for psychosis
- Availability of in-hospital cognitive behavioural therapy or referral to community-based cognitive behavioural therapy for adults with schizophrenia

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

09

Family Intervention

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered family intervention.

Sources: American Psychiatric Association, 2020[2] | National Institute for Health and Care Excellence, 2014[16] | Scottish Intercollegiate Guidelines Network, 2013[18] | World Health Organization, 2012[24]

Definitions

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

Family intervention: This intervention should:

- Include at least 10 planned sessions (these may be part of the inpatient setting; planning for subsequent sessions should be part of the discharge planning
- Be delivered by an appropriately trained health care provider
- Involve the person with schizophrenia whenever possible
- Be sensitive to the cultural and spiritual characteristics of the individual and their family
- Take account of the whole family's preference for either single-family intervention or multi-family group intervention
- Consider the relationship between the family and the person with schizophrenia
- Involve communication skills, problem solving, and education
- Have reasons discussed and documented when a patient chooses not to involve their family

Background

Family intervention aims to improve support and resilience and enhance the quality of communication and problem solving with the family, caregivers, and personal supports of a person with schizophrenia. It also seeks to provide insight into the person's condition and the relevant signs and symptoms to improve the ability of family members to anticipate and help reduce the risk of relapse.[27] Family intervention can be started in the inpatient setting or community.[16] Further information is available in the *Schizophrenia: Care in the Community for Adults*[1] quality standard.

What This Quality Statement Means

For Adults With Schizophrenia

Interventions should be offered to your family, caregivers, and personal supports to help them understand schizophrenia and its signs and symptoms. This will allow them to better support you, help you cope, and help to prevent relapse.

For Clinicians

Encourage people with schizophrenia to involve their family in their care. Offer families education and supports that align with their circumstances and needs.

For Health Services

Through adequately resourced systems and services, ensure that health care providers in hospitals can offer family intervention to people with schizophrenia and their families.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who receive family intervention
- Availability of in-hospital family intervention programs or referral to community-based family intervention programs for adults with schizophrenia and their family members

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

10

Follow-Up Appointment After Discharge

Adults with a primary diagnosis of schizophrenia who are discharged from an inpatient setting have a follow-up appointment within 7 days.

Source: Advisory committee consensus

Definition

Follow-up appointment: This visit can be with a health care provider (e.g., case worker, general or family practitioner, nurse practitioner, occupational therapist, psychiatrist, psychologist, social worker, or trained peer support worker)

Background

A follow-up appointment after hospitalization helps to support a person's 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. Further information is available in the *Transitions Between Hospital and Home*[5] quality standard.

What This Quality Statement Means

For Adults With Schizophrenia

Before you leave the hospital, you should have a follow-up appointment scheduled with your health care provider in the community.

For Clinicians

Make arrangements for people with schizophrenia who are discharged from hospital to receive a follow-up appointment within 7 days of discharge.

For Health Services

Ensure that systems, processes, and resources are in place for health care teams to arrange for a follow-up appointment for people within 7 days of discharge from an inpatient setting.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who have a follow-up appointment with a health care provider within 7 days of discharge
- Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who have a follow-up appointment with a physician (primary care provider or psychiatrist) within 7 days of discharge

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

11

Transitions in Care

Adults with a primary diagnosis of schizophrenia who are discharged from an inpatient setting have a team or provider who is accountable for communication and the coordination and delivery of a care plan that is tailored to their needs.

Source: Advisory committee consensus

Definition

Transitions in care: These occur when individuals transfer between different care settings (e.g., hospital, primary care, long-term care, home and community care) or between health care providers during the course of an acute or chronic illness. This process includes:

- Transfer of the care plan
- Provision of treatment history, including treatments that have succeeded and those that have failed
- Arrangements for housing
- Arrangements for follow-up services in the community for the patient as well as for any family, caregivers, and personal supports involved in their recovery
- Provision of an assessment of the level of service needs (assessed using a tool or instrument such as the Level of Care Utilization System [LOCUS]) to match resource intensity with care needs

Background

Transitions in care are important events that can introduce the risk of breakdowns in a person's care and of crucial information being lost or miscommunicated. It is important for people with schizophrenia who are leaving hospital to have a care plan that is shared between their providers in hospital and those in the community. Further information is available in the *Schizophrenia: Care in the*

Community for Adults[1] and *Transitions Between Hospital and Home*[5] quality standards.

What This Quality Statement Means

For Adults With Schizophrenia

When you are preparing to leave hospital, your health care professionals at the hospital should work with you to make sure that all important information is transferred to your health care provider or care team in the community and that you are connected to the supports that you need.

For Clinicians

When discharging people to the community, send their care plan to their team or provider who will be accountable for coordinating, communicating, and providing their care on an ongoing basis.

For Health Services

Ensure that systems, processes, and resources are in place for health care teams to share health information between settings, including communication platforms, standardized protocols, and tools (such as discharge planning protocols). Specifically, ensure that hospitals are able to share care plans with providers in the community once people are discharged.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults discharged from hospital with a primary diagnosis of schizophrenia who have their care plan made available to the receiving provider within 7 days
- Percentage of adults discharged from hospital with a primary diagnosis of schizophrenia who are experiencing homelessness

Measurement details for these indicators, as well as indicators to measure overarching goals for the entire quality standard, are presented in Appendix 2.

Emerging Practice Statement: Nonpharmacological Interventions in Hospital

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

Apart from cognitive behavioural therapy for psychosis and family intervention, we cannot provide guidance at this time on the use of other nonpharmacological treatments in acute care for adults who are admitted with a primary diagnosis of schizophrenia. There is a paucity of evidence or uncertainty in the evidence base relating to the effectiveness of such treatments; further evidence is needed before a quality statement can be developed.

Appendices

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 Schizophrenia

This quality standard consists of quality statements. These describe what high-quality care looks like in hospital for people with schizophrenia.

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

In addition, you may want to download this accompanying patient guide for people with schizophrenia who are in the hospital, to help you and your family have informed conversations with your health care providers. 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 in the hospital looks like for people with schizophrenia. 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 (Appendix 2). 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 schizophrenia care for adults in hospitals, which you can share with patients and families to help them have conversations with you and their other health care providers. Please make the patient guide available where you provide care
- Our measurement resources, which include our measurement guide of technical specifications for the indicators in this quality standard, and our "case for improvement" slide deck to help you to share why this standard was created and the data behind it
- 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 health care providers can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard
- The Health Equity Impact Assessment tool, which can help your organization consider how programs and policies impact population groups differently. This tool can help maximize positive impacts and reduce negative impacts, with an aim of reducing health inequities between population groups

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 health care professionals 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. Measurement to Support Improvement

The Schizophrenia Care for Adults in Hospitals Quality Standard Advisory Committee identified six indicators for this quality standard. These indicators can be used to monitor the progress being made to improve care in the hospital for adults with schizophrenia in Ontario. Some indicators are provincially measurable, while some can be measured using only locally sourced data.

Using data from these indicators will help you assess the quality of care you are delivering and the effectiveness of your quality improvement efforts. We realize this standard includes a lengthy list of statement-specific indicators. These indicators are provided as examples; you may wish to create your own quality improvement indicators based on the needs of your population. We recommend you identify areas to focus on in the quality standard and then use one or more of the associated indicators to guide and evaluate your quality improvement efforts.

To assess equitable delivery of care, you can collect data for locally measured indicators by patient socioeconomic and demographic characteristics, such as age, education, gender, income, language, race, and sex.

Our measurement guide provides more information and concrete steps on how to incorporate measurement into your planning and quality improvement work.

Measurement to support improvement

Indicators That Can Be Measured Using Provincial Data

Number of deaths by inpatient suicide among adults with a primary diagnosis of schizophrenia

- Denominator: number of acute care discharges in which schizophrenia is coded as the most responsible diagnosis
- Numerator: number of adults in the denominator who were discharged due to death by suicide
- Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who die by suicide within 30 days of discharge

- Denominator: number of acute care discharges in which schizophrenia is coded as the most responsible diagnosis

- Numerator: number of adults in the denominator who die within 30 days of discharge, with the leading cause of death identified as suicide
- Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Canadian Vital Statistics Death Database (Statistics Canada)

Rates of readmission to any facility within 7 days and 30 days of hospital discharge with a primary diagnosis of schizophrenia, stratified by the reason for readmission:

  - Any reason
  - A reason related to mental health and addictions
  - Schizophrenia

- Denominator: total number of acute care discharges from an episode of care in which schizophrenia was coded as the most responsible diagnosis
- Numerator: number of people in the denominator with subsequent readmission to an acute care hospital within 7 and 30 days of index hospitalization discharge for (1) any reason, (2) a mental health and addictions condition, or (3) a most responsible diagnosis of schizophrenia
- Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System

Rates of unscheduled emergency department visits after a hospital discharge with a primary diagnosis of schizophrenia within 7 days and 30 days, stratified by the reason for the visit:

  - Any reason
  - A reason related to mental health and addictions
  - Schizophrenia
  - Self-harm

- Denominator: total number of acute care discharges from an episode of care in which schizophrenia was coded as the most responsible diagnosis
- Numerator: number of people in the denominator with a subsequent unscheduled emergency department visit within 7 and 30 days of an index hospitalization discharge for (1) any reason, (2) a mental health and addictions condition, (3) a main problem of schizophrenia, or (4) a main problem or other problem of self-harm
- Data sources: Discharge Abstract Database, National Ambulatory Care Reporting System, Ontario Mental Health Reporting System

Indicators That Can Be Measured Using Only Local Data

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who experience an improvement in behavioural symptoms between admission and discharge, stratified by their length of stay

- Denominator: total number of acute care discharges in which schizophrenia was coded as the most responsible diagnosis
- Numerator: number of people in the denominator who experience an improvement in behavioural symptoms between admission and discharge
- Data sources: Ontario Mental Health Reporting System, Discharge Abstract Database, local data collection

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who experience an improvement in positive symptoms between admission and discharge, stratified by their length of stay

- Denominator: total number of acute care discharges in which schizophrenia was coded as the most responsible diagnosis
- Numerator: number of people in the denominator who experience an improvement in positive symptoms between admission and discharge
- Data sources: Ontario Mental Health Reporting System, Discharge Abstract Database, local data collection

How to Measure Improvement for Specific Statements

Quality Statement 1: Comprehensive Interprofessional Assessment

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who receive a comprehensive interprofessional assessment

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia
- Numerator: number of people in the denominator who receive a comprehensive interprofessional assessment
- Data sources: data could be reported through the Ontario Mental Health Reporting System.

Ability to generate Clinical Assessment Protocols from the Resident Assessment Instrument – Mental Health (RAI-MH) for people with schizophrenia

- Data source: local data collection

Access to an interprofessional team, within the hospital, for people with schizophrenia

- Data source: local data collection

Quality Statement 2: Screening for Substance Use

Percentage of adults presenting to hospital with a primary diagnosis of schizophrenia who are assessed for substance use

- Denominator: total number of adults admitted to an inpatient setting or seen in the emergency department who have a primary diagnosis of schizophrenia
- Numerator: number of people in the denominator who are assessed for substance use
- Data source: local data collection

Percentage of adults presenting to hospital with a primary diagnosis of schizophrenia who are found to have a substance use disorder and are offered treatment for concurrent disorders

- Denominator: total number of adults admitted to an inpatient setting or seen in the emergency department who have a primary diagnosis of schizophrenia and a substance use disorder (excludes adults who have received a referral for treatment for concurrent disorders for which they are currently awaiting initiation)
- Numerator: number of people in the denominator who are offered treatment for concurrent disorders
- Data source: local data collection

Quality Statement 3: Physical Health Assessment

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who received a comprehensive physical health assessment, (including a metabolic workup) within the past year

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia
- Numerator: number of people in the denominator who received a comprehensive physical health assessment (including a metabolic workup) within the past year
- Data source: local data collection

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who did not receive a comprehensive physical health assessment, including metabolic workup, within the past year but receive one during the current hospitalization

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia who did not receive a comprehensive physical health assessment (including a metabolic workup) within the past year
- Numerator: number of people in the denominator who receive a comprehensive physical health assessment (including a metabolic workup) during the current hospitalization
- Data source: local data collection

Quality Statement 4: Promoting Physical Activity and Healthy Eating

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who receive interventions that promote physical activity and/or healthy eating

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia
- Numerator: number of people in the denominator who:
  - Receive interventions promoting physical activity
  - Receive interventions promoting healthy eating
  - Receive interventions promoting both physical activity and healthy eating
- Data source: local data collection

Availability of programs that promote physical activity or healthy eating for adults admitted to an inpatient setting with a primary diagnosis of schizophrenia

- Data source: local data collection

Quality Statement 5: Promoting Smoking Cessation

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who smoke tobacco and who receive smoking cessation behavioural and/or pharmacological interventions

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia who smoke tobacco or who are quitting smoking tobacco but experiencing nicotine-withdrawal symptoms

- Numerator: number of people in the denominator who receive behavioural and/or pharmacological interventions to alleviate nicotine-withdrawal symptoms and help them reduce or stop smoking tobacco
- Data source: local data collection

Quality Statement 6: Treatment With Clozapine

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia whose symptoms have not responded to adequate trials of treatment with at least two different antipsychotic medications and who are offered clozapine

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia whose symptoms have not responded to adequate trials of treatment with at least two antipsychotic medications
- Numerator: number of people in the denominator who are offered clozapine
- Data source: local data collection

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia whose symptoms have not responded to adequate trials of treatment with at least two different antipsychotic medications and who receive clozapine

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia whose symptoms have not responded to adequate trials of treatment with at least two different antipsychotic medications and who were offered clozapine
- Numerator: number of people in the denominator who receive clozapine
- Data source: OMHRS, local data collection
- Note: A similar indicator, "treatment with clozapine," is available from the Ontario Hospital Association

Quality Statement 7: Treatment With Long-Acting Injectable Antipsychotic Medication

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who are offered a long-acting injectable antipsychotic medication

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia

- Numerator: number of people in the denominator who are offered a long-acting injectable antipsychotic medication
- Data source: local data collection

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who receive a long-acting injectable antipsychotic medication

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia
- Numerator: number of people in the denominator who receive a long-acting injectable antipsychotic medication
- Data source: OMHRS, local data collection
- Note: A similar indicator, "treatment with a long-acting injectable (LAI) antipsychotic medication," is available from the Ontario Hospital Association

Quality Statement 8: Cognitive Behavioural Therapy for Psychosis

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who are screened for the appropriateness of cognitive behavioural therapy for psychosis

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia
- Numerator: number of people in the denominator who are screened for the appropriateness of cognitive behavioural therapy for psychosis
- Data source: local data collection

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who are screened and referred for cognitive behavioural therapy for psychosis

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia who are screened and deemed appropriate for cognitive behavioural therapy for psychosis
- Numerator: number of people in the denominator who are referred for cognitive behavioural therapy for psychosis
- Data source: local data collection

Availability of in-hospital cognitive behavioural therapy or referral to community-based cognitive behavioural therapy for adults with schizophrenia

- Data source: local data collection

Quality Statement 9: Family Intervention

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who receive family intervention

- Denominator: total number of adults admitted to an inpatient setting with a primary diagnosis of schizophrenia (excludes those without a family and those who do not consent to family involvement)
- Numerator: number of people in the denominator who:
  - Receive family intervention during the inpatient stay *or*
  - Have family intervention arranged in their discharge plan
- Data source: local data collection

Availability of in-hospital family intervention programs or referral to community-based family intervention programs for adults with schizophrenia and their family members

- Data source: local data collection

Quality Statement 10: Follow-Up Appointment After Discharge

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who have a follow-up appointment with a health care provider within 7 days of discharge

- Denominator: total number of adults discharged from an inpatient setting after an admission for a primary diagnosis of schizophrenia
- Numerator: number of people in the denominator who have a follow-up appointment with a health care provider within 7 days of discharge
- Data source: Discharge Abstract Database, Ontario Mental Health Reporting System, local data collection, measurable for physicians who bill for services using the Ontario Health Insurance Plan

Percentage of adults admitted to hospital with a primary diagnosis of schizophrenia who have a follow-up appointment with a physician (primary care provider or psychiatrist) within 7 days of discharge

- Denominator: total number of adults discharged from an inpatient setting after an admission for a primary diagnosis of schizophrenia

- Numerator: number of people in the denominator who have a follow-up appointment with a physician (primary care provider or psychiatrist) within 7 days of discharge
- Data sources: Discharge Abstract Database, Ontario Mental Health Reporting System, Ontario Health Insurance Plan
- Note: A similar indicator, "follow-up with a physician within 7 days of discharge," is available from the Ontario Hospital Association

Quality Statement 11: Transitions in Care

Percentage of adults discharged from hospital with a primary diagnosis of schizophrenia who have their care plan made available to the receiving provider within 7 days

- Denominator: total number of adults discharged from an inpatient setting after an admission for a primary diagnosis of schizophrenia 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 of discharge
- Data source: OMHRS, local data collection
- Note: A similar indicator, "care plan made available to any receiving provider within 7 days," is available from the Ontario Hospital Association

Percentage of adults discharged from hospital with a primary diagnosis of schizophrenia who are experiencing homelessness

- Denominator: total number of adults discharged from an inpatient setting after an admission for a primary diagnosis of schizophrenia
- Numerator: number of people in the denominator who are experiencing homelessness
- Data source: local data collection

Appendix 3. Glossary

Adult: People aged 18 years and older.

Caregiver: 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 schizophrenia. Other terms commonly used to describe this role include "care partner," "informal caregiver," "family caregiver," "carer," and "primary caregiver."

Health care professionals: Regulated professionals, such as nurses, nurse practitioners, pharmacists, physicians, physiotherapists, psychologists, occupational therapists, social workers, and speech-language pathologists.

Health care providers: Health care professionals as well as people in unregulated professions, such as administrative staff, behavioural support workers, personal support workers, recreational staff, and spiritual care staff.

Health care team: All individuals who are involved in providing care (including health care professionals and health care providers).

Primary care provider: A family physician (also called a primary care physician) or nurse practitioner.

Appendix 4. 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

Health care professionals should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples 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 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 relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

Equity, Inclusion, Diversity and Anti-Racism

Care for people with schizophrenia should recognize the specific needs of marginalized, underserved, or other equity-deserving groups (e.g., Indigenous people, individuals who identify as 2-spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, pansexual and gender nonconforming [2SLGBTQIA+], specific cultural groups, or survivors of sexual abuse or violence).

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.[28]

Intersectionality

Intersectionality refers to the differences in experiences with discrimination and injustice based on social categorizations such as race, class, age, and gender. These interconnected categorizations are known to create overlapping and interdependent systems of discrimination or disadvantage.[29,30] For example, stigma experienced by people with an eating disorder can vary depending on their racial/ethnic background, their age, any language barriers, gender, sexual orientation, presentation or their perceived class, but it can also differ depending on clinical and other demographic characteristics. Therefore, understanding how the various aspects of people's identities intersect can provide insight on the complexities of the processes that cause health inequities, and an understanding of how different people experience stigma and discrimination.

Recovery

This quality standard is underpinned by the principle of recovery, as described in the Mental Health Strategy for Canada. People with schizophrenia can lead meaningful lives. People with schizophrenia 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."[31] As described in the Mental Health Strategy Canada, "recovery is understood as a process in which people living with mental health problems and illnesses are empowered and supported to be actively engaged in their own journey of well-being. The recovery process builds on individual, family, cultural and community strengths and enables people to enjoy a meaningful life in their community while striving to achieve their full potential."[32]

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.[33] 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."[33]

Reducing Stigma

People with schizophrenia often encounter beliefs and attitudes that stem from negative stereotypes about mental illness. Stigma, or the perception of stigma, can negatively affect a person's recovery, their ability to tell friends and family about their illness, and their willingness to seek help. Stigma may also impact a person's ability to access health care services.

Self-Management

People with schizophrenia and their families, caregivers, and personal supports should also receive services that are respectful of their rights and dignity, and that promote shared decision-making and self-management.[34] Further, people should be empowered to make informed choices about the services that best meet their needs.[31] People with schizophrenia should engage with their care providers in informed, shared decision-making about their treatment options. Each person is unique and has the right to determine their own path toward mental health and well-being.[34]

Social Determinants of Health

Homelessness and poverty are two 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, 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,[35] including social stigma, discrimination, and a lack of access to education, employment, income, and housing.[17]

Trauma-Informed Care

Trauma-informed care is health care that reflects an understanding of trauma and the impact that traumatic experiences can have on people.[36] This approach does not necessarily address the trauma directly. Rather, the approach acknowledges that a person may have experienced a previous traumatic event that may contribute to their current health concerns. It emphasizes understanding, respecting, and responding to the effects of trauma.[37-39]

Acknowledgements

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Ontario Health thanks the following individuals for their generous, voluntary contributions of time and expertise to help create this quality standard (credentials at the time of initial development in 2016):

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About Us

Ontario Health

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. We work to enhance patient experience, improve population health, enhance provider experiences, improve value and advance health equity.

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:

- 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: ontariohealth.ca/our-team

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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ISBN 978-1-4868-6944-2 (PDF)

Ontario Health