Schizophrenia

Care in the Community for Adults
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). It also provides guidance on early psychosis intervention for people who experience a first episode of schizophrenia. The quality standard focuses on care provided in the community, including primary care, hospital outpatient care, rehabilitation, and community supports and services.

The quality standard also applies to care in correctional facilities. People with schizophrenia and other mental health conditions are disproportionately represented in the correctional system.[1] For some people with schizophrenia, their first point of contact for mental health care occurs after they have become involved with the correctional system. For these individuals, it is particularly important that screening processes at intake be sufficiently well developed so that they can be diagnosed with schizophrenia.

Although this quality standard addresses care for people who have already been diagnosed with schizophrenia, the importance of having responsive services that ensure all Ontarians with schizophrenia can receive a diagnosis cannot be understated.

For a quality standard that addresses care for adults with schizophrenia who are seen in an emergency department or admitted to a hospital inpatient setting, please refer to *Schizophrenia: Care for Adults in Hospitals*.[2]

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 community looks like for people with schizophrenia.

Quality Statement 1: Care Plan and Comprehensive Assessment

Adults with schizophrenia have a care plan that is regularly reviewed and updated, and that is informed by a comprehensive assessment.

Quality Statement 2: Physical Health Assessment

Adults with schizophrenia receive a physical health assessment on a regular basis.

Quality Statement 3: Self-Management

Adults with schizophrenia have access to information and education that supports the development of self-management skills.

Quality Statement 4: Family Education, Support, and Intervention

Families of adults with schizophrenia are given ongoing education, support, and family intervention that is tailored to their needs and preferences.

Quality Statement 5: Access to Community-Based Intensive Treatment Services

Adults with schizophrenia have timely access to community-based intensive treatment services based on their needs and preferences.

Quality Statement 6: Housing

Adults with schizophrenia have a safe, affordable, stable living environment that reflects their needs and preferences.

Quality Statement 7: Antipsychotic Monotherapy

Adults with schizophrenia are prescribed a single antipsychotic medication, whenever possible.

Quality Statement 8: Treatment With Long-Acting Injectable Antipsychotic Medication

Adults with schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

Quality Statement 9: Treatment With Clozapine

Adults with schizophrenia whose symptoms have not responded to previous adequate trials of treatment with two different antipsychotic medications are offered clozapine.

Quality Statement 10: Continuation of Antipsychotic Medication

Adults with schizophrenia whose symptoms have improved with antipsychotic medication are advised to continue their antipsychotic medication for the long term.

Quality Statement 11: Cognitive Behavioural Therapy for Psychosis and Other Psychosocial Interventions

Adults with schizophrenia are offered cognitive behavioural therapy for psychosis and other evidence-based psychosocial interventions, based on their needs.

Quality Statement 12: Promoting Physical Activity and Healthy Eating

Adults with schizophrenia are offered readily accessible interventions that promote physical activity and healthy eating.

Quality Statement 13: Promoting Smoking Cessation

Adults with schizophrenia who smoke tobacco are offered pharmacological and nonpharmacological interventions to help them reduce or stop smoking tobacco.

Quality Statement 14: Assessing and Treating Substance Use Disorder

Adults with schizophrenia are asked about their substance use and, if appropriate, they are assessed for substance use disorder and offered treatment.

Quality Statement 15: Employment and Occupational Support

Adults with schizophrenia who wish to find work or return to work are offered supported employment programs. Adults with schizophrenia who are not seeking paid work are supported in other occupational or educational activities, in accordance with their needs and preferences.

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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 2018. 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[3]
- Updated links, secondary references, and data sources where applicable
- Added references to the *Schizophrenia: Care for Adults in Hospitals*[2] quality standard
- Updated formatting to align with current design and branding
- Updated accompanying quality standard resources were updated 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 the definition of a medication review to align with the *Medication Safety*[4] quality standard and added assessment for post-traumatic stress disorder and other reactions to trauma
- Quality statement 2: under Definitions, revised the assessment of diabetes to reflect the collection of either fasting blood glucose or glycated hemoglobin (HbA1c), rather than requiring both
- Quality statement 4: under Background, added a reference to the *Schizophrenia: Care for Adults in Hospitals*[2] quality standard
- Quality statement 9: in the quality statement, Definitions, and Background, revised wording with person-centred language
- Quality statement 13: under Definitions, revised products for nicotine replacement therapy to reflect availability in Ontario

- Quality statement 14: under Background, added references to the *Opioid Use Disorder*[5] and *Problematic Alcohol Use and Alcohol Use Disorder*[6] quality standards
- Appendix B: removed an indicator for quality statement 10 to streamline measurement for this statement
- Minor wording changes to other quality statements and indicators where applicable

A Note on Terminology

Substitute decision-maker: This refers to a person who makes care and treatment decisions on another person's behalf if that person becomes mentally incapable of making decisions for themself. Capacity is issue- or task-specific.[7] The substitute decision-maker should be involved in ongoing discussions with the person about their goals of care, wishes, values, and beliefs so that the substitute decision-maker is empowered to participate in the health care consent process, if required. The substitute decision-maker makes decisions based on their understanding of the person's wishes or, if these wishes are unknown or not applicable, makes choices that are consistent with the person's known values and beliefs and that are in the person's best interests.

Ontario's *Health Care Consent Act* outlines a hierarchical list of people who are automatically considered to be a substitute decision-maker when a person is incapable of making decisions about their own care.[8] If a capable person prefers to assign someone to this role other than their automatic substitute decision-maker, they can formally appoint someone else using a "Power of Attorney for Personal Care."[9] This is a legal document in which one person gives another person the authority to make personal care decisions on their behalf if they become mentally incapable.[7]

Capacity or mental capacity: Under Ontario's *Health Care Consent Act*, a person is capable with respect to a health care decision if they understand the information that is needed to make a decision and appreciate the consequences of the decision or lack of decision.[8] Capacity is issue- or task-specific.[7] A person's specific capacity to understand information and appreciate the decisions that must be made should be respected so that their abilities are recognized.[10]
A person may be capable with respect to making some health care decisions but incapable with respect to others.[8] A person may also be capable of making a health care decision at one time but incapable at another time.[8] If a person is incapable of making a health care decision about a treatment or plan of

treatment, the substitute decision-maker can give or refuse consent on the person's behalf.[8]

Community treatment order: This refers to a legal order, issued by a physician, to provide a comprehensive plan for community-based treatment or care to a person with a serious mental illness who has had difficulties maintaining their mental health in the community.[11] Informed by a community treatment plan, the order outlines the medications, medical appointments, and other aspects of care that the physician believes are necessary to allow the person to stay well in the community, rather than remain in hospital.[12,13] The plan may include (but is not limited to) the treatments outlined in this quality standard.

A community treatment order is developed by a physician in collaboration with the person receiving treatment (or their substitute decision-maker, if applicable) and any other people or organizations that will assist the person in the community.[12] A community treatment order is valid only if the person (or their substitute decision-maker) provides consent.[13] Ontario's *Mental Health Act* defines the criteria necessary for issuing and renewing a community treatment order.[11]

Why This Quality Standard Is Needed

Schizophrenia is a severe, chronic mental health condition that usually begins 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.[14] Negative symptoms include apathy, social withdrawal, emotional flatness, and a restriction in the amount and content of speech.[14] Cognitive features include problems with memory, attention, planning, and organizing.[15]

In Canada, about 1 in 100 people have schizophrenia.[16] A 2012 report identified schizophrenia as one of the five mental health and addictions–related conditions with the greatest impact on the life and health of people in Ontario.[17] The risk of developing schizophrenia is influenced by a combination of genetic, physical, psychological, and environmental factors.[18] The risk is higher in men, in people living in cities, and in families of recent immigrants.[16,19]

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.[20,21] People with schizophrenia are also much more likely to die by suicide compared to people without schizophrenia.[22,23] In addition, people with schizophrenia are at increased risk for having other psychiatric conditions, including substance use disorders,

depression, and anxiety. They are also more likely to experience trauma, homelessness, and unemployment.[18,24]

People with schizophrenia face important gaps in the quality of care they receive in Ontario. Only 26.8% of those who are hospitalized for schizophrenia receive a follow-up visit with a physician within 7 days, and people hospitalized for schizophrenia have a high rate (16.6%) of readmission within 30 days of discharge.[25] Rates of emergency department visits for schizophrenia vary widely across the province (Health Quality Ontario, unpublished data, 2015). Access to psychiatrists also varies across Ontario: in 2009, the number of psychiatrists per 100,000 people ranged from 7.2 to 62.7 per 100,000 individuals across Ontario's 14 local health integration networks.[26]

People with schizophrenia are disproportionately affected by homelessness, and are often precariously housed.[27,28] About 520,000 people living with mental illness are inadequately housed in Canada and of those, as many as 120,000 are homeless.[28] People with schizophrenia are overrepresented in these populations: it is estimated that 6% of the homeless population in Toronto has schizophrenia.[29]

This quality standard includes 15 quality statements that address areas identified by the Schizophrenia Care in the Community Quality Standard Advisory Committee as having high potential to improve care in the community for people with schizophrenia in Ontario.

Measurement to Support Improvement

The Schizophrenia Care in the Community Quality Standard Advisory Committee identified five overarching indicators to monitor the progress being made to improve care in the community for people with schizophrenia in Ontario.

Indicators That Can Be Measured Using Provincial Data

- Percentage of adults hospitalized for schizophrenia who have had an unplanned hospital readmission for a mental health or addictions condition within 30 days of discharge

- Percentage of adults hospitalized for schizophrenia who had a follow-up visit with a trained mental health physician:
  - Within 7 days of hospital discharge
  - Within 28 days of hospital discharge

Indicators That Can Be Measured Using Only Local Data

- Percentage of adults with schizophrenia who report unmet care needs
- Percentage of adults with schizophrenia who report living in stable housing for the past year
- Percentage of adults hospitalized for schizophrenia who had a follow-up visit with a trained mental health professional:
  - Within 7 days of hospital discharge
  - Within 28 days of hospital discharge

Quality Statements to Improve Care

01

Care Plan and Comprehensive Assessment

Adults with schizophrenia have a care plan that is regularly reviewed and updated, and that is informed by a comprehensive assessment.

Sources: American Psychiatric Association, 2020[3] | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24]

Definitions

Care plan: A care plan includes:

- Results of the comprehensive assessment (see definition below)
- Mutually agreed-upon goals based on the person's needs, strengths, and preferences, including activities of daily living, housing, daily structure and employment, symptom reduction, and family and social relationships
- Interventions, activities, and other steps the person and others might take to help them achieve their goals, optimize their capacity to function as independently as possible, and support their social inclusion
- A relapse prevention plan
- A crisis plan
- Roles and responsibilities of health and community service providers

Regularly reviewed and updated: The care plan should be reviewed every 6 to 12 months, or sooner if there is a clinical need or a significant change in a person's goals. Reviewing the care plan may require a partial or full reassessment, including revisiting recovery and treatment goals.

Comprehensive assessment: In collaboration with the individual, and their family member(s), as appropriate, the comprehensive assessment should be undertaken by health care professionals who have expertise in the care of people with schizophrenia. It should be informed by communication with the person's primary

care provider, other mental health care providers, and/or community treatment providers. The assessment should address the following:

- Self-identified goals, aspirations, personal strengths, and resources that support personal recovery
- Psychiatric symptoms and impairments; risk of harm to self or others; current and past treatments and responses; alcohol consumption and use of prescribed and nonprescribed drugs (see Quality Statement 14)
- Medical considerations, including medical history and physical examination to assess medical conditions
- Medication review (including prescription and over-the-counter medications, vitamins and minerals, herbal and natural health products, traditional medicines, medication samples from prescribers, etc.)
- Physical health and well-being (see Quality Statement 2)
- 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); consider neuropsychological assessment for people with an intellectual disability or functional impairment
- 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, and participation in peer and self-help activities)
- Occupational and educational histories (educational attainment and opportunities, employment, and occupational support; see Quality Statement 15)
- Sources of income
- Activities of daily living, instrumental activities of daily living, and home management
- Legal history and current legal involvement
- Capacity to make personal care and financial decisions, as described in the *Ontario Substitute Decisions Act*[9]
- Service needs (assessed using a tool or instrument such as the Level of Care Utilization System or the Ontario Common Assessment of Need) to match resource intensity with care needs

Background

Every person with schizophrenia should be involved, whenever possible, in developing, implementing, reviewing, and updating their care plan with their health care professional. Ideally, the care plan is also informed by input from their family, caregivers, and personal supports. It needs to consider the whole person and be tailored to the person's goals, personal strengths, and resources; reflect their cultural beliefs and realities; and address the range of issues that may impact their health and well-being. It should aim to reduce symptoms, improve psychosocial functioning, and help the person fulfill their individual needs and aspirations.[30] Regular review of the care plan will enable the person and their health care professional to review progress, revisit goals, and make adjustments for changing needs and preferences. If a person has a community treatment order, their community-based treatment plan should be informed, whenever possible, by the person's care plan and recovery goals.

A comprehensive assessment of the person with schizophrenia should inform the development of the care plan. The comprehensive assessment allows health care providers to thoroughly explore the biological, psychological, and social factors that may have contributed to the onset, course, and outcome of the person's illness, and that may influence their recovery. An assessment can determine a baseline level of functioning, activity, and participation, and can be used to track changes in the person's status over time. Validated assessment tools and instruments should be used, where available. The assessment may take place over several encounters to gain a full understanding of the person and support their engagement.[31] Depending on how care is organized, the components of the assessment may be carried out by several members of the health care team, or the person with schizophrenia may be referred to other health care professionals, as needed, to complete the assessment.

A copy of the care plan and findings from the assessment should be shared with the person with schizophrenia, relevant health care providers, and the person's family or caregivers, unless the person indicates that they do not want such information shared.

What This Quality Statement Means

For Adults With Schizophrenia

A care plan is a written document between you and your health care professional that you agree to. It describes your goals, the care and services you will receive, and who will provide them. Your health care professional should work with you to

update your care plan regularly, and your family or caregivers can be involved in making and updating the plan, if you agree.

Your care plan should be informed by a thorough assessment of your physical and mental health. This will include questions about your medical history and what medications you are taking. It also should look at your social situation, your goals, how you are feeling, and how you are coping with the impact of symptoms on your daily life.

If you are on a community treatment order, your care plan and goals will be used to inform your community-based treatment plan whenever possible.

For Clinicians

Work with adults with schizophrenia (and their family or caregivers, if they agree) to create an individualized care plan. The plan documents mutually agreed-upon goals, individual concerns and preferences, care and services, and a crisis plan, and it incorporates the results of the comprehensive assessment. The plan should be reviewed and updated regularly.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place to help care providers develop, implement, and reassess care plans for adults with schizophrenia. This may include access to standardized care plan templates and comprehensive assessment tools, and access to the resources necessary to carry out the care plan.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who had a comprehensive assessment within 6 months of initial presentation
- Percentage of adults with schizophrenia who have a care plan that was reviewed in the past 12 months or when there was a significant change in their goals
- Percentage of adults with schizophrenia who have had their community service needs assessed using a standardized, validated tool

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

02

Physical Health Assessment

Adults with schizophrenia receive a physical health assessment on a regular basis.

Sources: American Psychiatric Association, 2020[3] | | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Scottish Intercollegiate Guidelines Network, 2013[32]

Definition

Physical health assessment: The following should be assessed and recorded at baseline before starting antipsychotic medication (or as soon as possible if the medication needs to be started quickly). They should also be monitored and recorded regularly and systematically during treatment, especially when titrating medications. Validated assessment tools and instruments should be used, where available. Each assessment should inform the care plan (see Quality Statement 1).

- Weight and body mass index (at baseline, weekly for the first 6 weeks, then at 12 weeks, 1 year, and annually, plotted over time)
- Waist circumference (at baseline and annually, plotted over time)
- Pulse and blood pressure (at baseline, 12 weeks, 1 year, and annually)
- Fasting blood glucose or glycated hemoglobin (HbA1c; at baseline, 12 weeks, 1 year, and annually)
- Blood lipid panel: total cholesterol, low- and high-density lipoprotein cholesterol, and triglycerides (at baseline, 12 weeks, 1 year, and annually)
- Prolactin (as clinically indicated)
- Electrocardiogram (as clinically indicated)
- Neurological adverse effects, such as acute extrapyramidal symptoms and tardive dyskinesia
- Overall physical health (with particular attention to conditions common in people with schizophrenia, including cardiovascular disease, diabetes and metabolic syndrome, and lung disease)

- Age-appropriate physical health screening (e.g., a Pap test, mammography, colonoscopy) and immunizations
- Hearing and vision screening
- Nutritional intake and level of physical activity
- Smoking status
- Alcohol and drug use
- Sexual health
- Dental health

Background

Adults with schizophrenia have poorer physical health and a shorter life expectancy than the general population: on average, 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.[20,21] Common conditions that contribute to the high risk of morbidity and premature mortality in people with schizophrenia include cardiovascular disease, diabetes and metabolic syndrome, and lung disease.[18,33] Factors that contribute to increased morbidity and mortality in people with schizophrenia include smoking, poor diet, physical inactivity, and adverse effects of medication,[34] as well as reduced health-seeking behaviour and lower adherence to medical treatments. Further, people with schizophrenia are at high risk for under-recognition and under-treatment of physical health conditions by health care providers.[33-36]

Supporting the physical health of people with schizophrenia is an essential part of improving their overall health outcomes, promoting their capacity to set and achieve recovery goals, and enabling them to participate fully in their community. As part of this, it is important to comprehensively assess and monitor their physical health to enable treatment, if necessary. Access to timely and high-quality primary health care is also key for managing people's general and preventive health care needs, including regular screening (e.g., cervical cancer, colon cancer), immunizations, and management of any chronic health conditions. Mental health care providers should ensure that people with schizophrenia have their physical health needs addressed concurrently in primary care, integrated primary care and mental health services, or specialized clinic settings. Mental health care providers should facilitate and support people in accessing primary care.

What This Quality Statement Means

For Adults With Schizophrenia

As part of your regular appointments, your health care professional should assess you for health problems that are common in people with schizophrenia, such as diabetes, weight gain, heart disease, and lung disease. These assessments might result in changes to your care plan.

For Clinicians

Complete a physical assessment that focuses on conditions that are common in people with schizophrenia. The assessment should inform the person's care plan.

For Organizations and Health Services Planners

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

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who have a comprehensive physical health assessment within 12 weeks after starting antipsychotic medication
- Percentage of adults with schizophrenia who have had a comprehensive physical health assessment within the previous 12 months

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

03

Self-Management

Adults with schizophrenia have access to information and education that support the development of self-management skills.

Sources: American Psychiatric Association, 2020[3] | | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24]

Definition

Self-management: Self-management involves people gaining the knowledge, skills, and confidence to actively manage their own recovery. For people with schizophrenia, self-management education should include information about:

- Causes, symptoms, and treatment of schizophrenia
- Effective use of medication
- Identifying and coping with symptoms
- Managing stress
- Self-care strategies
- Crisis planning
- Building a social support network
- Relapse prevention and management
- Setting personal recovery goals
- Available mental health and other support services and how to access them, including locally available services and supports available online

Background

For people with schizophrenia, the ability to actively self-manage their health and well-being is an important factor in reducing the risk of relapse and a key step in the recovery journey. Self-management involves[18,37]:

- Learning about schizophrenia and treatment options
- Improving illness-management skills
- Understanding recovery and developing recovery strategies
- Developing and maintaining social relationships
- Gaining skills to cope with the impact of symptoms, stress, and life changes

Peer support may help people manage their own health and recovery.[38]

What This Quality Statement Means

For Adults With Schizophrenia

Your health care professional should give you information to help you learn about schizophrenia and your treatment options to manage your condition so you can be actively involved in developing your care plan. You should also be given information about support services and groups that are available in your community and online.

For Clinicians

Offer self-management education to adults with schizophrenia. Education should align with their needs and stage of illness, and focus on empowering people to engage in their own recovery. If you are not able to provide education onsite, ensure that people have access to it elsewhere (e.g., through a partnership with a local organization).

For Organizations and Health Services Planners

Ensure that health care professionals are able to offer self-management education or refer people to local programs.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who have received education about self-management
- Percentage of adults with schizophrenia who report feeling confident in the self-management of their symptoms

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

04

Family Education, Support, and Intervention

Families of adults with schizophrenia are given ongoing education, support, and family intervention that is tailored to their needs and preferences.

Sources: American Psychiatric Association, 2020[3] | | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Schizophrenia Patient Outcomes Research Team, 2010[39] | Scottish Intercollegiate Guidelines Network, 2013[32]

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.

Education: Education consists of evidence-based information provided verbally or in a print or multimedia format. It should include, at a minimum, information about the following:

- Diagnosis and management of schizophrenia
- Outcomes and recovery
- Available support services and how to access them
- The *Mental Health Act*[11] and other legislation relevant to mental health care in Ontario (e.g., the *Health Care Consent Act*[8] and the *Substitute Decisions Act*[9])
- Self-care and coping strategies
- Role of teams and services
- Getting help in a crisis
- Legal issues

Support: Families should have access to a range of supports, which may include:

- Support and information available by telephone and through the Internet
- Support groups
- Respite for caregivers

Family intervention: This intervention should:

- Include at least 10 planned sessions
- Be delivered by an appropriately trained practitioner
- 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 multifamily 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—which can include relatives, caregivers, or people from a broader circle—can play a vital role in supporting a person's recovery, promoting their well-being, and providing care.[40] Families may benefit from information and support according to their circumstances and needs, such as programs for the parents, siblings, or children of people with schizophrenia; financial assistance; and respite care.[40]

Family members who have ongoing contact with a person with schizophrenia may benefit from family intervention. Family intervention aims to improve family members' support and resilience and enhance the quality of their communication and problem-solving. Delivered by a trained practitioner, it also seeks to provide insight into the condition of the person with schizophrenia and to teach family members to identify the signs and symptoms of relapse, improving their ability to anticipate and help reduce the risk of relapse.[41] Family intervention can be started

in the inpatient setting or community.[18] Further information is available in the *Schizophrenia: Care for Adults in Hospitals*[2] quality standard.

People with schizophrenia should be encouraged to include family members in their treatment and recovery. If a person with schizophrenia chooses not to involve their family, family members may still find it valuable to participate in education and access support services.

What This Quality Statement Means

For Adults With Schizophrenia

Families can play a vital role in supporting a person's recovery, promoting their well-being, and providing care. If you are a family member of someone who has schizophrenia, the health care professional should give you opportunities to learn about schizophrenia and to get support if you need it. This is important so you can help your family member while also looking after your own needs.

For Clinicians

Encourage people with schizophrenia to involve their family in their care. Offer families education, supports, and family intervention that align with their circumstances and needs. If you are not able to provide these onsite, ensure that people have access to them elsewhere (e.g., through a partnership with a local organization).

For Organizations and Health Services Planners

Ensure that family-focused education and supports and family intervention are available for families when they need them.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia whose family members receive education, support, and family intervention by a trained practitioner
- Percentage of adults with schizophrenia whose family members or unpaid caregivers report continued feelings of distress, anger, or depression over a 12-month period

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

05

Access to Community-Based Intensive Treatment Services

Adults with schizophrenia have timely access to community-based intensive treatment services based on their needs and preferences.

Sources: American Psychiatric Association, 2020[3] | | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Schizophrenia Patient Outcomes Research Team, 2010[39] | Scottish Intercollegiate Guidelines Network, 2013[32]

Definitions

Timely access: Early psychosis intervention should be accessible within 2 weeks of referral, irrespective of the person's age or the duration of untreated psychosis.[18,42] Intake for assertive community treatment or intensive case management should be initiated within 2 weeks after initial contact.[30,43]

Intensive treatment services:

- People experiencing a first episode of schizophrenia should have access to early psychosis intervention.[18,24,31,32,39] This involves specialized treatment and support provided by a multidisciplinary team to reduce treatment delays, promote recovery, and reduce relapse.[18] These services provide a full range of pharmacological, psychological, social, occupational, and educational interventions, as well as support services for families.[18]
- People who have difficulty engaging with mental health services should have access to assertive community treatment or intensive case management:
    - Assertive community treatment involves intensive treatment, rehabilitation, and support provided by a multidisciplinary team.[24,31,32,39,44] Team members work with the person to provide services that are tailored to meet the person's needs and goals. Services include assertive outreach; pharmacological, psychological, social, and

occupational interventions; daily living support; and crisis assessment and intervention[30,45]

- Intensive case management involves a case manager who provides intensive, assertive outreach and facilitates coordinated access to services, supports, and resources from across the mental health system, as well as from other systems (e.g., housing, addictions, justice, education, social services)[24,31,43,45,46]

Background

Depending on their needs, people with schizophrenia may benefit from intensive treatment services, such as early psychosis intervention, assertive community treatment, and intensive case management. People experiencing a first episode of schizophrenia should have access to early psychosis intervention, which serves young people with early psychosis (usually between the ages of 13 and 35 years) and their families. People with schizophrenia who have more complex service needs and difficulty engaging or staying in treatment may benefit from assertive community treatment or intensive case management.[31,32,39]

Services should be recovery-oriented and available to people regardless of factors such as gender, age, income, race or ethnicity, culture, immigration status, linguistic identity, or whether they live in a rural or urban area. People's needs and preferences change over their lifespan and illness; a person may require different services (or changes in the intensity of services) at different times,[40] so services should allow for flexibility to match the services to a person's needs. Assessment of level-of-service needs (using a tool such as the Level of Care Utilization System [LOCUS] or the Ontario Common Assessment of Need [OCAN]) can be useful in matching resource intensity with care needs.

Detailed provincial program standards set out by the Ministry of Health and Long-Term Care (now the Ministry of Health) are available for assertive community treatment teams,[30] intensive case management,[43] and early psychosis intervention.[47] These standards establish expectations for program requirements, such as staff qualifications and staff-to-client ratios, so that services are delivered consistently across Ontario and incorporate evidence-based practices.

What This Quality Statement Means

For Adults With Schizophrenia

Depending on your needs, your health care professional may connect you with specialized treatment services such as:

- An early psychosis intervention program if you are experiencing schizophrenia for the first time. Psychosis is a treatable condition that affects your mind and can result in difficulty deciding what's real and what's not
- Something called "assertive community treatment." This is a team of health care professionals working together to provide you with various services to meet your needs, such as medications, counselling, life skills, and housing and employment supports
- Something called "intensive case management." This is similar to assertive community treatment, but in this instance a case manager is at the core of your supports, connecting you to services to meet your needs, such as medication support, mental health programs, and housing, employment, life skills, and justice services

These services are designed to help you to live in the community, manage your symptoms, and reach your goals.

For Clinicians

Refer people to the community-based services that will best meet their needs; for example:

- People experiencing a first episode of schizophrenia to an early psychosis intervention program
- People who have difficulty engaging with mental health services to assertive community treatment or intensive case management

Consider assessing service needs using a tool (e.g., Level of Care Utilization System [LOCUS] or Ontario Common Assessment of Need [OCAN]). Advise people on available services and how to access them.

For Organizations and Health Services Planners

Ensure that people with schizophrenia have timely and equitable access to the intensive treatment services they need, when they need them, by providing adequately resourced systems and services. Work collaboratively with stakeholders, communities, and people with lived experience, using local data and evidence to plan and develop population-based services that reach and meet the needs of all people with schizophrenia, particularly those who are socially disadvantaged or have barriers to accessing care. Ensure that health care professionals are aware of services and able to connect or refer people to them.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with a first presentation of schizophrenia who receive early psychosis intervention within 2 weeks of referral
- Percentage of adults with schizophrenia who have been assessed as requiring intensive case management who receive intensive case management within 2 weeks of referral
- Percentage of adults with schizophrenia who have been assessed as requiring assertive community treatment who receive assertive community treatment within 2 weeks of referral
- Percentage of adults with schizophrenia who have had their need for community services assessed using a standardized, validated tool

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

06

Housing

Adults with schizophrenia have a safe, affordable, stable living environment that reflects their needs and preferences.

Sources: Royal Australian and New Zealand College of Psychiatrists, 2016[24] | World Health Organization, 2012[48]

Definition

Safe, affordable, stable living environment: The person's living environment is facilitated using a continuum of community housing and support services according to the person's needs and preferences, which may include:

- Home modifications
- Supported housing
- Independent housing with support services
- Affordable general housing
- Housing First interventions for people who are homeless or precariously housed, which may be delivered in conjunction with intensive care management or assertive community treatment (e.g., At Home/Chez Soi)[31]

Background

Safe, affordable, stable, well-maintained housing supports good physical and mental health, facilitates social inclusion, and is an important foundation for recovery.[24,28,49] When a person's housing is not safe, affordable, stable, or of good quality, that person is at increased risk of negative outcomes related to their health and well-being.[28,50,51]

All people with schizophrenia—including those who are experiencing homelessness and those who have a concurrent disorder—should have access to housing and support services that meet their needs. People's housing needs vary and may change over time, so housing and support services need to be flexible and tailored to a person's strengths and needs, while also being timely,

accessible, affordable, and based on the person's preferences. Standardized tools such as the Service Prioritization Decision Assistance Tool may be helpful for assessing a person's needs and support requirements.

What This Quality Statement Means

For Adults With Schizophrenia

It's easier to focus on your recovery when you don't have to worry about having somewhere to live. Your health care professional should connect you with services that can help you find a safe, affordable, stable place to live, as well as support services (such as medication management, income supports, meal preparation, assertive community treatment or case management, and recreational and support activities), if you need them.

For Clinicians

Ask adults with schizophrenia about their housing, including if they have access to safe, affordable, stable housing and support services that meet their needs and preferences. Ensure connection with service providers who can assist them with their housing needs.

For Organizations and Health Services Planners

Ensure that adults with schizophrenia can access the housing and support services they need, when they need them, within the constraints of locally available resources. Ensure that health care providers are aware of these services and able to connect or refer people to them.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who report living in a safe, affordable, and stable living environment
- Percentage of adults with schizophrenia who report being homeless or precariously housed

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

07

Antipsychotic Monotherapy

Adults with schizophrenia are prescribed a single antipsychotic medication, whenever possible.

Sources: | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Scottish Intercollegiate Guidelines Network, 2013[32] | World Health Organization, 2012[48]

Background

Antipsychotic medication is usually effective in resolving psychotic symptoms and in preventing recurrence of symptoms.[18] Whenever possible, only one antipsychotic medication should be prescribed at a time, and at the lowest dose effective for the person with schizophrenia.[18] The use of antipsychotic medication—including benefits, risks, clinical response, and side effects—should be discussed with the person with schizophrenia. Whenever possible, family members should be included in these discussions. People with schizophrenia who are taking antipsychotic medications may also require other types of medications such as antidepressant and mood-stabilizing medication to treat their symptoms.

A person's medication and dosage should be reviewed regularly, including response, observed benefits, and side effects.[18] Offering a long-acting injectable antipsychotic medication should be considered early in the course of antipsychotic treatment (see Quality Statement 8). If psychotic symptoms do not improve with antipsychotic medication, consider the potential causes of nonresponse, including incorrect diagnosis, inadequate dose, poor adherence, concurrent substance use, and physical illness.[18] If the person with schizophrenia does not achieve an adequate response after trials of two different antipsychotic agents given separately at therapeutic doses for a sufficient duration, treatment with clozapine should be considered (see Quality Statement 9).

What This Quality Statement Means

For Adults With Schizophrenia

Antipsychotic medication reduces the intensity of psychotic symptoms, including hallucinations and delusions. Your health care professional should discuss with you the potential benefits, harms, and side effects of antipsychotic medication so that you can make informed decisions about your care together. If you have family or others involved in your care, they should also receive this information.

Usually, a health care professional will offer one antipsychotic medication at a time. However, there might be times when they recommend more than one antipsychotic medication.

If your symptoms don't get better or you experience significant side effects when taking an antipsychotic medication, talk with your health care professional about switching to a different medication.

For Clinicians

Adults with schizophrenia should usually be prescribed one antipsychotic medication at a time. Regularly monitor and document people's symptoms and side effects. In situations where more than one antipsychotic medication is prescribed, regularly assess for effectiveness and side effects.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place for health care professionals to appropriately trial one antipsychotic medication at a time and monitor people's response to treatment.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who have been prescribed and are taking a single antipsychotic medication
- Percentage of adults with schizophrenia who have had their antipsychotic medication reviewed in the past 12 months

- Percentage of adults with schizophrenia who have been prescribed an antipsychotic medication (or their substitute decision-makers) who felt involved in discussions about their medications, including benefits, risks, clinical response, and side effects

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

08

Treatment With Long-Acting Injectable Antipsychotic Medication

Adults with schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

Sources: American Psychiatric Association, 2020[3] | | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Scottish Intercollegiate Guidelines Network, 2013[32] | World Health Organization, 2012[48]

Definition

Long-acting injectable antipsychotic medication: Antipsychotic medication may be given as an intramuscular injection every 2 weeks to every 3 months, depending on the medication. Health care professionals should discuss the option of long-acting injectable antipsychotic medications with the person early in their course of treatment. Whenever possible, family members should be included in these discussions.

Background

Long-acting injectable antipsychotic medications can improve treatment adherence and prevent relapse.[18,52] Relapses may contribute to worsening outcomes over the course of the illness.[53] Treatment with long-acting injectable medications provides people with their medication on a consistent schedule and provides clinicians with a valid measure of treatment adherence, the major determinant of relapse.[18]

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

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

For Organizations and Health Services Planners

Provide adequately resourced systems and services so that clinicians can offer long-acting injectable antipsychotic medications to adults with schizophrenia.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who have been offered a long-acting injectable antipsychotic medication
- Percentage of adults with schizophrenia who have been prescribed a long-acting injectable antipsychotic medication (or their substitute decision-makers) who felt involved in discussions about their medication, including benefits, risks, clinical response, and side effects

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

09

Treatment With Clozapine

Adults with schizophrenia whose symptoms have not responded to previous adequate trials of treatment with two different antipsychotic medications are offered clozapine.

Sources: American Psychiatric Association, 2020[3] | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Schizophrenia Patient Outcomes Research Team, 2010[39] | Scottish Intercollegiate Guidelines Network, 2013[32]

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[54]) after trials of two different antipsychotic medications at adequate dosage and duration, and with reasonable assurance of medication adherence during the trials.

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.[18] A trial of clozapine should also be considered for people with schizophrenia who experience substantial side effects from other antipsychotic medications,[24] who exhibit persistent symptoms of aggression or violent behaviours, or who have persistent suicidal thoughts or behaviours.[24,31,39]

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 2).[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, talk with your health care professional about taking a medication called clozapine. Clozapine is taken orally.

For Clinicians

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

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place so clinicians can offer clozapine as a treatment for schizophrenia, and so they can monitor and manage the risks associated with clozapine.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who receive clozapine
- Percentage of adults with schizophrenia whose symptoms have not responded to adequate trials of treatment with at least two different antipsychotic medications, and who receive clozapine
- Percentage of adults with schizophrenia who have had their clozapine medication reviewed in the past 12 months

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

10

Continuation of Antipsychotic Medication

Adults with schizophrenia whose symptoms have improved with antipsychotic medication are advised to continue their antipsychotic medication for the long term.

Sources: American Psychiatric Association, 2020[3] | Schizophrenia Patient Outcomes Research Team, 2010[39]

Definition

Continue antipsychotic medication for the long term: Most people with schizophrenia will need to take antipsychotic medication for life to prevent a relapse.

Background

People with an established schizophrenia diagnosis who experience remission from an acute episode with an antipsychotic medication can reduce their risk of relapse and development of treatment resistance by continuing to take the medication.[24,31,55,56] The use of antipsychotic medication—including benefits, risks, clinical response, and side effects—should be reviewed with the person with schizophrenia at least once a year.[18,24] The lowest dose that maximizes effectiveness and minimizes side effects should be used.[39] Treatment with a long-acting injectable antipsychotic medication should be offered early in the course of antipsychotic treatment (see Quality Statement 7).

Any trial to reduce or discontinue antipsychotic medication should be carried out under close supervision by the treating psychiatrist and clinical team and include frequent follow-up to monitor for early signs of recurrence or relapse. Whenever possible, family members should be included in discussions about the risks associated with medication discontinuation, how to identify signs of recurrence, and the steps to take if symptoms recur.[48]

What This Quality Statement Means

For Adults With Schizophrenia

If an antipsychotic medication works to make your symptoms better, you will likely need to keep taking it to prevent symptoms from recurring. Your health care professional should review your medication with you once a year to make sure it continues to work for you and to address any side effects.

For Clinicians

Ensure that adults with schizophrenia continue to take their antipsychotic medication and that they and their family are educated about the role of maintenance medication in helping them stay well.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place so that adults with schizophrenia whose symptoms have improved can continue treatment with antipsychotic medication, and that regular medication reviews can be conducted.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who have been dispensed an antipsychotic medication who have continuously been dispensed an antipsychotic medication since initiation
- Percentage of adults with schizophrenia who experience a relapse

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

11

Cognitive Behavioural Therapy for Psychosis and Other Psychosocial Interventions

Adults with schizophrenia are offered cognitive behavioural therapy for psychosis and other evidence-based psychosocial interventions, based on their needs.

Sources: American Psychiatric Association, 2020[3] | Health Quality Ontario, 2018[57] | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Schizophrenia Patient Outcomes Research Team, 2010[39] | Scottish Intercollegiate Guidelines Network, 2013[32] | World Health Organization, 2012[48]

Definitions

Cognitive behavioural therapy for psychosis: This therapy should be:

- Started during the initial phase, the acute phase, or the recovery phase
- Started in the community or in-patient setting
- Delivered over at least 16 planned sessions spanning 4 to 9 months
- Delivered one-on-one, ideally, but can be delivered in a group, given resource availability
- Delivered by an appropriately trained health care professional in accordance with a treatment manual

Other evidence-based psychosocial interventions: Based on people's needs, other interventions to consider include:

- Cognitive behavioural therapy for concurrent depression and anxiety in people with schizophrenia[18,24,32]
- Cognitive remediation for people with schizophrenia who have cognitive impairment that affects functioning[24,32]

Background

There is evidence supporting the effectiveness of cognitive behavioural therapy for psychosis and other psychosocial interventions for people with schizophrenia with certain indications. Cognitive behavioural therapy is a form of psychotherapy delivered by a trained health care professional that helps a person become more conscious of their beliefs and patterns of thinking. It provides strategies to reshape their beliefs and thoughts to achieve a positive outcome.

Cognitive behavioural therapy for psychosis is more effective when delivered in conjunction with antipsychotic medication. Cognitive behavioural therapy for psychosis has been shown to be effective in reducing symptom severity and re-hospitalizations in people with schizophrenia.[18] Evidence also supports offering cognitive behavioural therapy for treatment of concurrent depression and anxiety in people with schizophrenia.[18,24,32]

Cognitive remediation is a psychosocial intervention that may be considered for people with schizophrenia who have cognitive impairment.[24,31,32] Cognitive remediation aims to improve basic cognitive processes, including memory, concentration, social cognition, and problem-solving.[24,58] It is an intervention based on behavioural training, facilitated by trained clinicians.[58] There is growing evidence that when it is applied as an adjunct to supported employment programs, cognitive remediation can enhance employment outcomes.[59]

What This Quality Statement Means

For Adults With Schizophrenia

You should be offered nondrug interventions as part of your treatment, based on your needs. Two types are cognitive behavioural therapy and cognitive remediation.

In cognitive behavioural therapy, you would talk with a health care professional about your thoughts and beliefs and learn how they can affect the way you behave and deal with problems.

In cognitive remediation, you would perform learning activities that help you improve your memory, concentration, and problem-solving skills.

For Clinicians

Ensure that cognitive behavioural therapy and cognitive remediation are offered to adults with schizophrenia who may benefit.

For Organizations and Health Services Planners

Provide adequately resourced systems and services to ensure that adults with schizophrenia can access cognitive behavioural therapy and cognitive remediation. 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 with schizophrenia who have received cognitive behavioural therapy for psychosis
- Percentage of adults with schizophrenia and concurrent depression and anxiety who have received cognitive behavioural therapy for depression and anxiety
- Percentage of adults with schizophrenia and cognitive impairments that affect their functioning who have received cognitive remediation
- Local availability of cognitive behavioural therapy programs given by trained and certified professionals
- Local availability of cognitive remediation programs given by trained and certified professionals

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

12

Promoting Physical Activity and Healthy Eating

Adults with schizophrenia are offered readily accessible interventions that promote physical activity and healthy eating.

Sources: National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Scottish Intercollegiate Guidelines Network, 2013[32]

Definition

Interventions that promote physical activity and healthy eating: Behavioural interventions that provide information and support to increase physical activity levels and healthy eating.

Background

There are many reasons why people with schizophrenia experience a higher incidence of physical health conditions (see Quality Statement 2), but one important group of causes is lifestyle factors, including poor nutrition and a lack of physical activity.[18] Several of the medications used to treat schizophrenia may also cause weight gain.[18,24] Offering interventions that promote physical activity and healthy eating to people with schizophrenia can help to improve their physical and mental health.[18] Such programs need to be affordable and accessible. People with schizophrenia and their families should also be educated about the importance of physical activity and healthy eating and encouraged to participate in related programs.

What This Quality Statement Means

For Adults With Schizophrenia

A healthy lifestyle can help improve your physical and mental health. Your health care professional should give you information about programs that help you exercise and eat healthy foods.

For Clinicians

Be aware of local programs for healthy eating and physical activity, and encourage adults with schizophrenia to access them.

For Organizations and Health Services Planners

Ensure that interventions are available in the community to promote physical activity and healthy eating for adults with schizophrenia.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who regularly receive interventions that promote physical activity and healthy eating
- Local availability of programs that promote healthy eating and physical activity for adults with schizophrenia
- Percentage of adults with schizophrenia who report being active during their leisure time

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

13

Promoting Smoking Cessation

Adults with schizophrenia who smoke tobacco are offered pharmacological and nonpharmacological interventions to help them reduce or stop smoking tobacco.

Sources: National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Schizophrenia Patient Outcomes Research Team, 2010[39]

Definition

Interventions to help people reduce or stop smoking tobacco: A range of pharmacological and nonpharmacological interventions are available to help people reduce or stop smoking tobacco, including:

- 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.[60] High tobacco use contributes to the main causes of morbidity and mortality in people with schizophrenia.[61] Smoking may also interfere with the effectiveness of certain antipsychotic medications.[62]

People with schizophrenia who want to reduce or stop smoking should be offered pharmacological and nonpharmacological interventions that are aligned with their readiness for change.[39,63] Validated screening tools can assist with monitoring tobacco use. Health care providers should monitor a person's psychiatric symptoms, medication dosage, and response when they are reducing or stopping smoking.[63]

What This Quality Statement Means

For Adults With Schizophrenia

Quitting or cutting down on smoking can help improve your physical and mental health. Your health care professional should talk with you about ways to stop smoking or smoke less.

For Clinicians

Offer behavioural interventions, counselling, or medications to adults with schizophrenia who smoke tobacco to help them reduce or stop smoking.

For Organizations and Health Services Planners

Ensure that behavioural interventions and medications are available in the community to help adults with schizophrenia reduce or stop smoking.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who smoke tobacco and who have developed a plan in the past 12 months to reduce or stop tobacco use
- Percentage of adults with schizophrenia who smoke tobacco and receive at least one pharmacological or nonpharmacological intervention to help them reduce or stop smoking tobacco
- Percentage of adults with schizophrenia who smoke tobacco daily

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

14

Assessing and Treating Substance Use Disorder

Adults with schizophrenia are asked about their substance use and, if appropriate, they are assessed for substance use disorder and offered treatment.

Sources: National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Schizophrenia Patient Outcomes Research Team, 2010[39] | Scottish Intercollegiate Guidelines Network, 2013[32]

Definition

Substance use disorder: The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* defines substance use disorder as a problematic pattern of substance use leading to clinically significant impairment in daily life or distress, occurring within a 12-month period.[14] The manual lists 11 symptoms of substance use disorder. The presence of two or three symptoms indicates mild substance use disorder; four or five symptoms indicates moderate substance use disorder; and six or more symptoms indicates severe substance use disorder.[14]

Background

Substance use and substance use disorders are more common in people with schizophrenia than in the general public.[46,64] Substance use is associated with poor functional recovery and a higher risk of relapse and hospitalization.[46] Substance use may exacerbate the symptoms of schizophrenia and worsen its course, as well as limit the ability of antipsychotic medications to control symptoms. Substance use may also interfere with the therapeutic effects of nonpharmacological treatments.[46]

Health care professionals should routinely screen people with schizophrenia for use of a range of substances, including alcohol, cannabis, tobacco, prescription or nonprescription medications, and illicit drugs.[18] Validated screening tools (e.g., Global Appraisal of Individual Needs–Short Screener [GAIN-SS]) can assist with screening for substance use and identify people who would benefit from further evaluation. If a person's substance use is causing them significant impairment or

distress, the person should be assessed for substance use disorder via the most current criteria in the *Diagnostic and Statistical Manual of Mental Disorders*.[14]

Substance use should not prevent people with schizophrenia from receiving treatment or services. Treatment for concurrent disorders should be integrated with mental health and addictions services and take into account people's needs, preferences, and readiness to change.[24,46]

Further information is available in the Opioid Use Disorder[5] and *Problematic Alcohol Use and Alcohol Use Disorder*[6] quality standards.

What This Quality Statement Means

For Adults With Schizophrenia

Alcohol and drugs may make your schizophrenia symptoms worse and make your treatment less effective. Your health care professional should ask if you use alcohol and drugs and offer you treatment (if you need it) to help you stop using them.

For Clinicians

Ask adults with schizophrenia about their substance use. If necessary, provide them with a more thorough assessment for a possible diagnosis of substance use disorder, and offer treatment for concurrent disorders.

For Organizations and Health Services Planners

Ensure that systems and resources are in place to allow care providers to screen for substance use and assess for substance use disorder. Ensure that pathways to treatment for concurrent disorders are in place for when substance use disorder is identified.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who have been assessed in the past year for substance use
- Percentage of adults with schizophrenia and substance use disorder who receive treatment for substance use disorder

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

15

Employment and Occupational Support

Adults with schizophrenia who wish to find work or return to work are offered supported employment programs. Adults with schizophrenia who are not seeking paid work are supported in other occupational or educational activities, in accordance with their needs and preferences.

Sources: American Psychiatric Association, 2020[3] | National Institute for Health and Care Excellence, 2014[18] | Royal Australian and New Zealand College of Psychiatrists, 2016[24] | Schizophrenia Patient Outcomes Research Team, 2010[39] | World Health Organization, 2012[48]

Definitions

Supported employment: This is an approach to vocational rehabilitation that involves placing people in competitive jobs (i.e., permanent jobs paying commensurate wages that any person can apply for[65]) right away and providing them with ongoing job support.[18] Key elements of supported employment include developing job opportunities, focusing on individual preferences, conducting a rapid job search, ensuring availability of ongoing job supports, and integrating vocational and mental health services.[39]

Other occupational or educational activities: These activities may include pre-vocational training, supported education, and volunteering.[18,24]

Background

People with schizophrenia experience high rates of unemployment.[66] Engaging in meaningful, productive work and other activities reduces social isolation, promotes inclusivity, and is an essential element of recovery.[66] Barriers to employment include stigma and discrimination; lack of opportunities for education and skills development; limited ongoing support to get and keep a job; and disincentives in income support or benefit programs, where returning to paid work can mean the loss of health care benefits or subsidies.[66] People should also be supported in other meaningful occupational or educational activities and interests, regardless of their desire for or participation in paid employment.

Promising new opportunities have emerged in the form of work integration social enterprises and paid peer-provider and peer-support positions in the mental health system.[66,67]

What This Quality Statement Means

For Adults With Schizophrenia

Your health care provider should talk with you about programs that could help you to achieve your goals for work and education.

For Clinicians

Ask adults with schizophrenia about their employment, volunteering, and other occupational and educational interests and goals. Include this information in their care plan (see Quality Statement 1). Connect people with supports and services that can assist with these pursuits.

For Organizations and Health Services Planners

Ensure that adults with schizophrenia can access supported employment programs and other occupational and educational activities within the constraints of locally available resources. Ensure that health care providers are aware of and able to connect people to these services.

QUALITY INDICATORS: HOW TO MEASURE IMPROVEMENT FOR THIS STATEMENT

- Percentage of adults with schizophrenia who wish to work who participate in supported employment programs
- Percentage of adults with schizophrenia who are not seeking paid work who participate in other occupational or educational activities, in accordance with their needs and preferences
- Local availability of supported employment programs for people with schizophrenia
- Local availability of supported pre-vocational training, education, and volunteering programs for people with schizophrenia
- Percentage of adults with schizophrenia who report contributing meaningfully to their community and to society

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: Peer Support, Illness Management and Recovery Training, Wellness Recovery Action Planning, and Social Skills Training

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

We cannot provide guidance at this time on peer support, illness management and recovery training, or wellness recovery action planning because of conflicting recommendations in the guidelines used to develop the quality statements. Although there is a growing body of literature showing the effectiveness of these interventions, further evidence is needed before a quality statement can be made. The advisory committee suggested these were important areas to be considered in future work.

Social skills training is not a new intervention; however, we cannot provide guidance at this time on the use of social skills training because of conflicting recommendations in the guidelines used to develop the quality statements. Although there is a large and growing body of literature showing that social skills training may improve social functioning and reduce relapse rates in people with schizophrenia,[68] further evidence is needed before a quality statement can be made.

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 Adults With Schizophrenia

This quality standard consists of quality statements. These describe what high-quality care in the community looks like 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 receiving care in the community, 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 community 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 for adults with schizophrenia receiving care in the community, 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 in the Community for Adults Quality Standard Advisory Committee identified five indicators for this quality standard. These indicators can be used to monitor the progress being made to improve care in the community for people 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

Percentage of adults hospitalized for schizophrenia who have had an unplanned hospital readmission for a mental health or addictions condition within 30 days of discharge

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

Percentage of adults hospitalized for schizophrenia who had a follow-up visit with a trained mental health physician:
    - Within 7 days of hospital discharge
    - Within 28 days of hospital discharge
- Denominator: total number of acute care discharges from episode of care in which schizophrenia was coded as most responsible diagnosis
- Numerator: number of people in the denominator who within 7 days or 28 days of discharge following a schizophrenia-related hospitalization had 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
- Note: A similar indicator, "follow up with a physician within 7 days of discharge," is available from the Ontario Hospital Association

Indicators That Can Be Measured Using Only Local Data

Percentage of adults with schizophrenia who report unmet care needs

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report unmet care needs
- Data sources: local data collection, Ontario Common Assessment of Need
- Suggested stratification: type of need

Percentage of adults with schizophrenia who report living in stable housing for the past year

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report living in stable housing for the past year
- Data sources: local data collection, Ontario Common Assessment of Need

Percentage of adults hospitalized for schizophrenia who had a follow-up visit with a trained mental health professional:

    - Within 7 days of hospital discharge
    - Within 28 days of hospital discharge
- Denominator: total number of acute care discharges from episodes of care in which schizophrenia was coded as most responsible diagnosis

- Numerator: number of people in the denominator who, within 7 days and 28 days of discharge following schizophrenia-related hospitalization, had a follow-up visit with a trained mental health professional
- Data sources: Ontario Mental Health Reporting System, Registered Persons Database, Discharge Abstract Database for the denominator; Ontario Health Insurance Plan Claims History Database (for physician follow-up), local data collection (for non-physician provider follow-up care) for the numerator

How to Measure Improvement for Specific Statements

Quality Statement 1: Care Plan and Comprehensive Assessment

Percentage of adults with schizophrenia who had a comprehensive assessment within 6 months of initial presentation

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who had a comprehensive assessment within 6 months of initial presentation
- Data source: local data collection

Percentage of adults with schizophrenia who have a care plan that was reviewed in the past 12 months or when there was a significant change in their goals

- Denominator: total number of adults with schizophrenia who have a care plan
- Numerator: number of people in the denominator whose care plan was reviewed in the past 12 months or when there was a significant change in their goals
- Data source: local data collection

Percentage of adults with schizophrenia who have had their community service needs assessed using a standardized, validated tool

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have had their community service needs assessed using a standardized, validated tool (such as the Level of Care Utilization System or the Ontario Common Assessment of Need)
- Data source: local data collection

Quality Statement 2: Physical Health Assessment

Percentage of adults with schizophrenia who have a comprehensive physical health assessment within 12 weeks after starting antipsychotic medication

- Denominator: total number of adults with schizophrenia who are started on antipsychotic medication
- Numerator: number of people in the denominator who have a comprehensive physical health assessment within 12 weeks after starting antipsychotic medication
- Data source: local data collection

Percentage of adults with schizophrenia who have had a comprehensive physical health assessment within the previous 12 months

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have had a comprehensive physical health assessment within the previous 12 months
- Data source: local data collection

Quality Statement 3: Self-Management

Percentage of adults with schizophrenia who have received education about self-management

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have received education about self-management
- Data source: local data collection

Percentage of adults with schizophrenia who report feeling confident in the self-management of their symptoms

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who respond "Confident" or "Very confident" to the following question: "How confident are you in your ability to manage your schizophrenia symptoms?" (Response options: Very confident, Confident, Not confident, Not at all confident, Unsure)
- Data source: local data collection

Quality Statement 4: Family Education, Support, and Intervention

Percentage of adults with schizophrenia whose family members receive education, support, and family intervention by a trained practitioner

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator whose family members receive education, support, and family intervention by a trained practitioner
- Data source: local data collection

Percentage of adults with schizophrenia whose family members or unpaid caregivers report continued feelings of distress, anger, or depression over a 12-month period

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator whose family members or unpaid caregivers report continued feelings of distress, anger, or depression over a 12-month period (indicator adapted from Resident Assessment Instrument–Home Care [RAI-HC])
- Data source: local data collection

Quality Statement 5: Access to Community-Based Intensive Treatment Services

Percentage of adults with a first presentation of schizophrenia who receive early psychosis intervention within 2 weeks of referral

- Denominator: total number of adults with a first presentation of schizophrenia
- Numerator: number of people in the denominator who receive early psychosis intervention within 2 weeks of referral
- Data source: local data collection

Percentage of adults with schizophrenia who have been assessed as requiring intensive case management who receive intensive case management within 2 weeks of referral

- Denominator: total number of adults with schizophrenia who have been assessed as requiring intensive case management
- Numerator: number of people in the denominator who receive intensive case management within 2 weeks of referral
- Data source: local data collection
- Potential stratification: level of need (high vs. low)

Percentage of adults with schizophrenia who have been assessed as requiring assertive community treatment who receive assertive community treatment within 2 weeks of referral

- Denominator: total number of adults with schizophrenia who have been assessed as requiring assertive community treatment
- Numerator: number of people in the denominator who receive assertive community treatment within 2 weeks of referral
- Data source: local data collection
- Potential stratification: level of need (high vs. low)

Percentage of adults with schizophrenia who have had their need for community services assessed using a standardized, validated tool

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have had their need for community services assessed using a standardized, validated tool (such as the Level of Care Utilization System or the Ontario Common Assessment of Need)
- Data source: local data collection

Quality Statement 6: Housing

Percentage of adults with schizophrenia who report living in a safe, affordable, and stable living environment

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report living in a safe, affordable, and stable living environment
- Data sources: Ontario Common Assessment of Need, local data collection

Percentage of adults with schizophrenia who report being homeless or precariously housed

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report being homeless or precariously housed
- Data sources: Ontario Common Assessment of Need, local data collection

Quality Statement 7: Antipsychotic Monotherapy

Percentage of adults with schizophrenia who have been prescribed and are taking a single antipsychotic medication

- Denominator: total number of adults with schizophrenia who have been prescribed an antipsychotic medication
- Numerator: number of people in the denominator who are taking a single antipsychotic medication
- Data source: local data collection

Percentage of adults with schizophrenia who have had their antipsychotic medication reviewed in the past 12 months

- Denominator: total number of adults with schizophrenia who have been prescribed an antipsychotic medication
- Numerator: number of people in the denominator who have had their antipsychotic medication reviewed in the past 12 months (including response, observed benefits, and side effects), or more frequently if clinically indicated
- Data source: local data collection

Percentage of adults with schizophrenia who have been prescribed an antipsychotic medication (or their substitute decision-makers) who felt involved in discussions about their medications, including benefits, risks, clinical response, and side effects

- Denominator: total number of adults with schizophrenia who have been prescribed an antipsychotic medication
- Numerator: number of people in the denominator (or their substitute decision-makers) who felt involved in discussions about their medications, including benefits, risks, clinical response, and side effects
- Data source: local data collection

Quality Statement 8: Treatment With Long-Acting Injectable Antipsychotic Medication

Percentage of adults with schizophrenia who have been offered a long-acting injectable antipsychotic medication

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have been offered a long-acting injectable antipsychotic medication
- Data source: local data collection

Percentage of adults with schizophrenia who have been prescribed a long-acting injectable antipsychotic medication (or their substitute decision-makers) who felt involved in discussions about their medication, including benefits, risks, clinical response, and side effects

- Denominator: total number of adults with schizophrenia who have been prescribed a long-acting injectable antipsychotic medication
- Numerator: number of people in the denominator (or their substitute decision-makers) who felt involved in discussions about their medication, including benefits, risks, clinical response, and side effects
- Data source: local data collection

Quality Statement 9: Treatment With Clozapine

Percentage of adults with schizophrenia who receive clozapine

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who receive clozapine
- Data source: local data collection

Percentage of adults with schizophrenia who did not respond adequately to treatment with at least two different antipsychotic medications, and who receive clozapine

- Denominator: total number of adults with schizophrenia who did not respond adequately to treatment with at least two different antipsychotic medications
- Numerator: number of people in the denominator who receive clozapine
- Data source: local data collection

Percentage of adults with schizophrenia who have had their clozapine medication reviewed in the past 12 months

- Denominator: total number of adults with schizophrenia who have been prescribed clozapine
- Numerator: number of people in the denominator who have had their clozapine medication reviewed in the past 12 months (including response, observed benefits, and side effects), or more frequently if clinically indicated
- Data source: local data collection

Quality Statement 10: Continuation of Antipsychotic Medication

Percentage of adults with schizophrenia who have been dispensed an antipsychotic medication who have continuously been dispensed an antipsychotic medication since initiation

- Denominator: total number of adults with schizophrenia who have been dispensed an antipsychotic medication
- Numerator: number of people in the denominator who have continuously been dispensed an antipsychotic medication since initiation
- Data sources: Ontario Drug Benefit Claims Database (for those age 65 and older; measures if the prescription was dispensed, not necessarily taken), local data collection (for those younger than age 65 and for those receiving antipsychotics not included in the Ontario Drug Benefit Claims Database, and to calculate the denominator)

Percentage of adults with schizophrenia who experience a relapse

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who experience a relapse (a return or worsening of symptoms)
- Data sources: Local data collection, National Ambulatory Care Reporting System (for relapses resulting in an emergency department visit), Discharge Abstract Database (for relapses resulting in a hospitalization), Ontario Health Insurance Plan Claims Database (for relapses resulting in a physician visit)
- Potential stratification: use of antipsychotics at the time of relapse; sector of care

Quality Statement 11: Cognitive Behaviour Therapy for Psychosis and Other Psychosocial Interventions

Percentage of adults with schizophrenia who have received cognitive behavioural therapy for psychosis

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have received cognitive behavioural therapy for psychosis
- Data source: local data collection

Percentage of adults with schizophrenia and concurrent depression and anxiety who have received cognitive behavioural therapy for depression and anxiety

- Denominator: total number of adults with schizophrenia and concurrent depression and anxiety
- Numerator: number of people in the denominator who have received cognitive behavioural therapy for depression and anxiety
- Data source: local data collection

Percentage of adults with schizophrenia and cognitive impairments that affect their functioning who have received cognitive remediation

- Denominator: total number of adults with schizophrenia and cognitive impairments that affect their functioning
- Numerator: number of people in the denominator who have received cognitive remediation
- Data source: local data collection

Local availability of cognitive behavioural therapy programs given by trained and certified professionals

- Data source: local data collection

Local availability of cognitive remediation programs given by trained and certified professionals

- Data source: local data collection

Quality Statement 12: Promoting Physical Activity and Healthy Eating

Percentage of adults with schizophrenia who regularly receive interventions that promote physical activity and healthy eating

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who regularly receive interventions that promote physical activity and healthy eating
- Data source: local data collection

Local availability of programs that promote healthy eating and physical activity for adults with schizophrenia

- Data source: local data collection

Percentage of adults with schizophrenia who report being active during their leisure time

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report being active during their leisure time
- Data sources: local data collection, Canadian Community Health Survey
- Exclusion: survey non-response categories (refusal, don't know, not stated)

Quality Statement 13: Promoting Smoking Cessation

Percentage of adults with schizophrenia who smoke tobacco and who have developed a plan in the past 12 months to reduce or stop tobacco use

- Denominator: total number of adults with schizophrenia who smoke tobacco
- Numerator: number of people in the denominator who have developed a plan in the past 12 months to reduce or stop tobacco use
- Data source: local data collection

Percentage of adults with schizophrenia who smoke tobacco and receive at least one pharmacological or nonpharmacological intervention to help them reduce or stop smoking tobacco

- Denominator: total number of adults with schizophrenia who smoke tobacco
- Numerator: number of people in the denominator who receive at least one pharmacological or nonpharmacological intervention to help them reduce or stop smoking tobacco
- Data source: local data collection
- Potential stratification: intervention method (i.e., pharmacological or nonpharmacological)

Percentage of adults with schizophrenia who smoke tobacco daily

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report smoking tobacco daily
- Data sources: local data collection, Canadian Community Health Survey

Quality Statement 14: Assessing and Treating Substance Use Disorder

Percentage of adults with schizophrenia who have been assessed in the past year for substance use

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have been assessed in the past year for substance use
- Data source: local data collection

Percentage of adults with schizophrenia and substance use disorder who receive treatment for substance use disorder

- Denominator: total number of adults with schizophrenia and substance use disorder
- Numerator: number of people in the denominator who receive treatment for substance use disorder
- Data source: local data collection

Quality Statement 15: Employment and Occupational Support

Percentage of adults with schizophrenia who wish to work and who participate in supported employment programs

- Denominator: number of adults with schizophrenia who wish to work
- Numerator: number of people in the denominator who participate in supported employment programs
- Data source: local data collection

Percentage of adults with schizophrenia who are not seeking paid work and who participate in other occupational or educational activities, in accordance with their needs and preferences

- Denominator: number of adults with schizophrenia who are not seeking paid work
- Numerator: number of people in the denominator who participate in other occupational or educational activities, in accordance with their needs and preferences
- Data source: local data collection

Local availability of supported employment programs for people with schizophrenia

- Data source: local data collection

Local availability of supported pre-vocational training, education, and volunteering programs for people with schizophrenia

- Data source: local data collection

Percentage of adults with schizophrenia who report contributing meaningfully to their community and to society

- Denominator: total number of adults with schizophrenia who respond to the question, "In the past month, how often did you feel that you had something important to contribute to society?" (Response options: Every day; Almost every day; About 2 or 3 times a week; About once a week; Once or twice; Never)[69]
- Numerator: number of people in the denominator who respond "Every day," "Almost every day," or "About 2 or 3 times a week"
- Data sources: local data collection, Canadian Community Health Survey

Appendix 3. Glossary

Adult: Person 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).

Home: A person's usual place of residence. This may include personal residences, retirement residences, assisted-living facilities, long-term care facilities, hospices, and shelters.

Primary care: A setting where people receive general health care (e.g., screening, diagnosis, and management) from a regulated health care professional whom the person can access directly without a referral. This is usually the primary care physician, family physician, nurse practitioner, or other health care professional with the ability to make referrals, request biological testing, and prescribe medications.[70,71]

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

Substitute decision-maker: A person appointed to make decisions on behalf of another. Ontario's *Health Care Consent Act* outlines a hierarchical list of people who are automatically considered a substitute decision-maker when a person is incapable of making decisions about their own care.[8] If a capable person prefers to assign someone to this role other than their automatic substitute decision-maker, they can formally appoint someone else using a "Power of Attorney for Personal Care."[9]

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.

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.[72]

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.[73,74]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 ongoing limitations caused by mental health problems and illnesses."[75] 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."[40]

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.[76] 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." [76]

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.[40] Further, people should be empowered to make informed choices about the services that best meet their needs.[75] 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.[40]

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,[77] including social stigma, discrimination, and a lack of access to education, employment, income, and housing.[25]

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.[78,79] 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.[80,81]

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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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