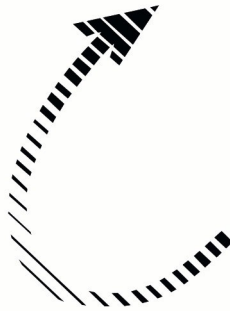


**Instruments 2.
Strumenti 2.**



**SOCIETA' ITALIANA
DI EPIDEMIOLOGIA
PSICHIATRICA
S.I.E.P.**

**PROJECT SIEP-DIRECT'S*
INDICATORS FOR ASSESSING
DISCREPANCIES BETWEEN ROUTINE PRACTICE AND EVIDENCE
IN PSYCHIATRIC COMMUNITY TREATMENTS
PROVIDED TO PEOPLE WITH SCHIZOPHRENIA**

ENGLISH VERSION
October 2008

This set of indicators has been developed by
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in collaboration with the Experts' Workgroup of the
"PROJECT SIEP-DIRECT"

The *National Institute for Clinical Excellence* (NICE) has been consulted during the production of this document and can confirm that the set of the SIEP clinical indicators used have been based on the recommendations detailed in the NICE clinical guideline on schizophrenia. NICE has approved the use of those materials relating to its guidelines and the links made with them. (*NICE Committee, July 2008*)

* **The Project SIEP-DIRECT'S** (Discrepancy between Routine practice and Evidence in psychiatric Community Treatments on Schizophrenia) has been conceived and promoted by Mirella Ruggeri during her Presidency mandate of the Italian Society of Psychiatric Epidemiology (October 2003-october 2007), and the Project's conduction coordinated by Domenico Semisa and Mirella Ruggeri herself.

The set of indicators, once developed, has been first discussed with a Group of Italian Experts constituted by (in alphabetical order): Fabrizio Asioli; Andrea Balbi; Giacinto Buscaglia; Giuseppe Carrà; Massimo Casacchia; Giuseppe Corlito; Walter Di Munzio; Arcadio Erlicher; Antonio Lasalvia; Antonio Lora; Alessandra Marinoni; Maurizio Miceli; Carla Morganti; Pierluigi Morosini; Mirella Ruggeri; Domenico Semisa.

In a subsequent phase, the set of indicators and the overall Project's design have been revised by an International Advisory Board constituted by: (in alphabetical order): Gillian Leng (London), Itzhack Levav (Gerusalem), Tommaso Losavio (Roma), Mario Maj (Napoli), Alessandra Marinoni (Pavia), Pierluigi Morosini (Roma), Steve Pilling (London), Shekhar Saxena (Geneva), Michele Tansella (Verona).

THE INDICATORS

1. The SIEP-DIRECT'S Project indicator system is intended for use by all those in contact with mental health services and receiving a diagnosis of schizophrenia according to the following diagnostic criteria:
 - a. ICD 10: F2 group (Schizophrenia, schizotypal syndrome and delusional syndromes)
 - b. ICD 9 CM : 295.0-9 – 297 - 298.3 – 298 - 299
2. The time frame for each indicator is the year preceding the assessment (i.e.: the time frame for assessments being conducted in the summer 2005, is the year 2004); instances of different time frames are specified in the corresponding indicator text.
3. For the definition of different types of facilities and intervention see *Il Sistema Informativo Nazionale per la Salute Mentale – Modello per la rilevazione di strutture, personale, attività e prestazioni dei Dipartimenti di Salute Mentale – Testo approvato dalla Conferenza fra lo Stato, le Regioni e le Province Autonome – Seduta 11 ottobre 2001*. The can be downloaded at <http://www.nsis.ministerosalute.it/>. The indicators are based on the recommendations derived from the NICE Guidelines for Schizophrenia (NICE, 2004)
4. Data marked with (#) are reported several times in the indicator list (as numerators or denominators): it is important that the same value be maintained for the different indicators (e.g., if the number of patients in contact with a given mental health service is 825, this value should remain unchanged each time the number of patients in contact with that mental health service is requested as numerator or denominator).
5. The general structure of each indicator is the following:

	Indicator number
INDICATOR	Indicator name
<i>RECOMMENDATION</i>	<i>The specific NICE recommendation from which the indicator is derived and level of evidence</i>
MEASURE	It may be quantitative (i.e. percentage) or qualitative (i.e. YES-NO)
NUMERATOR	For percentages
DENOMINATOR	For percentages
SOURCE	Describes the source of information
NOTES	This section reports both operational definitions and instructions for calculating the indicator.

When it is not possible to specifically rate an indicator, use:

- **Not applicable = NA** (to be used when the indicator is not applicable in the context being considered; the reason for the indicator's inapplicability should be reported in the accompanying data notes)
- **Not reported = NR** (to be used when it is not possible to collect any information on the indicator being assessed)

GUIDELINES, PROCEDURES AND PRACTICES

“**Clinical guidelines**” are written documents intended to assist clinicians in making decisions about appropriate treatment for specific conditions. Guidelines are different from procedures, because in addition to clinical experience, they are based on the best research evidence available, and because they address situations for which recommendations may not be absolute, but only probabilistic. In other words, in certain situations, it is possible, or even necessary that clinicians not follow the guidelines, provided the physicians state their decision and specify their reasons. Guidelines should insofar as possible be based on research evidence (each recommendation should be at least accompanied by its “level of evidence” specification, classified according the hierarchy proposed

by the Cochrane Collaboration or by similar scales). Moreover, and similarly to procedures, guidelines should be easily accessible by all interested staff; they should be up-to-date or confirmed by no more than 5 years; and various categories of professionals from all fields of interest--together with an expert in systematic review methodology and possibly, at least one--patient- and carer organisation member--should be involved in first draft development and local guideline adaptation.

“Procedure” is a written document aiming to facilitate staff uniformity in professional behaviour, discourage unjustified variations in professional behaviour and, therefore, to prevent clinical error (Morosini & Perraro, 1999). Moreover, and similarly to guidelines, procedures should be easily accessible by all interested staff; they should be up-to-date or confirmed by no more than 5 years; and various categories of professionals from all fields of interest--together with an expert in systematic review methodology and possibly, at least one--patient- and carer organisation member--should be involved in first draft development and local guideline adaptation.

Regardless of whether procedures are in place or not, **“good practices”** should be available. When procedures or guidelines are available, good practices should document their proper application. If procedures or guidelines are unavailable, good practices should be confirmed by the fact (based, e.g., on clinical records, CQI programs, training courses, interviews with professionals or focus groups) that they are performed homogeneously by different staff members in most situations or patients to which they refer (Morosini *et al.*, 2000). Focus groups assess the congruence of the practices taking place in a given mental health service with respect to the NICE guideline-derived recommendations.

It is important to note that the data collected in the context of the SIEP Project should be complemented with all the written documents (guidelines and procedures) to which they refer. In addition to a written document, a formal assessment should be conducted (e.g., by focus group or specific study) for all items examining a guideline and/or of a procedure’s quality and/or adherence and/or application in clinical routine.

The word “carers” has been used throughout the text: the term does not strictly refer to patients’ family members, but more extensively to all individuals providing continuous informal care to patients, whether linked by family ties or not.

FRAMEWORK DATA

These data should be available at the beginning of the data collection phase; they appear several times in the indicators (marked by #) or are useful for characterising the NHS Department of Mental Health (DMH) being assessed or for describing patient characteristics:

1. Number of professionals working in the service by professional category (as of December 31st of the reference year of data collection)
2. Number of patients who have had at least one contact with the participating DMH or one admission in the participating DMH inpatient facilities (corresponding to the 1-year treated prevalence of schizophrenia)
3. Number of patients with DMH contact living with their families (with partner and/or parents and/or adult children)
4. Number of patients with DMH contact who are of working age and number of non-working condition, sex, and age
5. Number of first-episode patients with DMH contact (given by summing the nr. Of patients with schizophrenia diagnosis at their first psychiatric admission and at their first CMHC outpatient contact)

6. Number of patients in contact with the Community Mental Health Centre (CMHC) (all patients who had at least one CMHC outpatient contact or with other DMH outpatient facilities)
7. Number of patients discharged from the General Hospital Psychiatric Ward (GHPW) in the considered timeframe.

DATA SOURCES

Possible information sources for data collection are:

- **DMH information systems**, which are used to record data on patient characteristics and type of interventions received. Examples of data collected through information systems are: number of patients with multiple in-patient admissions, number of patients receiving psychoeducational interventions, number of patients receiving at least one contact every three months, etc.
- Specific local **research projects**—these projects can be organisationally onerous, but they are necessary for obtaining information on specific, otherwise-unexplorable areas. Although it is possible to use data drawn from research projects conducted in the assessed mental health service over the previous five years, a new study on a given indicator topic must be carried out if no specific research projects have been conducted during this time frame. Two research strategies are indicated:
 - .1. **questionnaire administration on patient samples** (e.g., the indicator assessing the quality of information on schizophrenia provided by service staff to patients and their carers)
 - .2. **reviews of clinical notes**

An optimal sample size cannot be easily defined, as it is inevitably linked to the availability of human resources involved in data collection and the quality of local information systems. Overall, for research conducted on relatively infrequent cases (such as first-episode patients, or patients on depot antipsychotic treatment) all potentially available participants must be recruited; for research on more frequent observations (such as antipsychotic drug dosages, data collection can be limited to a sample (e.g., inpatients admitted between January-April 2005 and treated with average antipsychotic doses over the standard range). It should be specified in the accompanying data notes whether the information is drawn from all eligible cases or from a sample; in the latter instance, sample size should be always indicated.
- **DMH Direction** represents the main information source on the availability of procedures and guidelines.
- **Focus Groups** represent the main source of information on the adequacy of local practices with respect to the NICE recommendations. Two types of focus groups are indicated:
 1. **Multidisciplinary focus groups**, made up of various mental health professional categories, together with patient/carer organization representatives.
 2. **Specialist focus groups**, made up of a single category of mental health professionals. For example, focus groups addressing psychopharmacological treatment issues should be composed mainly of psychiatrists.

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**PROJECT SIEP-DIRECT'S
INDICATORS FOR ASSESSING
DISCREPANCIES BETWEEN ROUTINE PRACTICE AND EVIDENCE
IN PSYCHIATRIC COMMUNITY TREATMENTS PROVIDED TO PEOPLE WITH
SCHIZOPHRENIA**

1. CARE ACROSS ALL PHASES

1. Promoting optimism among professionals
2. Assessment of health and social care needs
3. Intensity of community mental health care provided to patients
4. Intensity of community mental health care provided to carers
5. Availability and utilization of written information on schizophrenia for patients
6. Availability and utilization of written information on schizophrenia for carers
7. Written procedures concerning information and informed consent for treatment
8. Practices related to the informed consent for treatment
9. Patient satisfaction with information received
10. Carer satisfaction with information received
11. Participation in non psychoeducational family or carer support programmes
12. Patient satisfaction with clarity of language used by staff members
13. Carer satisfaction with clarity of language used by staff members
14. Availability and utilization of written material in languages different from Italian

Note. This Section contains the indicators pertaining to all the NICE Guidelines recommendations for Schizophrenia, with the exception of the recommendations 4.1.8.1 and 4.1.8.2 concerning the “Advance directives” which are considered not applicable to the Italian mental health service context.

RECOMMENDATION	<i>4.1.1.1 Health professionals should work in partnership with service patients and carers, offering help, treatment and care in an atmosphere of hope and optimism. LEVEL OF EVIDENCE GPP</i>
INDICATOR	1.1 Promoting optimism among professionals
MEASURE	Ratings: 0 = less than 10% of professionals express optimism on the treatment of schizophrenia and on most patients' (approximately > 80%) capacity to actively collaborate 1 = 10%-25% of professionals express optimism on the treatment of schizophrenia and on most patients' (approximately > 80%) capacity to actively collaborate. 2 = 26%-50% of professionals express optimism on the treatment of schizophrenia and on the capacity of patients to actively collaborate 3 = 51%-75% of professionals express optimism on the treatment of schizophrenia and on the capacity of patients to actively collaborate 4 = more than 75% of professionals express optimism on the treatment of schizophrenia and on the capacity of patients to actively collaborate
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group

RECOMMENDATION	<i>4.1. 2.1. Service patients and their relatives seeking help should be assessed and receive treatment at the earliest possible opportunity. LEVEL OF EVIDENCE GPP</i>
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RECOMMENDATION	<i>4.1.3.1 The assessment of needs for health and social care of people with schizophrenia should be comprehensive and should address medical, social, psychological, occupational, economic, physical and cultural issues</i> LEVEL OF EVIDENCE GPP
INDICATOR	1.2 Assessment of health and social care needs
MEASURE	Percentage
NUMERATOR	Number of outpatient clinical notes in the previous year making (even passing) mention of patients' living and/or family and/or occupational conditions, or mentioning that patients' social problems had been discussed during a staff meeting
DENOMINATOR	Number of patients with CMHC contact during the previous year (#)
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes
NOTES	Staff meetings represent coordinating and monitoring activities undertaken by DMH staff (meetings/discussions on individual DMH cases): they are focussed on individual patients and their specific care needs

RECOMMENDATION	<i>4.1.4.1 Health professionals involved in the routine treatment and management of schizophrenia should take time to build a supportive and empathic relationship with service patients and carers; this should be regarded as an essential element of the routine care offered</i> LEVEL OF EVIDENCE GPP
INDICATOR	1.3 Intensity of community mental health care provided to patients
MEASURE	Percentage of patients by number of service contacts in the previous year (6 classes: 0; 1-2; 3-5; 6-10; 11-20; >20)
NUMERATOR	Number of patients by number of contacts in the previous year
DENOMINATOR	Number of patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system
NOTES	<ul style="list-style-type: none"> Carer contact, as assessed in indicator 1.4, should not be considered Both individual and group CMHC interventions, together with day centre attendance should be included.
INDICATOR	1.4 Intensity of community mental health care provided to carers
MEASURE	Percentage of patients by number of carer contacts with the CMHC in the previous year (6 classes: 0;1-2; 3-5; 6-10; 11-20; >20)
NUMERATOR	Number of patients by number of carer contacts with the CMHC in the previous year
DENOMINATOR	Number of patients with CMHC contact living with family members/carers (parents, brothers/sisters, partners, children) in the previous year
SOURCE	<ul style="list-style-type: none"> DMH information system

RECOMMENDATION	<i>4.1.4.2 Clear and intelligible information should be made available to service patients and their families about schizophrenia and its possible causes, and about the possible role families can have in promoting recovery and reducing relapse</i> LEVEL OF EVIDENCE GPP
INDICATOR	1.5 Availability and utilization of written information on schizophrenia for patients
MEASURE	Ratings 0 = written information for service patients is unavailable 1 = written information is available, but it is seldom used by the service staff (in

	<p>less than 25% of cases)</p> <p>2 = written information is available, and it is used by the service staff in 26%-50% of cases</p> <p>3 = written information is available and is used in 51%-75% of cases</p> <p>4 = written information is available and is used in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group
NOTES	<p>The questionnaire should explore the following aspects:</p> <ol style="list-style-type: none"> aetiology of the disorder symptoms' characteristics pharmacological treatments and side effects psychosocial interventions course of illness interventions provided by the DMH <p>For each item, patients should be asked whether they have received thorough information</p>
INDICATOR	1.6 Availability and utilization of written information on schizophrenia for carers
MEASURE	<p>Ratings</p> <p>0 = written information for carers is unavailable</p> <p>1 = written information is available, but it is seldom used by the service staff (in less than 25% of cases)</p> <p>2 = written information is available, and it is used by the service staff in 26%-50% of cases</p> <p>3 = written information is available, and it is used in 51%-75% of cases</p> <p>4 = written information is available, and it is used in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group

RECOMMENDATION	<p><i>4.1.5.1 Health professionals should make all efforts necessary to ensure that a service patient can give meaningful and properly informed consent before treatment is initiated, giving adequate time for discussion and the provision of written information.</i></p> <p>LEVEL OF EVIDENCE GPP</p>
INDICATOR	1.7 Written procedures concerning information and informed consent for treatment
MEASURE	<p>Ratings:</p> <p>0 = written procedures on information to be provided to patients and carers, on information provision procedures, and informed consent procedures are unavailable</p> <p>1 = written procedures are available, but they are too generic or cover less than half of the listed contents (information to be provided to patients and carers, modalities for the information provision and modalities to be used to gain informed consent from patients)</p> <p>2 = written procedures are available, detailed, and cover the majority of the listed contents (information to be provided to patients and carers, modalities for the information provision and modalities be used to gain informed consent from patients)</p> <p>3 = written procedures are available, detailed and cover all the listed contents (information to be provided to patients and carers, modalities for the information provision and modalities be used to gain informed consent from patients); rules and responsibilities are not clearly defined</p> <p>4 = written procedures are available, detailed, cover all the listed contents (information to be provided to patients and carers, modalities for the information provision and modalities be used to gain informed consent from patients) and clearly define rules and responsibilities</p>
SOURCE	<ul style="list-style-type: none"> DMH Direction

INDICATOR	1.8 Practices related to the informed consent for treatment
MEASURE	Rate the indicator based on the frequency with which the DMH staff obtains informed consent to treatment from patients 0 = never 1 = less than 25% of cases 2 = 26-50% of cases 3 = 51-75% of cases 4 = more than 75% of cases
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group

<i>RECOMMENDATION</i>	<i>4.1.6.1 Health professionals should provide accessible information about schizophrenia and its treatment to service patients and carers; this should be considered an essential part of the routine treatment and management of schizophrenia</i> LEVEL OF EVIDENCE GPP
INDICATOR	1.9 Patient satisfaction with information received
MEASURE	Percentage
NUMERATOR	Number of patients who report having received sufficient information on at least three of the topics listed in the Notes, as assessed by a specific questionnaire (see items 1-6 of the <i>Patients Questionnaire</i> in the Section “Instruments 3.”, scores “4” and “5”)
DENOMINATOR	Number of patients completing the questionnaire
SOURCE	<ul style="list-style-type: none"> Specific research on a representative sample of service patients
NOTES	The questionnaire should explore the following topics: <ol style="list-style-type: none"> aetiology of the disorder symptoms’ characteristics course of illness pharmacological treatments and side effects psychosocial interventions interventions provided by the DMH For each item, patients should be asked whether they have received satisfactory information.
INDICATOR	1.10 Carer satisfaction with information received
MEASURE	Percentage
NUMERATOR	Number of carers reporting they have received sufficient information on the patient’s disorder with respect to at least three of the topics listed in the Notes, as assessed by a specific questionnaire (see items 1-6 of the <i>Caregivers Questionnaire</i> in the Section “Instruments 3.”, scores “4” and “5”)
DENOMINATOR	Number of service patients completing the questionnaire
SOURCE	<ul style="list-style-type: none"> Specific research on a representative sample of carers--one carer for each patient--and selecting, among possible carers, individuals spending the most time with that patient
NOTES	The questionnaire should explore the following topics: <ol style="list-style-type: none"> aetiology of the disorder symptoms’ characteristics course of illness pharmacological treatments and side effects psychosocial interventions interventions provided by the DMH For each item, carers should be asked whether they have received satisfactory information.

RECOMMENDATION	4.1.6.2 <i>In addition to the provision of good-quality information, families and carers should be offered the opportunity to participate in family or carer support programmes, where these exist</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	1.11 Participation in non psychoeducational family or carer support programmes
MEASURE	Percentage
NUMERATOR	Number of families receiving family or carer support programmes conducted by CMHC staff members in the previous year
DENOMINATOR	Number of patients with CMHC contact living with family members/carers (parents, brothers/sisters, partners, children) in the reference year
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes • DMH information system
NOTES	<ul style="list-style-type: none"> • The numerator for family interventions is given by the number of families involved in these activities; different family members from the same family participating in a given group should be considered only once. • Family or carer support programmes refer to family interventions that differ from structured psychoeducational interventions, such as staff-conducted carer groups focussed on discussion and support, carer self-help groups (in the latter instance, without staff member intervention).

RECOMMENDATION	4.1.7.1 <i>When talking to service patients and carers, health professionals should avoid using clinical language, or at least keep it to a minimum. Where clinical language is used, service patients and carers should have access to written explanations</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	1.12 Patient satisfaction with clarity of language used by staff members
MEASURE	Number of patients reporting they have received information on their disorder in clear and intelligible language, which avoids any clinical jargon, as assessed by a specific questionnaire (see item 7 of the <i>Patients Questionnaire</i> in the Section “Instruments 3.”)
NUMERATOR	Number of patients reporting they have received satisfactory information (scores “4” and “5” reported on item 7 of the questionnaire)
DENOMINATOR	Number of service patients completing the questionnaire
SOURCE	<ul style="list-style-type: none"> • Specific research conducted on a representative service patient sample
INDICATOR	1.13 Carer satisfaction with clarity of language used by staff members
MEASURE	Number of caregivers reporting they have received information on the patient’s disorder in clear and intelligible language, which avoids any clinical jargon, as assessed by a specific questionnaire (see item 7 of the <i>Caregivers Questionnaire</i> in the Section “Instruments 3”)
NUMERATOR	Number of caregivers reporting they have received satisfactory information (scores “4” and “5” reported on item 7 of the questionnaire)
DENOMINATOR	Number of service patients and carers completing the questionnaire
SOURCE	<ul style="list-style-type: none"> • Specific research conducted on a representative carer sample

RECOMMENDATION	4.1.7.2 <i>All services should provide written material in the language of the service patient, and interpreters should be sought for people who have difficulty in speaking Italian</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	1.14 Availability and utilization of written material in languages different

	from Italian
MEASURE	Ratings 0 = written material in languages other than Italian is unavailable 1 = written material is available, but is seldom used by the service staff (in less than 25%) 2 = written material is available and is used by service staff in 26%-50% of cases 3 = written material is available and is used in 51%-75% of cases 4 = written material is available and is used in more than 75% of cases NA = NOT APPLICABLE
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group
NOTES	This indicator applies only to DMH population catchment areas with > 10% of their inhabitants speaking languages other than Italian.

1. INITIATION OF TREATMENT (THE FIRST EPISODE)

1. First CMHC outpatient visit waiting times
2. Early intervention services or programs
3. Intake procedures and guidelines for treating first-episode patients
4. Differentiated activities for treating first-episode patients
5. Frequency of CMHC contacts with first-episode patients
6. Frequency of CMHC contacts with carers of first-episode patients
7. Other crisis resolution services for first-episode patients
8. Guidelines for the pharmacological treatment of first episode
9. Initiation of treatment with atypical antipsychotics
10. Oral antipsychotics dosages prescribed for first episode
11. Supporting patients and carers in their decision to seek a second diagnostic opinion

Note. This Section lists indicators pertaining to all of the NICE Guideline recommendations for Schizophrenia, with the exception of recommendation 4.2.3.1, which concerns early psychopharmacological treatments provided by general practitioners, considered to be not applicable to the Italian [mental health] service context.

RECOMMENDATION	4.2.1.1 <i>In primary care, all people with suspected or newly diagnosed schizophrenia should be referred urgently to secondary mental health services for assessment and development of a care plan.</i> LEVEL OF EVIDENCE GPP
INDICATOR	2.1 First CMHC outpatient visit waiting times
MEASURE	Frequency distribution of patients at first CMHC contact by waiting time from first psychiatric referral (waiting times are grouped into 4 classes : 1-2 days; 3-7 days ; 7-14 days; > 14 days)
NUMERATOR	Number of patients at first CMHC contact in the previous year by waiting time classes
DENOMINATOR	Number of patients at first CMHC contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system Local Health Unit information system
NOTES	Both workdays and holidays should be considered when calculating waiting times

RECOMMENDATION	4.2.2.1 <i>Because many people with actual or possible schizophrenia have difficulty in getting help, treatment and care at an early stage, it is recommended that early intervention services are developed to provide the correct mix of specialist pharmacological, psychological, social, occupational and educational interventions at</i>
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	<i>the earliest opportunity</i> LEVEL OF EVIDENCE GPP
INDICATOR	2.2 Early intervention services or programs
MEASURE	Ratings: 0 = no early detection and intervention programs are available for first-episode patients 1 = no specific programs are available at the moment, but early intervention programs are scheduled to take place by the next year 2 = some specific programs are available, but are neither systematic nor implemented in routine clinical practice 3 = specific programs are available, implemented in routine clinical practice and planned by the DMH, with dedicated staff; no specific early intervention services are available 4 = specific services providing early interventions for first-episode patients are available
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
NOTES	The availability of specific early intervention services for first-episode patients is reflected by the presence of DMH facilities focussed specifically on early intervention and which have dedicated staff providing care to individuals with recent onset schizophrenia, for a well-defined portion of their working hours
INDICATOR	2.3 Intake procedures and guidelines for the treating first-episode patients
MEASURE	Ratings : 0 = neither written intake procedures nor guidelines for the treatment of first-episode patients are available 1 = written intake procedures and /or guidelines for the treatment of first-episode patients are available, but are generic 2 = written detailed intake procedures are available, but guidelines for the treatment of first-episode patients are lacking or are generic 3 = both written detailed intake procedures and guidelines for the treatment of first-episode patients are available; specific rules and responsibilities are not well-defined (written care pathways are lacking) 4 = same as 3, but rules and responsibilities are well-defined (written care pathways are available)
SOURCE	<ul style="list-style-type: none"> • DMH Direction
INDICATOR	2.4 Differentiated activities for treating first-episode patients
MEASURE	Rate the indicator based on the availability of differential activities provided by DMH staff specifically focused on first-episode patients 0 = none 1 = less than 25% of cases 2 = 26-50% of cases 3 = 51-75% of cases 4 = more than 75% of cases
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
INDICATOR	2.5 Frequency of CMHC contacts with first-episode patients
MEASURE	Percentage of first-episode patients by mean number of CMHC contacts/month (5 classes: 0; 1-2; 3-5; 6-10; >10). Consider the previous year as the timeframe of reference.
NUMERATOR	Number of first-episode patients by mean number of CMHC contacts by months of treatment duration in the previous year
DENOMINATOR	Number of first-episode patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> • DMH information system
NOTES	<ul style="list-style-type: none"> • Patients experiencing a first episode might have had DMH contact in the previous year for less than 12 months; frequency categories should therefore

	<p>be calculated based on patients' mean number of monthly service contacts.</p> <ul style="list-style-type: none"> • contacts with carers as assessed in the following indicator should not be included; both inpatient and residential contacts should also be excluded. • both individual and group community contacts, together with day centre attendance, should be included
INDICATOR	2.6 Frequency of CMHC contacts with carers of first-episode patients
MEASURE	Percentage of first-episode patients by mean number of CMHC contacts/month of carers (5 classes: 0; 1-2; 3-5; 6-10; >10). Consider the previous year as the timeframe of reference.
NUMERATOR	Number of first-episode patients by mean number of CMHC contacts of carers by months of patient treatment duration in the previous year
DENOMINATOR	Number of first-episode patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> • DMH information system
NOTES	<ul style="list-style-type: none"> • Patients experiencing a first episode might have had DMH contact in the previous year for less than 12 months; frequency categories should therefore be calculated based on patients' mean number of monthly service contacts. • Interventions for carers are aimed at gaining information, improving relations among family members; providing information, emotional support, and education on psychiatric disorders; and increasing carers' ability to cope with patients' behaviour and disabilities. They include both meetings with carers and structured family psycho-educational interventions. <p>CARER/FAMILY MEETINGS are interventions aimed at examining intra-family problems and/or involving informal resources in therapeutic/rehabilitation programs. Unstructured information may be provided during meetings. Family members, other carers, key informants participate during these meetings without patients present, and are not taught to adopt specific techniques.</p> <p>They include: meetings with carers without patient participation, even if previous individual sessions with patients have occurred (as long as the two types of interventions are distinct and take place on different occasions).</p> <p>They exclude: meetings in which both patients and carers simultaneously participate (→ individual sessions, individual psychotherapy, psychiatric outpatient contacts); structured psycho-educational interventions (→ family psycho-educational interventions); family therapy (→ family psychotherapy); telephone contacts.</p> <p>PSYCHOEDUCATIONAL FAMILY INTERVENTION (INDIVIDUAL AND GROUP), single family or multi-family intervention.</p> <p>Psychoeducational interventions imply the adoption of specific techniques and require specific training for therapists administering them. They generally aim at providing family members or informal carers with information on the characteristics, course, and treatment of psychiatric disorders through well-defined, structured programmes. They also use structured training strategies, to help families improve the ways they communicate and to increase family members' capacity for dealing with problems and coping with stress.</p> <p>Psychoeducational interventions may be focussed on one family at a time or may be delivered as multi-family group interventions; they may or may not include the presence of patients.</p> <p>Multi-family group sessions take place following planned modalities and intervals and are aimed at discussing problems that arise out of daily living with a psychiatric patient and learning the best ways to deal with them. Strategies adopted by these groups may be different from the techniques used in psychoeducational interventions.</p> <p>They include: psychoeducational interventions for either single family or multi-</p>

	<p>family groups; non psychoeducational family interventions. They exclude: unstructured family interventions (→informal meetings with family members/carers), family psychotherapies (family psychotherapy), group psychotherapy, and family self-help groups.</p> <ul style="list-style-type: none"> • The numerator for family interventions is given by the number of families involved in these activities; different family members from the same family participating in a given group should be considered only once. • The denominator is given by the number of patients having had at least one CHMC contact in the previous year.
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RECOMMENDATION	<p>4.2.2.2 <i>Where the needs of the service patient or carer exceed the capacity of early intervention services (or where such services are not available), referral to crisis resolution and home treatment teams, acute day hospitals or in-patient services should be considered</i> LEVEL OF EVIDENCE GPP</p>
INDICATOR	2.7 Other crisis resolution services for first-episode patients
MEASURE	<p>Percentage of cases treated by each of the following services:</p> <ol style="list-style-type: none"> 1. Home treatment 2. Day Centre 3. General Hospital Psychiatric Ward (GHPW) 4. Acute day hospital 5. Crisis resolution team 6. Residential rehabilitative facility <p>NA = not applicable, to be reported when a give/ type of service is unavailable in the DMH</p>
NUMERATOR	Number of first-episode patients in the previous year by typology of crisis resolution service received
DENOMINATOR	number of first-episode patients in the previous year
SOURCE	<ul style="list-style-type: none"> • DMH information system • Outpatient, inpatient, and day hospital clinical notes and clinical notes available in other facilities providing care to first episode patients
NOTES	This indicator specifically concerns crisis resolution interventions for first-episode patients. Only the first crisis should be considered for a patient having experienced several crises during the previous year.

RECOMMENDATION	<p>4.2.4.1 <i>It is recommended that the oral atypical antipsychotic drugs are considered in the choice of first-line treatments for individuals with newly diagnosed schizophrenia</i> LEVEL OF EVIDENCE NICE 2000</p> <p>4.2.4.2 <i>Pharmacotherapy with an atypical antipsychotic drug at a dosage at the lower end of the standard range is the preferred treatment for a person experiencing a first episode of schizophrenia</i> LEVEL OF EVIDENCE C</p>
INDICATOR	2.8 Guidelines for the pharmacological treatment of first episode
MEASURE	<p>Rate the indicator considering whether or not and to what extent written guidelines address the following aspects:</p> <ul style="list-style-type: none"> • Utilisation of oral atypical antipsychotic drugs as the first-line choice for treating individuals with newly diagnosed schizophrenia • Utilisation of atypical antipsychotic drugs at dosages at the lower end of the standard range <p>0 = guidelines addressing this specific topic have not been adopted</p>

	<p>1 = guidelines addressing this specific topic have not been adopted, but they are scheduled to be adopted</p> <p>2 = adopted guidelines are generic</p> <p>3 = adopted guidelines address only one of the two recommendations</p> <p>4 = adopted guidelines address both recommendations</p>
SOURCE	<ul style="list-style-type: none"> DMH Direction
INDICATOR	2.9 Initiation of treatment with atypical antipsychotics
MEASURE	Percentage
NUMERATOR	Number of patients with newly diagnosed schizophrenia, at first CMHC contact or first General Hospital Psychiatric Ward (GHPW) admission in the previous year, who received oral atypical antipsychotics for first-episode treatment
DENOMINATOR	Number of patients with newly diagnosed schizophrenia at first CMHC contact or first General Hospital Psychiatric Ward (GHPW) admission in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system Both inpatient and outpatient clinical notes
INDICATOR	2.10 Oral antipsychotics dosages prescribed for first episode
MEASURE	Percentage
NUMERATOR	Number of patients with newly diagnosed schizophrenia, at first CMHC contact or first General Hospital Psychiatric Ward (GHPW) admission in the previous year, who received oral atypical antipsychotics at a dosage at the lower end of the standard range
DENOMINATOR	Number of patients with newly diagnosed schizophrenia at first contact with the CMHC or at first admission to the GHPW in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system Both inpatient and outpatient clinical notes
NOTES	Standard dose range is set out in the National Formulary

RECOMMENDATION	<p>4.2.5.1 <i>A decision by the service patient, and carer where appropriate, to seek a second opinion on the diagnosis should be supported, particularly in view of the considerable personal and social consequences of being diagnosed with schizophrenia</i></p> <p><i>LEVEL OF EVIDENCE GPP</i></p>
INDICATOR	2.11 Supporting patients and carers in their decision to seek a second diagnostic opinion
MEASURE	<p>Ratings</p> <p>0 = the service staff generally hamper patients or carers in seeking a second diagnostic opinion</p> <p>1 = the service staff usually do not hamper patients or carers in seeking a second diagnostic opinion, but do not suggest this option nor support patients or carers in seeking a second opinion</p> <p>2 = the service staff usually suggest that patients or carers seek a second diagnostic opinion, but seldom support them in seeking this opinion.</p> <p>3 = the service staff usually both suggest that patients or carers seek a second diagnostic opinion and support them in seeking this opinion, but only within the DMH</p> <p>4 = the same as 3, but also outside the DMH</p>
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group

3. TREATMENT OF THE CRISIS

3.A THE ACUTE EPISODE

1. Service-level crisis management
2. Service-level crisis management practices
3. CMHC filter activity in crisis management
4. Home-based crisis treatment
5. Frequency of domiciliary contacts following General Hospital Psychiatric Wards (GHPW) discharge
6. Frequency of day hospital contacts during acute episode
7. Social, expressive, practical-manual and physical activities
8. Guidelines for the pharmacological treatment of acute episode
9. Acute episode treatment practices
10. Information on prescribed antipsychotic drugs
11. Pharmacological treatment Monitoring
12. Below-standard-range antipsychotic drugs dosages
13. Over-standard-range antipsychotic drugs dosages
14. Switching from conventional to atypical antipsychotics
15. Atypical antipsychotic drugs as first-choice treatment
16. Prescription of a single type of antipsychotic drug
17. Monitoring of body weight in patients treated with atypical antipsychotics
18. Active listening skill training for staff members and the empathic approach
19. Patients treated with other types of psychotherapy

Note. This Section contains the indicators pertaining to all the NICE Guidelines for Schizophrenia recommendations, with the exception of the following: 4.3.1.1 concerning community mental health teams, because they are too generic, and 4.3.3.1 concerning the encouragement of service patients to write their own account of their illness in their notes, because considered not applicable to the Italian [mental health] service context.

RECOMMENDATION	<p>4.3.1.2 Crisis resolution and home treatment teams should be used as a means of managing crises for service patients, and as a means of delivering high-quality acute care. In this context, teams should pay particular attention to risk monitoring as a high-priority routine activity LEVEL OF EVIDENCE B</p> <p>4.3.1.3 Crisis resolution and home treatment should be considered for people with schizophrenia who are in crisis, to augment the services provided by early intervention services and assertive outreach teams LEVEL OF EVIDENCE C</p> <p>4.3.1.4 Crisis resolution and home treatment should be considered for people with schizophrenia who might benefit from early discharge from hospital following a period of in-patient care LEVEL OF EVIDENCE C</p> <p>4.3.1.5 Acute day hospitals should be considered as a clinically and economically effective option for the provision of acute care, both as an alternative to acute admission to in-patient care and to facilitate early discharge from hospital LEVEL OF EVIDENCE A</p>
INDICATOR	3.1 Service-level crisis management
MEASURE	<p>Ratings: 0 = service-level crisis management is inadequate (e.g., few hospital psychiatric inpatient beds are available; alternative acute inpatient facilities are unavailable; staff members do not provide alternative intervention specifically aimed at crisis resolution) 1 = service-level crisis management is sufficient, although exclusively focussed on hospital treatment (number of inpatient beds is adequate; the total of patients in crisis</p>

	<p>are admitted to hospital)</p> <p>2 = service-level crisis management is adequate and focussed on various inpatient facilities (both hospital, day hospital and residential beds are available; patients may be admitted to either of these facilities according to their needs)</p> <p>3 = service-level crisis management is more than adequate and is focussed on hospital- and, partially, on home treatment (both hospital, day hospital, and residential beds are available; staff members provide intensive home treatment in at least one third of cases; patients may receive either of these interventions according to their needs)</p> <p>4 = service-level crisis management is excellent and is balanced between hospital and home treatment (both hospital, day hospital and residential beds are available; staff members provide intensive home treatments in at least one half of cases; dedicated crisis resolution and home treatment teams can be available; patients may receive any of these interventions according to their needs)</p>
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
NOTES	<ul style="list-style-type: none"> • Day hospitals are units that provide diagnostic and treatment services, during the daytime, for acutely ill individuals who would otherwise be treated in traditional psychiatric in-patient units • In scoring the indicator, community beds should be considered equivalent to residential beds. • Crisis resolution and home treatment teams (CRHTTs) are characterised by several key elements: <ul style="list-style-type: none"> ○ mental health care is provided by a multidisciplinary mini-staff (which usually includes a psychiatrist) based in the CMHC ○ mental health care is exclusively provided to a well-defined group of patients suffering from serious mental illness ○ all the team members share responsibilities in caring for patients, so that different professionals may take care of the same patient, avoiding an individual caseload for each member ○ CRHTTs aim to provide comprehensive psychiatric and social care to each patient, avoiding any referrals to other agencies ○ mental health care is provided at home or on the workplace ○ treatment is delivered in assertive way for not collaborating patients ○ it is emphasised the need to come to an agreement with patients regarding the pharmacological treatment
INDICATOR	3.2 Service-level crisis management practices
MEASURE	<p>Rate the indicator based on the frequency of patients who receive non hospital inpatient care as crisis management</p> <p>a) home treatment, or treatment provided where they usually reside, 0 = none 1 = under 10% 2 = 11-24% 3 = 25-49% 4 = over 50%</p> <p>b) services such as crisis resolution team, acute day-hospital, or day centre 0 = none 1 = less than 10% 2 = 11-24% 3 = 25-49% 4 = over 50%</p> <p>c) community beds or residential beds 0 = none</p>

	<p>1 = less 10%</p> <p>2 = 11-24%</p> <p>3 = 25-49%</p> <p>4 = over 50%</p>
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group
NOTES	<p>Patients seen by psychiatrists in emergency departments and who are not subsequently admitted to General Hospital Psychiatric Wards should also be included</p>
INDICATOR	3.3 CMHC filter activity in crisis management
MEASURE	<p>Rate the indicator based on the frequency of patients experiencing a crisis, who have either been referred to the emergency department or hospitalised without previous CMHC staff evaluation</p> <p>0 = all, with few exceptions</p> <p>1 = over 75%</p> <p>2 = 75-51%</p> <p>3 = 50-26%</p> <p>4 = 25% or less</p>
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group
INDICATOR	3.4 Home-based crisis treatment
MEASURE	Percentage
NUMERATOR	Number of patients with CMHC contact in the previous year receiving at least six weekly domiciliary visits during the first two post-crisis weeks
DENOMINATOR	Number of patients with CMHC contact in the previous year who experienced a crisis and were not hospitalised
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes DMH information system
NOTES	<p>Crisis resolution and home treatment teams (CRHTTs) are a form of service that provides crisis-oriented intensive home treatment of an acute psychiatric episode by staff with a specific remit to deal with such situations, in and beyond 'office hours'. CRHTTs aim to avoid admitting acutely ill people to hospital by providing intensive home-based support</p>
INDICATOR	3.5 Frequency of domiciliary contacts following General Hospital Psychiatric Wards (GHPW) discharge
MEASURE	Percentage
NUMERATOR	Number of patients receiving at least one domiciliary visit in the week following General Hospital Psychiatric Ward (GHPW) discharge, in the previous year
DENOMINATOR	Number of patients discharged from the GHPW in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system
INDICATOR	3.6 Frequency of day hospital contacts during acute episode
MEASURE	Percentage
NUMERATOR	Number of patients admitted to day hospitals in the previous year
DENOMINATOR	Number of patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system
NOTES	<p>Day hospitals are units that provide diagnostic and treatment services, during the daytime, for acutely ill individuals who would otherwise be treated in traditional psychiatric in-patient units.</p>

RECOMMENDATION	<p>4.3.1.6 Social, group and physical activities are an important aspect of comprehensive service provision for people with schizophrenia as the acute phase recedes, and afterwards. All care plans should record the arrangements for such activities</p>
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	<i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	3.7 Social, expressive, practical-manual, and physical activities
MEASURE	Percentage, by number of interventions in the year, by intervention class
NUMERATOR	Number of patients who receiving social, expressive, practical-manual, and physical interventions in the previous year by the following classes: 0; 1-4; 5 –9; ≥10
DENOMINATOR	Number of patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system
NOTES	<p>SOCIAL INTERVENTIONS (INDIVIDUAL AND GROUP) They are aimed at helping patients move within various contexts and interact with non-family members, as well as improve their social interaction skills through recreational or focussed activities. These activities may take place internally or externally with respect to mental health service facilities, including patient involvement in social initiatives and community recreational activities. Patients’ family members or other informal carers may be also involved.</p> <ul style="list-style-type: none"> They include: a) individual interventions: recreational activities and meetings focussed on single patients, leisure activities (such as going to the cinema, restaurants, shows/exhibitions, etc.); b) group-based interventions: group-based recreational activities and group meetings, such as socialisation groups, discussion groups, reading groups, groups focussed on specific topics, groups gathering to listen to music or watch a film, cooking groups, etc. They exclude: with respect to group-based interventions, structured rehabilitation groups (such as groups in which patients dine together, but focus specifically on the acquisition of meal preparation abilities) (basic skills training); family groups (educational and psychoeducational interventions for family/carers). <p>HOLIDAYS Interventions with recreational and socialisation aims, to be conducted outside family- and care contexts, with time limits and staff in attendance 24 hours. They also include excursions and day trips with the presence of service staff. These interventions should be rated based on duration in days.</p> <ul style="list-style-type: none"> They include: holidays, excursions and trips. <p>EXPRESSIVE, PRACTICAL-MANUAL AND PHYSICAL INTERVENTIONS (INDIVIDUAL AND GROUP)</p> <p>a. EXPRESSIVE INTERVENTIONS</p> <ul style="list-style-type: none"> They include: activities such as drawing, painting, photography, theatre and drama, etc. <p>b. PRACTICAL-MANUAL INTERVENTIONS</p> <ul style="list-style-type: none"> They include: woodworking, sewing and knitting, gardening, etc. They exclude: activities specifically focused on supporting employment, such as woodworking, aimed at helping patients find/participate in job training programs or craft work activities (prevocational training). <p>c. PHYSICAL INTERVENTIONS</p> <ul style="list-style-type: none"> They include: exercise classes, psychomotor integration activities, body expression activities, relaxation techniques, dance therapy, etc.

RECOMMENDATION	<p>4.3.2.1 <i>The choice of antipsychotic drug should be made jointly by the individual and the clinician responsible for treatment, based on an informed discussion of the relative benefits of the drugs and their side-effect profiles. The individual’s advocate or carer should be consulted where appropriate</i></p> <p><i>LEVEL OF EVIDENCE NICE 2000</i></p> <p>4.3.2.2 <i>Antipsychotic therapy should be initiated as part of a comprehensive package of care that addresses the individual’s clinical, emotional and social needs. The</i></p>
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	<p><i>clinician responsible for treatment and the keyworker should monitor both therapeutic progress and tolerability of the drug on an ongoing basis. Monitoring is particularly important when individuals have just changed from one antipsychotic to another</i></p> <p>LEVEL OF EVIDENCE NICE 2000</p> <p><i>4.3.2.3 The dosage of conventional antipsychotic medication for an acute episode should be in the range 300-1000 mg chlorpromazine equivalents per day for a minimum of 6 weeks. Reasons for dosage outside this range should be justified and documented. The minimum effective dose should be used</i></p> <p>LEVEL OF EVIDENCE C</p> <p><i>4.3.2.4 In the treatment of acute episodes of schizophrenia, massive loading doses of antipsychotic medication, referred to as “rapid neuroleptisation”, should not be used</i></p> <p>LEVEL OF EVIDENCE C</p> <p><i>4.3.2.5 The oral atypical antipsychotic drugs should be considered as treatment options for individuals currently receiving conventional antipsychotic drugs who, despite adequate symptom control, are experiencing unacceptable side-effects, and for those in relapse who have previously experienced unsatisfactory management or unacceptable side-effects with conventional antipsychotic drugs. The decision as to what constitutes unacceptable side-effects should be taken following discussion between the patient and the clinician responsible for treatment</i></p> <p>LEVEL OF EVIDENCE NICE 2000</p> <p><i>4.3.2.6 When full discussion between the clinician responsible for treatment and the individual concerned is not possible, in particular in the management of an acute schizophrenic episode, the oral atypical drugs should be considered as the treatment options of choice because of the lower potential risk of extrapyramidal symptoms (EPS)</i></p> <p>LEVEL OF EVIDENCE NICE 2000</p> <p><i>4.3.2.7 It is not recommended that, in routine clinical practice, individuals change to one of the oral atypical antipsychotic drugs if they are achieving good control of their condition without unacceptable side-effects with a conventional antipsychotic drug</i></p> <p>LEVEL OF EVIDENCE NICE 2000</p> <p><i>4.3.2.8 Antipsychotic drugs, atypical or conventional, should not be prescribed concurrently, except for short periods to cover changeover</i></p> <p>LEVEL OF EVIDENCE C</p> <p><i>4.3.2.9 When prescribed chlorpromazine, individuals should be warned of a potential photosensitive skin response, as this is an easily preventable side-effect</i></p> <p>LEVEL OF EVIDENCE B</p> <p><i>4.3.2.10 Where a potential to cause weight gain or diabetes has been identified for the atypical antipsychotic being prescribed, there should be routine monitoring in respect of these potential risks</i></p> <p>LEVEL OF EVIDENCE B</p>
INDICATOR	3.8 Guidelines for the pharmacological treatment of acute episode
MEASURE	<p>Rate the indicator considering whether and to what extent written guidelines for antipsychotic treatment address the following aspects :</p> <ul style="list-style-type: none"> • utilisation of high doses of antipsychotics is not recommended • standard dose ranges of various antipsychotics are specified • indications for the changes from a conventional antipsychotic to an atypical one are specified and the change is not recommended if the typical antipsychotic achieves good control of clinical condition without unacceptable side-effects • utilisation of an oral atypical antipsychotic is recommended in the management of an acute episode when a full discussion with the patient is not possible • utilisation of a single type of antipsychotic drug is recommended, except for short periods to cover changeover • warning patients of a potential photosensitive skin response when prescribed

	<p>chlorpromazine is recommended</p> <ul style="list-style-type: none"> • routine monitoring of body weight and diabetes when prescribing atypical antipsychotics (i.e. olanzapine) is recommended <p>0 = no specific guidelines have not been adopted on this topic 1 = no specific guidelines have been adopted on this topic, but they are scheduled to be adopted 2 = the adopted guidelines are generic and include only a part of the recommendations 3 = the adopted guidelines include the majority of the recommendations 4 = the adopted guidelines include the totality of the recommendations</p>
SOURCE	<ul style="list-style-type: none"> • DMH direction
INDICATOR	3.9 Acute episode treatment practices
MEASURE	<p>Rate the indicator on the basis of the frequency with which the recommendations on pharmacological treatment of the acute episode are adhered</p> <p>a) specific attention to the dose range of different antipsychotics: 0= the service staff pay specific attention the dose range of different antipsychotics in less than 10% of cases 1 = the service staff pay specific attention the dose range of different antipsychotics in 10%-25% of cases 2 = the service staff pay specific attention the dose range of different antipsychotics in 26%-50% of cases 3 = the service staff pay specific attention the dose range of different antipsychotics in 51%-75% of cases 4 = the service staff pay specific attention the dose range of different antipsychotics in more than 75% of cases</p> <p>b) utilisation of high doses of antipsychotics : 0= the service staff prescribe high doses of antipsychotics in more than 75% of cases 1 = the service staff prescribe high doses of antipsychotics in 51%-75% of cases 2 = the service staff prescribe high doses of antipsychotics in 26%-50% of cases 3 = the service staff prescribe high doses of antipsychotics in 10%-25% of cases 4 = the service staff prescribe high doses of antipsychotics in less than 10% of cases</p> <p>c) utilisation of a single type of antipsychotic drug, except for short periods to cover changeover : 0= the service staff use a single type of antipsychotic drug in less than 10% of cases 1 = the service staff use a single type of antipsychotic drug in 10%-25% of cases 2 = the service staff use a single type of antipsychotic drug in 26%-50% of cases 3 = the service staff use a single type of antipsychotic drug in 51%-75% of cases 4 = the service staff use a single type of antipsychotic drug in more than 75% of cases</p> <p>d) change from conventional antipsychotics to atypical antipsychotics only in cases of lack of efficacy or unacceptable side-effects: 0= in less than 10% of cases change from conventional antipsychotics to</p>

	<p>atypical antipsychotics is due to lack of efficacy of the previous treatment or to the presence of unacceptable side-effects 1 = in 10%-25% of cases change from conventional antipsychotics to atypical antipsychotics is due to lack of efficacy of the previous treatment or to the presence of unacceptable side-effects 2 = in 26%-50% of cases change from conventional antipsychotics to atypical antipsychotics is due to lack of efficacy of the previous treatment or to the presence of unacceptable side-effects 3 = in 51%-75% of cases change from conventional antipsychotics to atypical antipsychotics is due to lack of efficacy of the previous treatment or to the presence of unacceptable side-effects 4 = in more than 75% of cases change from conventional antipsychotics to atypical antipsychotics is due to lack of efficacy of the previous treatment or to the presence of unacceptable side-effects</p> <p>e) careful monitoring of both therapeutic progress and side effects of drugs prescribed: 0= the service staff carefully monitor side effects of drugs prescribed in less than 10% of cases 1 = the service staff carefully monitor side effects of drugs prescribed in 10%-25% of cases 2 = the service staff carefully monitor side effects of drugs prescribed in 26%-50% of cases 3 = the service staff carefully monitor side effects of drugs prescribed in 51%-75% of cases 4 = the service staff carefully monitor side effects of drugs prescribed in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> Specialist focus group
INDICATOR	3.10 Information to patients on prescribed antipsychotic drugs
MEASURE	Percentage
NUMERATOR	Number of patients who report having received satisfactory information on antipsychotic drugs, as assessed by a specific questionnaire (see items 8 of the <i>Patients Questionnaire</i> in the Section “Instruments 3”, scores “4” and “5”)
DENOMINATOR	Number of patients with DMH contact (#)
SOURCE	<ul style="list-style-type: none"> Specific research on a representative sample of patients
INDICATOR	3.11 Pharmacological treatment monitoring *
MEASURE	Percentage
NUMERATOR	Number of patients treated with antipsychotics in the previous year with a time interval of >3 months between two consecutive outpatient contacts.
DENOMINATOR	Number of patients with DMH contact in the previous year treated with antipsychotics (#)
SOURCE	<ul style="list-style-type: none"> DMH information system
NOTES	<p>Periods during which patients are housed in residential facilities should be excluded.</p> <p><i>* This indicator also assesses recommendation 4.4.5.4</i></p>
INDICATOR	3.12 Below-standard-range antipsychotic dosages
MEASURE	Percentage
NUMERATOR	Number of patients undergoing GHPW hospitalisation for an acute episode during the period under consideration and treated with average antipsychotic doses of < 300 mg chlorpromazine equivalents
DENOMINATOR	Number of patients undergoing GHPW hospitalisation for an acute episode during the considered period
SOURCE	<ul style="list-style-type: none"> DMH information system

	<ul style="list-style-type: none"> • Inpatient clinical notes
NOTES	Specify the duration of the period under consideration. Consistently with the other indicators, 'previous year' should be the time frame used; when this is not possible due to large sample size (and thus, to an excess of information), a sample drawn from a period of at least four months should be used.
INDICATOR	3.13 Over-standard-range antipsychotic dosages
MEASURE	Percentage
NUMERATOR	Number of patients with GHPW hospitalisation for an acute episode during the considered period and treated with average doses of antipsychotics of > 1000 mg of chlorpromazine equivalents
DENOMINATOR	Number of patients with GHPW hospitalisation during the time considered period
SOURCE	<ul style="list-style-type: none"> • DMH information system • Inpatient clinical notes
NOTES	Specify the duration of the considered period. Consistently with the other indicators, 'previous year' should be the time frame used; when this is not possible due to large sample size (and thus, to an excess of information), a sample drawn from a period of at least four months should be used.
INDICATOR	3.14 Switching from conventional to atypical antipsychotics *
MEASURE	Percentage of patients with CMHC contact treated with conventional antipsychotics who switched to atypical antipsychotics during the considered period, by reasons motivating the change: <ul style="list-style-type: none"> • presence of side-effects • lack of efficacy in controlling symptoms • other (specify in the notes) • no detectable reasons
NUMERATOR	Number of patients with CMHC contact treated with conventional antipsychotics who switched to atypical antipsychotics during the considered period, by reasons motivating the change
DENOMINATOR	Number of patients with CMHC contact treated with conventional antipsychotics who switched to atypical antipsychotics during the considered period
SOURCE	<ul style="list-style-type: none"> • DMH information system • Outpatient clinical notes
NOTES	<ul style="list-style-type: none"> • Specify the duration of the considered period. Consistently with the other indicators, 'previous year' should be the time frame used; when this is not possible due to large sample size (and thus, to an excess of information), a sample drawn from a period of at least four months should be used. • Lack of efficacy refers to a treatment that has not managed prevent at least one hospitalisation or one equivalent crisis condition over a one year period <p><i>* This indicator also assesses recommendations 4.4.5.2 and 4.4.5.3</i></p>
INDICATOR	3.15 Atypical antipsychotic drugs as first-choice treatment
MEASURE	Percentage
NUMERATOR	Number of patients at their first GHPW hospitalisation, not previously treated with antipsychotic drugs, who receive an atypical antipsychotic as a first-choice drug
DENOMINATOR	Number of patients at their first GHPW hospitalisation, not previously treated with antipsychotic drugs
SOURCE	<ul style="list-style-type: none"> • DMH information system • Inpatient clinical notes
INDICATOR	3.16 Prescription of a single type of antipsychotic drug *
MEASURE	Percentage

NUMERATOR	Number of patients concurrently receiving two types of antipsychotic drugs during the considered period
DENOMINATOR	Number of patients with CMHC contact during the considered period
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes
NOTES	<ul style="list-style-type: none"> Except for short periods to cover changeover Specify the duration of the considered period. Consistently with the other indicators, ‘previous year’ should be the time frame used; when this is not possible due to large sample size (and thus, to an excess of information), a sample drawn from a period of at least four months should be used <p><i>* This indicator also assesses recommendation 4.4.5.16</i></p>
INDICATOR	3.17 Monitoring of body weight in patients treated with atypical antipsychotics
MEASURE	Percentage
NUMERATOR	Number of patients treated with atypical antipsychotic drugs for which body weight is recorded every six months in outpatient clinical notes
DENOMINATOR	Number of patients with CMHC contact and treated with atypical antipsychotic drugs
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes

<i>RECOMMENDATION</i>	<i>4.3.3.2 Psychoanalytic and psychodynamic principles may be considered to help health professionals to understand the experience of individual service patients and their interpersonal relationships</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	3.18 Active listening skill training for staff members and the empathic approach
MEASURE	Percentage, by professional category
NUMERATOR	Number of service staff by professional category trained in active listening skills and the empathic approach
DENOMINATOR	Number of DMH staff members at 31/12 by professional category
SOURCE	<ul style="list-style-type: none"> DMH Direction
NOTES	Training in active listening skills and the empathic approach includes participation in structured psychotherapy training programmes and in supervision groups focussed on the acquisition of interpersonal abilities

<i>RECOMMENDATION</i>	<i>4.3.3.3 The assessment of needs for health and social care of people with schizophrenia should be comprehensive and should address medical, social, psychological, occupational, economic, physical and cultural issues</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	This recommendation is assessed by indicator 4.5 “Assessing health care needs” in the Section Promoting Recovery

<i>RECOMMENDATION</i>	<i>4.3.3.4 Cognitive–behavioural therapy should be available as a treatment option for people with schizophrenia.</i> <i>LEVEL OF EVIDENCE A</i>
INDICATOR	This recommendation is assessed by indicator 4.15 “Patients receiving cognitive-behavioural psychotherapy” in the Section Promoting Recovery

<i>RECOMMENDATION</i>	<i>4.3.3.5 Family interventions should be available to the families of people with schizophrenia who are living with or who are in close contact with the service use</i> <i>LEVEL OF EVIDENCE A</i>
INDICATOR	This recommendation refers to an intervention similar to that described in recommendation 4.4.4.6; its application is assessed by the following “Promoting Recovery” section indicators:

	4.17 Psychoeducational family intervention guidelines 4.18 Practices in the provision of psychoeducational family interventions to 4.19 Availability of staff skills for psychoeducational family interventions 4.20 Psychoeducational family interventions for patients discharged from General Hospital Psychiatric Wards
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RECOMMENDATION	<p>4.3.3.6 <i>Counselling and supportive psychotherapy are not recommended as discrete interventions in the routine care of people with schizophrenia where other psychological interventions of proven efficacy are indicated and available. However, service patient preferences should be taken into account, especially if other more efficacious psychological treatments are not locally available</i></p> <p>LEVEL OF EVIDENCE C</p>
INDICATOR	3.19 Patients treated with other types of psychotherapy
MEASURE	Percentage
NUMERATOR	Number of patients treated in the previous year receiving <i>supportive psychotherapy</i> only, or psychotherapy other than cognitive-behavioural therapy
DENOMINATOR	Number of patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes • DMH information system

3.B THE EARLY POST-ACUTE PERIOD

20. Pharmacological continuation treatment guidelines
21. Pharmacological continuation treatment practices
22. Post-acute episode continuation of antipsychotic treatment
23. Gradual withdrawal from antipsychotic medication
24. Monitoring symptoms following withdrawal from antipsychotic treatment

RECOMMENDATION	<p>4.3.3.7 <i>Given the high risk of relapse following an acute episode, the continuation of antipsychotic drugs for up to 1–2 years after a relapse should be discussed with service patients, and with carers where appropriate</i></p> <p>LEVEL OF EVIDENCE GPP</p> <p>4.3.3.8 <i>Withdrawal from antipsychotic medication should be undertaken gradually while regularly monitoring signs and symptoms for evidence of potential relapse</i></p> <p>LEVEL OF EVIDENCE GPP</p> <p>4.3.3.9 <i>Following withdrawal from antipsychotic medication, monitoring for signs and symptoms of potential relapse should continue for at least 2 years after the last acute episode</i></p> <p>LEVEL OF EVIDENCE GPP</p>
INDICATOR	3.20 Pharmacological continuation treatment guidelines
MEASURE	<p>Rate the indicator by considering whether and to what extent written guidelines for antipsychotic continuation treatment address the following aspects:</p> <ul style="list-style-type: none"> • continuing antipsychotic treatment for up to 1 year after an acute episode is recommended; • gradual withdrawal from antipsychotic medication and regular monitoring for signs and symptoms of relapse is recommended; • monitoring symptoms following withdrawal from antipsychotic medication for at least 2 years after the last acute episode is recommended <p>0 = no specific guidelines have been adopted on this topic</p>

	<p>1 = no specific guidelines have been adopted on this topic, but they are scheduled to be adopted</p> <p>2 = the adopted guidelines are generic and address only one recommendation</p> <p>3 = the adopted guidelines address at least two recommendations</p> <p>4 = the adopted guidelines address all the three recommendations</p>
SOURCE	<ul style="list-style-type: none"> DMH Direction
INDICATOR	3.21 Pharmacological continuation treatment practices
MEASURE	<p>Rate the indicator based on the frequency with which pharmacological continuation treatment recommendations are followed.</p> <p>a) Continuation of antipsychotic treatment for up to 1-2 years following an acute episode</p> <p>0 = continuation treatment duration is 1-2 years in no/very few cases (less than 10%)</p> <p>1 = continuation treatment duration is 1-2 years in 10%-25% of cases</p> <p>2 = continuation treatment duration is 1-2 years in 26%-50% of cases</p> <p>3 = continuation treatment duration is 1-2 years in 51%-75% of cases</p> <p>4 = continuation treatment duration is 1-2 years in more than 75% of cases</p> <p>b) If drug is discontinued, withdrawal is undertaken gradually</p> <p>0 = withdrawal from medication is undertaken gradually in no/very few cases (less than 10%)</p> <p>1 = withdrawal from medication is undertaken gradually in 10%-25% of cases</p> <p>2 = withdrawal from medication is undertaken gradually in 26%-50% of cases</p> <p>3 = withdrawal from medication is undertaken gradually in 51%-75% of cases</p> <p>4 = withdrawal from medication is undertaken gradually in more than 75% of cases</p> <p>c) Symptom monitoring following antipsychotic drug withdrawal</p> <p>0 = monitoring of symptoms following drug withdrawal takes place in no/very few cases (less than 10%)</p> <p>1 = monitoring of symptoms following drug withdrawal takes place in 10%-25% of cases</p> <p>2 = monitoring of symptoms following drug withdrawal takes place in 26%-50% of cases</p> <p>3 = monitoring of symptoms following drug withdrawal takes place in 51%-75% of cases</p> <p>4 = monitoring of symptoms following drug withdrawal takes place in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> Specialist focus group
INDICATOR	3.22 Post-acute episode continuation of antipsychotic treatment
MEASURE	Percentage
NUMERATOR	Number of patients with GHPW hospitalisation in the previous year who consensually discontinued antipsychotic medication earlier than 1 year
DENOMINATOR	Number of patients with DMH contact with GHPW hospitalisation in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system Outpatient clinical notes
NOTES	<ul style="list-style-type: none"> For each patient, the 12-month period following the first hospitalisation in the year should be considered; hospitalisations for non-clinical reasons (e.g., for social problems, physical disease, etc.) should be excluded.
INDICATOR	3.23 Gradual withdrawal from antipsychotic medication

MEASURE	Percentage
NUMERATOR	Number of patients for which there is no evidence from outpatient clinical notes that withdrawal from antipsychotic medication has been undertaken gradually over at least one month
DENOMINATOR	Number of patients with CMHC contact who consensually withdrew from antipsychotic medication
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes
NOTES	<ul style="list-style-type: none"> Gradual withdrawal refers to discontinuation from an antipsychotic drug occurring over a period of at least one month, as reported in the outpatient clinical note.
INDICATOR	3.24 Monitoring symptoms following withdrawal from antipsychotic treatment
MEASURE	Percentage
NUMERATOR	Number of patients consensually withdrawing from antipsychotic medication 24-48 months previously and having had at least one service contact every six months for at least two years after withdrawal
DENOMINATOR	Number of patients with CMHC contact had consensually withdrawing from antipsychotic medication 24 -48 months previously
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes

4.PROMOTING RECOVERY

4.A RELATIONS WITH THE PRIMARY CARE SECTOR AND MONITORING PATIENTS' PHYSICAL HEALTH

1. Information systems in general practice
2. General practitioner and DMH staff relations in the regular monitoring of patients' physical health and treatment of their physical conditions
3. Physical health monitoring provided by general practitioners
4. CMHC monitoring of physical health
5. Health care needs assessment
6. General practice-DMH protocols
7. Meetings focused on carer needs

Note. This Section contains the indicators pertaining to all the NICE Guidelines recommendations for Schizophrenia, with the exception of recommendations 4.4.3.1 (B), 4.4.3.3 (B), 4.4.3.4 (GPP), and 4.4.3.5 (C) concerning assertive outreach teams and crisis resolution teams, which do not exist in the Italian mental health care system and are therefore considered not applicable to the Italian context. Wherever possible, e.g., for recommendations 4.4.3.2 and 4.4.3.6., the definition of "multiproblematic patients" and the care provided to this specific patients' typology was substantially considered in the context of Italy's equivalent intensive community-oriented treatment.

RECOMMENDATION	4.4.1.1 <i>The setting up of practice case registers is recommended as an essential step in monitoring the physical and mental health of people with schizophrenia in primary care</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	4.1 Information systems in general practice
MEASURE	Percentage, by general practitioner-adopted typology of data collected in the information system
NUMERATOR	Number of general practitioners working in the DMH catchment area with information systems having data on: <ol style="list-style-type: none"> a. psychiatric diagnosis b. patients' contacts with their general practitioners c. psychopharmacological treatment
DENOMINATOR	<ol style="list-style-type: none"> a. Number of general practitioners working in the DMH catchment area b. Number of general practitioners working in the DMH catchment area c. Number of general practitioners working in the DMH catchment area
SOURCE	<ul style="list-style-type: none"> • Local Health Unit (LHU) Direction

RECOMMENDATION	4.4.1.2 <i>General practitioners (GPs) and other primary health care workers should regularly monitor the physical health of people with schizophrenia registered with their practice</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	4.2 General practitioner and DMH staff relations in the regular monitoring of patients' physical health and treatment of their physical conditions
MEASURE	Ratings: 0 = Relations between GPs and the DMH staff in the regular monitoring and treatment of patient's physical health and conditions--even for those at risk or suffering from a somatic disorder--are nearly absent (less than 10% of cases) 1 = Relations between GPs and the DMH staff are present for 10%-25% of patients suffering from a somatic disorder 2 = Relations between GPs and the DMH staff are present for 26%-50% of patients suffering from a somatic disorder

	3 = Relationships between GPs and the DMH staff are present for 51%-75% of patients suffering from a somatic disorder 4 = Relationships between GPs and the DMH staff are present for more than 75% of patients suffering from a somatic disorder
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group
INDICATOR	4.3 Physical health monitoring provided by general practitioners
MEASURE	Percentage of patients, by classes of age (18/34 ; 35/54 ; >55 years)
NUMERATOR	Number of patients undergoing at least one general practitioner examination in the previous year, by classes of age, as assessed by a specific questionnaire (see item 9 of the <i>Patients Questionnaire</i> in the Section “Instruments 3.”)
DENOMINATOR	Number of patients with DMH contact (#), by classes of age
SOURCE	<ul style="list-style-type: none"> Questionnaire to be administered to patients

<i>RECOMMENDATION</i>	4.4.1.3 <i>Physical health checks should pay particular attention to endocrine disorders such as diabetes and hyperprolactinaemia, cardiovascular risk factors such as blood pressure and lipid levels, side-effects of medication, and lifestyle factors such as smoking. These must be recorded in the notes.</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	4.4 CMHC monitoring of physical health
MEASURE	Percentage of the different types of exams:
NUMERATOR	Number of patients for which the following parameters <ul style="list-style-type: none"> a. blood pressure b. glucose levels c. cholesterol and triglyceride levels d. ECG were detected and recorded in their outpatient clinical notes in the previous year
DENOMINATOR	<ul style="list-style-type: none"> a. Number of patients with CMHC contact (#) b. Number of patients with CMHC contact (#) c. Number of patients with CMHC contact (#) d. Number of patients with CMHC contact (#)
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes

<i>RECOMMENDATION</i>	4.4.1.4 <i>The decision to refer a service user from primary care back to the mental health services is a complex clinical judgement that should take account of the views of the service user and, where appropriate, carers...Referral may be considered in a number of circumstances, including the following:</i> <ul style="list-style-type: none"> • <i>if treatment adherence is a problem, referral is usually indicated</i> • <i>if response to treatment is poor, referral is a higher priority</i> • <i>if comorbid substance misuse is suspected, referral is indicated</i> • <i>if the level of risk to self or others is increased, referral is indicated</i> • <i>if a person with schizophrenia has newly joined a general practice list, referral to secondary services for assessment and care programming is indicated, subject to the full agreement of the service user.</i> <i>LEVEL OF EVIDENCE GPP</i>
INDICATOR	This practice is assessed by indicator 4.6

<i>RECOMMENDATION</i>	4.4.2.1 <i>A full assessment of health and social care needs should be undertaken regularly, including assessment of accommodation and quality of life. The frequency of these assessments should be based upon clinical need, and discussed with the service patient. The agreed frequency of assessment should be documented in the care plan</i>
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	<p><i>LEVEL OF EVIDENCE GPP</i></p> <p>4.3.3.3 The health care and needs assessment of individuals suffering from schizophrenia should be thorough and should concern the medical, social, psychological, employment, economic, and physical context, and cultural aspects of these individuals.</p> <p><i>LEVEL OF EVIDENCE GPP</i></p>
INDICATOR	4.5 Health care needs assessment *
MEASURE	Percentage
NUMERATOR	Number of outpatient clinical notes in the previous year making (even passing) mention of patients' health care needs (e.g., blood pressure or smoking habits) or of any discussion of patients' health problems during staff meetings
DENOMINATOR	Number of patients with CMHC contact (#)
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes
NOTES	<p>Staff meetings represent coordinating and monitoring activities undertaken by DMH staff (meetings/discussions on individual DMH cases): they are focussed on individual patients and their specific care needs.</p> <p><i>* This indicator also assesses recommendation 4.3.3.3</i></p>

RECOMMENDATION	<p>4.4.2.2 Primary and secondary care services, in conjunction with the service patient, should jointly identify which service will take responsibility for assessing and monitoring the physical health care needs of service patients. This should be documented in both primary and secondary care notes and care plans</p> <p><i>LEVEL OF EVIDENCE GPP</i></p>
INDICATOR	4.6 General practice - DMH protocols *
MEASURE	<p>Rate the indicator based on the degree of complexity of existing protocols established between primary care services and the DMH concerning the physical health care needs of service patients and identification of services assuming responsibility for the assessment and monitoring of service patients' physical health care needs</p> <p>0 = no protocols between primary care services and the DMH are available 1 = protocols between primary care services and the DMH are unavailable, but are scheduled to be produced 2 = a protocol is available, but is generic 3 = a protocol is available; it is detailed (it specifies rules and responsibilities), but no checks are scheduled 4 = a protocol is available; it is detailed (it specifies rules and responsibilities), and periodical checks are scheduled</p>
SOURCE	<ul style="list-style-type: none"> DMH Direction
NOTES	<i>* This indicator also assesses recommendation 4.4.1.4</i>

RECOMMENDATION	<p>4.4.2.3 All non-professional carers who regularly look after a person on the care programme approach should have assessments of their own caring, physical and mental health needs, at a frequency agreed in conjunction with the carer and recorded in the carer's own plan</p> <p><i>LEVEL OF EVIDENCE GPP</i></p>
INDICATOR	4.7 Meetings focused on carer needs
MEASURE	Percentage

NUMERATOR	Number of patients whose carers have received at least one specific session with the service staff in the previous year
DENOMINATOR	Number of patients with DMH contact living with carers/family members (parents, brothers/sisters, partners, children) in the previous year (#)
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes • DMH information system
NOTES	<ul style="list-style-type: none"> • Interventions for carers/families are aimed at gaining information, improving relations among family members; providing information, emotional support, and education on psychiatric disorders; and increasing carers' ability to cope with patients' behaviour and disabilities. They include both meetings with carers and structured family psycho-educational interventions. <p>CARER/FAMILY MEETINGS are interventions aimed at examining intra-family problems and/or involving informal resources in therapeutic/rehabilitation programs. Unstructured information may be provided during meetings. Family members, other carers, key informants participate during these meetings without patients present, and are not taught to adopt specific techniques.</p> <p>They include: meetings with carers without patient participation, even if previous individual sessions with patients have occurred (as long as the two types of interventions are distinct and take place on different occasions)</p> <p>They exclude: meetings in which both patients and carers participate simultaneously (→ individual sessions, individual psychotherapy, psychiatric outpatient contacts); structured psycho-educational interventions (→ family psycho-educational interventions); family therapy (→ family psychotherapy); telephone contacts.</p>

4.B SERVICES FOR MULTIPROBLEMATIC PATIENTS

8. Multiproblematic patients
9. Procedures for multiproblematic patients
10. Intensity of care for multi problematic patients
11. Coordination and integration of care for multiproblematic patients

RECOMMENDATION	<p>4.4.3.2 <i>Assertive outreach teams should be provided for people with serious mental disorders, including schizophrenia, who make extensive use of in-patient services and who have a history of poor engagement with services, leading to frequent relapse or social breakdown (as manifested by homelessness or seriously inadequate accommodation)</i></p> <p><i>LEVEL OF EVIDENCE B</i></p>
INDICATOR	4.8 Multiproblematic patients
MEASURE	Percentage
NUMERATOR	Number of multiproblematic patients in the previous year
DENOMINATOR	Number of patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> • DMH information system
NOTES	<p>The term “multiproblematic” refers to patients showing at least one of the following characteristics:</p> <ul style="list-style-type: none"> • poor engagement with services (unilateral interruption of service contacts for a period longer than 90 days in the previous year); • multiple psychiatric admissions in one year; • homelessness or seriously inadequate accommodation (lack of heating, hot water, etc.) or at imminent risk (in < 6 mos.) of becoming homeless
INDICATOR	4.9 Procedures for multiproblematic patients
DEFINITION	Availability of procedures specifying should be done for multiproblematic patients

MEASURE	Ratings: 0 = written procedures for the treatment of multiproblematic patients are unavailable 1 = written procedures for the treatment of multiproblematic patients are unavailable, but they are scheduled to be produced 2 = written procedures for the treatment of multiproblematic patients are available, but they are generic regarding the type of care it should provided 3 = written procedures for the treatment of multiproblematic patients are available, they are detailed regarding the type of care it should provided (they clearly specify rules, responsibilities and periods of check), but refer to the DMH only 4 = written procedures for the treatment of multiproblematic patients are available, they are detailed regarding the type of care it should provided (they clearly specify rules, responsibilities and periods of check) and they are jointly adopted by the DMH and other health and non health services that may be involved in the therapeutic project
SOURCE	DMH Direction
INDICATOR	4.10 Intensity of care for multi problematic patients
MEASURE	Ratings: 0 = multiproblematic patients, with very few exceptions, are never identified 1 = attention is devoted to identifying multiproblematic patients, but very little or nothing specific is being done for them 2 = a specific intervention plan is available for at least 25% of multiproblematic patients and it is implemented 3 = a specific intervention plan is available for at least 50% of multiproblematic patients and it is implemented 4 = a specific intervention plan is available for at least 75% of multiproblematic patients and it is implemented
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group

RECOMMENDATION	<i>4.4.3.6 Integrating the care of people with schizophrenia who receive services from community mental health teams, assertive outreach teams, early intervention services, and crisis resolution and home treatment teams should be carefully considered</i> LEVEL OF EVIDENCE GPP
INDICATOR	4.11 Coordination and integration of care for multiproblematic patients
MEASURE	Ratings: 0 = specific integration activities for multiproblematic patients are unavailable 1= service staff perform such activities occasionally, but only within the CMHC 2 = service staff perform such activities occasionally--not only within the CMHC, but also in collaboration with other DMH services; case reviews are not conducted on a regular basis 3 = service staff perform such activities periodically--not only within the DMH, but also in collaboration with other agencies (both social and health services); case reviews are not conducted on a regular basis 4 = service staff perform such activities periodically--not only within the DMH but also in collaboration with other agencies (both social and health services); all of these parties participate in multiproblematic patient case reviews on a regular basis
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
NOTES	For the definition of 'multiproblematic patients' see indicator 4.7

4.C INDIVIDUAL PSYCHOLOGICAL INTERVENTIONS

12. Guidelines for cognitive-behavioural psychotherapy for psychoses
13. Provision of cognitive-behavioural therapy to patients with poor treatment adherence, poor insight, or persisting psychotic symptoms

- 14. Availability of cognitive-behavioural psychotherapy skills for psychoses
- 15. Patients receiving cognitive-behavioural psychotherapy
- 16. Patients receiving longer treatments with cognitive-behavioural therapy

RECOMMENDATION	<p>4.4.4.1 Cognitive-behavioural therapy should be available as a treatment option for people with schizophrenia <i>LEVEL OF EVIDENCE A</i></p> <p>4.4.4.2 Cognitive-behavioural therapy should be offered to people with schizophrenia who are experiencing persisting psychotic symptoms <i>LEVEL OF EVIDENCE A</i></p> <p>4.4.4.3 Cognitive-behavioural therapy should be considered as a treatment option to assist in the development of insight <i>LEVEL OF EVIDENCE B</i></p> <p>4.4.4.4 Cognitive-behavioural therapy may be considered as a treatment option in the management of poor treatment adherence <i>LEVEL OF EVIDENCE C</i></p>
INDICATOR	4.12 Guidelines for cognitive-behavioural psychotherapy for psychoses
MEASURE	<p>Rate the indicator considering whether written guidelines address the following aspects or not:</p> <ul style="list-style-type: none"> • Cognitive-behavioural therapy is recommended for patients with schizophrenia • CBT is recommended for patients with schizophrenia experiencing persisting psychotic symptoms • CBT is recommended in the management of poor treatment adherence • an adequate course of CBT last more than 6 months' and should include more than ten planned sessions <p>0 = specific guidelines on this topic have not been adopted 1 = specific guidelines on this topic have not been adopted, but are scheduled to be adopted 2 = the adopted guidelines are generic and address only a part of the recommendations 3 = the adopted guidelines address most of the recommendations 4 = the adopted guidelines address nearly all the recommendations</p>
SOURCE	<ul style="list-style-type: none"> • DMH Direction
INDICATOR	4.13 Provision of cognitive-behavioural therapy to patients with poor treatment adherence, poor insight, or persisting psychotic symptoms
MEASURE	<p>Ratings:</p> <p>0 = cognitive-behavioural therapy is not provided to patients with poor treatment adherence, poor insight or persisting psychotic symptoms 1 = cognitive-behavioural therapy is provided to less than 26% of patients with poor treatment adherence, poor insight or persisting psychotic symptoms 2 = cognitive-behavioural therapy is provided to 26%-50% of cases 3 = cognitive-behavioural therapy is provided to 51%-75% of cases 4 = cognitive-behavioural therapy is provided to more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
INDICATOR	4.14 Availability of in cognitive-behavioural psychotherapy skills for psychoses
MEASURE	Percentage, by professional category (psychiatrists, psychologists, social workers, nurses)

NUMERATOR	Number of service staff trained in cognitive-behavioural psychotherapy for psychoses, by professional category
DENOMINATOR	Number of service staff working in the DMH as of 31/12, by professional category
SOURCE	DMH Direction
NOTES	Cognitive-behavioural psychotherapy is a psychological intervention that encourages recipients to establish links between their thoughts, feelings, and actions with respect to current and/or past symptoms; it helps recipients re-evaluate their perceptions, beliefs, and thought processes related to these target symptoms. The intervention involves at least one of the following: <ul style="list-style-type: none"> • monitoring of recipients' own thoughts, feelings, and behaviour with respect to target symptoms; • promoting alternative ways of coping with the target symptom; • reducing stress
INDICATOR	4.15 Patients receiving cognitive-behavioural psychotherapy *
MEASURE	Percentage
NUMERATOR	Number of patients receiving at least three sessions of cognitive-behavioural psychotherapy in the previous year
DENOMINATOR	Number of patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes • DMH information system
NOTES	A given patient is considered as being treated if he/she has received at least three sessions of cognitive-behavioural psychotherapy over one year * <i>This indicator also assesses recommendation 4.3.3.4</i>

<i>RECOMMENDATION</i>	<i>4.4.4.5 Longer treatments with cognitive-behavioural therapy are significantly more effective than shorter ones, which may improve depressive symptoms but are unlikely to improve psychotic symptoms. An adequate course of cognitive-behavioural therapy to generate improvements in psychotic symptoms in these circumstances should be of more than 6 months' duration and include more than ten planned sessions</i> LEVEL OF EVIDENCE B
INDICATOR	4.16 Patients receiving longer treatments with cognitive-behavioural therapy
MEASURE	Percentage
NUMERATOR	Number of patients receiving more than ten sessions of cognitive-behavioural psychotherapy in the previous year
DENOMINATOR	Number of patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes • DMH information system

4. D FAMILY/CARER ACTIVITIES

17. Psychoeducational family intervention guidelines
18. Practices in the provision of psychoeducational family interventions to patients with recent relapse or persisting symptoms
19. Availability of staff skills or psychoeducational family interventions
20. Psychoeducational family interventions for patients discharged from General Hospital Psychiatric Wards
21. Intensity of psychoeducational family interventions
22. Patients' participation in psychoeducational family interventions
23. Psychoeducational family or multi-family intervention

<i>RECOMMENDATION</i>	<i>4.4.4.6 Family interventions should be available to families who are living with or who are in close contact with a relative with schizophrenia</i>
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	<p><i>LEVEL OF EVIDENCE A</i></p> <p>4.4.4.7 <i>Family interventions should be offered to the families of people with schizophrenia who have recently relapsed or who are considered at risk of relapse</i></p> <p><i>LEVEL OF EVIDENCE A</i></p> <p>4.4.4.8 <i>Family interventions should be offered to the families of people with schizophrenia who have persisting symptoms</i></p> <p><i>LEVEL OF EVIDENCE A</i></p>
INDICATOR	4.17 Psychoeducational family interventions guidelines
MEASURE	<p>Rate the indicator considering whether written guidelines address the following aspects or not:</p> <ul style="list-style-type: none"> • the availability of psychoeducational family interventions is recommended • they should be specifically offered to the families of patients who have recently relapsed or who are considered at risk of relapse or • the families of patients who have persisting symptoms <p>0 = no specific guidelines on this topic have been adopted 1 = no specific guidelines on this topic have been adopted, but are scheduled to be adopted 2 = the adopted guidelines are generic and address only a part of the recommendations 3 = the adopted guidelines address most of the recommendations 4 = the adopted guidelines address nearly all the recommendations</p>
SOURCE	DMH Direction
INDICATOR	4.18 Practices in the provision of psychoeducational family interventions to patients with recent relapse or persisting symptoms
MEASURE	<p>Ratings:</p> <p>0 = psychoeducational family interventions are not provided to carers/family members of patients who have recently relapsed or have persisting symptoms 1 = psychoeducational family interventions are provided to less than 26% of carers/family members of patients who have recently relapsed or have persisting symptoms 2 = psychoeducational family interventions are provided in 26%-50% of cases 3 = psychoeducational family interventions are provided in 51% -75% of cases 4 = psychoeducational family interventions are provided in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
INDICATOR	4.19 Availability of staff skills for psychoeducational family interventions
MEASURE	Percentage
NUMERATOR	Number of service staff trained in the provision of psychoeducational family intervention, by professional category (psychiatrists, psychologists, social workers, nurses)
DENOMINATOR	Number of service staff working in the DMH as of 31/12, by professional category
SOURCE	DMH Direction
INDICATOR	4.20 Psychoeducational family interventions for patients discharged from General Hospital Psychiatric Wards
MEASURE	Percentage
NUMERATOR	Patients with one psychiatric hospitalisation in the previous year whose carers/family members received psychoeducational family interventions
DENOMINATOR	Patients with one psychiatric hospitalisation in the previous year living with carers/family (parents, brothers/sisters, partners, or children)
SOURCE	<ul style="list-style-type: none"> • DMH information system

RECOMMENDATION	4.4.4.9 <i>The duration of a family intervention programme should normally be longer than 6 months, and it should include more than ten sessions of treatment</i> LEVEL OF EVIDENCE B
INDICATOR	4.21 Intensity of psychoeducational family interventions
MEASURE	Percentage
NUMERATOR	Number of patients whose carers/family members received psychoeducational interventions in the previous year, by number of psychoeducational interventions in the year (1-3; 4-10; >10)
DENOMINATOR	Number of patients with DMH contact living with carers/family members (parents, brothers/sisters, partners, children) in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system
NOTES	<p>Single family- or multi-family psychoeducational family interventions imply the adoption of specific techniques and require specific training for therapists administering them. They generally aim at providing family members or informal carers with information on the characteristics, course, and treatment of psychiatric disorders through well-defined, structured programmes. They also use structured training strategies, to help families improve the ways they communicate and to increase family members' capacity for dealing with problems and coping with stress.</p> <p>Psychoeducational interventions may be focussed on one family at a time or may be delivered as multi-family group interventions; they may or may not include the presence of patients.</p> <p>Multi-family group sessions take place following planned modalities and intervals and are aimed at discussing problems that arise out of daily living with a psychiatric patient and learning the best ways to deal with them. Strategies adopted by these groups may be different from the techniques used in psychoeducational interventions.</p> <p>They include: psychoeducational interventions for either single family or multi-family groups; non psychoeducational family interventions.</p> <p>They exclude: unstructured family interventions (→informal meetings with family members/carers), family psychotherapies (family psychotherapy), group psychotherapy, and family self-help groups.</p> <ul style="list-style-type: none"> The numerator for family interventions is given by the number of families involved in these activities; different family members from the same family participating in a given group should be considered only once. The denominator is given by the number of patients having had at least one CHMC contact in the previous year living with carers/family (parents, brothers/sisters, partners or children)

RECOMMENDATION	4.4.4.10 <i>The service patient should normally be included in family intervention sessions, as doing so significantly improves the outcome. Sometimes, however, this is not practicable</i> LEVEL OF EVIDENCE B
INDICATOR	4.22 Patients' participation in psychoeducational family interventions
MEASURE	Percentage
NUMERATOR	Number of psychoeducational family interventions conducted with the presence of the identified service patient in the previous year
DENOMINATOR	Total of psychoeducational family interventions provided in the previous year
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes DMH information system

RECOMMENDATION	4.4.4.11 <i>Service patients and their carers may prefer single family interventions rather than multi-family group interventions</i>
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	<i>LEVEL OF EVIDENCE A</i>
INDICATOR	4.23 Psychoeducational intervention for single family or multi-family groups
MEASURE	Percentage
NUMERATOR	Number of psychoeducational multi-family group interventions in the previous year
DENOMINATOR	Total of psychoeducational interventions for single family and multi-family groups in the previous year
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes • DMH information system

4.E PHARMACOLOGICAL TREATMENT IN RELAPSE PREVENTION

24. Pharmacological relapse prevention guidelines
25. Opinions on intermittent dosage maintenance strategies
26. Depot antipsychotic treatment practices
27. CHMC-contact patients on depot antipsychotic treatment
28. Reasons for depot antipsychotic treatment
29. Frequency of adherence to recommended standard dosage ranges and depot preparations interval ranges
30. Depot antipsychotic treatment monitoring

RECOMMENDATION	<p>4.4.5.1 <i>The choice of antipsychotic drug should be made jointly by the individual and the clinician responsible for treatment, based on an informed discussion of the relative benefits of the drugs and their side-effect profiles. The individual's advocate or carer should be consulted where appropriate.</i></p> <p><i>LEVEL OF EVIDENCE NICE 2002</i></p>
INDICATOR	This practice is assessed by the indicator 3.10

RECOMMENDATION	<p>4.4.5.2 <i>The oral atypical antipsychotic drugs should be considered as treatment options for individuals currently receiving typical antipsychotic drugs who, despite adequate symptom control, are experiencing unacceptable side-effects, and for those in relapse who have previously experienced unsatisfactory management or unacceptable side-effects with typical antipsychotic drugs</i></p> <p><i>LEVEL OF EVIDENCE NICE 2002</i></p> <p>4.4.5.3 <i>It is not recommended that, in routine clinical practice, individuals change to one of the oral atypical antipsychotic drugs if they are currently achieving good control of their condition without unacceptable side-effects with typical antipsychotic drugs</i></p> <p><i>LEVEL OF EVIDENCE NICE 2002</i></p>
INDICATOR	These practices are assessed by indicator 3.14

RECOMMENDATION	<p>4.4.5.4 <i>Antipsychotic therapy should be initiated as part of a comprehensive package of care that addresses the individual's clinical, emotional and social needs. The clinician responsible for treatment and the key-worker should monitor both therapeutic progress and tolerability of the drug on an ongoing basis. Monitoring is particularly important when individuals have just changed from one antipsychotic to another.</i></p> <p><i>LEVEL OF EVIDENCE NICE 2002</i></p>
INDICATOR	This practice is assessed by indicator 3.11

RECOMMENDATION	<p>4.4.5.5 <i>Targeted, intermittent dosage maintenance strategies should not be used routinely in lieu of continuous dosage regimens</i></p> <p><i>LEVEL OF EVIDENCE C</i></p> <p>4.4.5.6 <i>Antipsychotic drugs, atypical or conventional, should not be prescribed</i></p>
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	<p>concurrently, except for short periods to cover changeover</p> <p>LEVEL OF EVIDENCE C</p> <p>4.4.5.7 A risk assessment should be performed by the clinician responsible for treatment and the multi-disciplinary team regarding concordance with medication, and depot preparations should be prescribed when appropriate</p> <p>LEVEL OF EVIDENCE NICE 2000</p> <p>4.4.5.8 Depot preparations should be a treatment option where a service patient expresses a preference for such treatment because of its convenience, or as part of a treatment plan in which the avoidance of covert non-adherence to an antipsychotic drug regimen is a clinical priority</p> <p>LEVEL OF EVIDENCE B</p> <p>4.4.5.9 For optimum effectiveness in preventing relapse, depot preparations should be prescribed within the standard recommended dosage and interval range</p> <p>LEVEL OF EVIDENCE A</p> <p>4.4.5.10 Following full discussion between the responsible clinician and the service patient, the decision to initiate depot antipsychotic injections should take into account the preferences and attitudes of the service patient towards the mode of administration and organisational procedures (for example, home visits and location of clinics) related to the delivery of regular intramuscular injections</p> <p>LEVEL OF EVIDENCE GPP</p> <p>4.4.5.11 Test doses should normally be used as set out in the national formulary</p> <p>LEVEL OF EVIDENCE GPP</p> <p>4.4.5.12 As with oral antipsychotic therapy, people receiving depot preparations should be maintained under regular clinical review, particularly in relation to the risks and benefits of the drug regimen</p> <p>LEVEL OF EVIDENCE GPP</p>
INDICATOR	4.24 Pharmacological relapse prevention guidelines
MEASURE	<p>Rate the indicator, by considering whether written guidelines address the following aspects or not:</p> <ul style="list-style-type: none"> • targeted, intermittent dosage maintenance strategies are discouraged; • concurrent prescription of two or more antipsychotics is discouraged; • regular clinical review is recommended for patients receiving depot preparations; • depot preparations are recommended for patients showing poor adherence to oral antipsychotic treatment or for those expressing a preference for such treatment; • depot preparations are recommended to be prescribed within the standard dosage range and interval range as set out in the national formulary. <p>0 = no specific guidelines on this topic have been adopted 1 = no specific guidelines on this topic have been adopted, but are scheduled to be adopted 2 = the adopted guidelines are generic and address only a part of the recommendations 3 = the adopted guidelines address most of the recommendations 4 = the adopted guidelines address nearly all the recommendations</p>
SOURCE	<ul style="list-style-type: none"> • DMH Direction
INDICATOR	4.25 Opinions on intermittent dosage maintenance strategies
MEASURE	<p>Rate the indicator based on the percentage of DMH psychiatrists who consider the use of intermittent dosage maintenance strategies a valid option</p> <p>0 = more than 75% 1 = 51- 75% 2 = 26% - 50% 3 = 25%- 10%</p>

	4 = none
SOURCE	<ul style="list-style-type: none"> Specialist focus group
INDICATOR	4.26 Depot antipsychotic treatment practices *
MEASURE	<p>Rate the indicator based on the frequency with which recommendations on depot treatment are followed:</p> <p>a) prescription of depot preparations should be a treatment option for patients showing poor adherence to oral antipsychotic treatment or for those expressing an explicit preference for such treatment 0 = prescription of depot preparations is seldom provided (less than 10%) to patients with poor treatment adherence or expressing an explicit preference for such treatment 1 = prescription of depot preparations is provided to 10%-25% of cases with poor treatment adherence or expressing an explicit preference for such treatment 2 = prescription of depot preparations is provided to 26%-50% of cases with poor treatment adherence or expressing an explicit preference for such treatment 3 = prescription of depot preparations is provided to 51%-75% of cases with poor treatment adherence or expressing an explicit preference for such treatment 4 = prescription of depot preparations is provided to more than 75% of cases with poor treatment adherence or expressing an explicit preference for such treatment</p> <p>b) depot preparations should be prescribed within the standard dosage ranges and interval ranges as set out in the National Formulary 0 = prescription of depot preparations adheres to the recommended standard dose ranges and interval ranges in very few cases (less than 10%) 1 = prescription of depot preparations adheres to recommended standard dose ranges and interval ranges in 10%-25% of cases 2 = prescription of depot preparations adheres to the recommended standard dose ranges and interval ranges in 26%-50% of cases 3 = prescription of depot preparations adheres to the recommended standard dose ranges and interval ranges in 51% –75% of cases 4 = prescription of depot preparations adheres to the recommended standard dose ranges and interval ranges in more than 75% of cases</p> <p>c) regular clinical review is performed for patients receiving depot preparations 0 = regular clinical review of patients receiving depot preparations is performed in very few cases (less than 10%) 1 = regular clinical review of patients receiving depot preparations is performed in 10%-25% of cases 2 = regular clinical review of patients receiving depot preparations is performed in 26%-50% of cases 3 = regular clinical review of patients receiving depot preparations is performed in 51%-75% of cases 4 = regular clinical review of patients receiving depot preparations is performed in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> Specialist focus group
NOTES	Standard dose ranges and interval ranges are set out in the National Formulary
INDICATOR	4.27 CHMC-contact patients on depot antipsychotic treatment
MEASURE	Percentage

NUMERATOR	Number of patients with CMHC contact treated with depot antipsychotic drugs in the previous year
DENOMINATOR	Number of patients with CMHC contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> • DMH information system • Outpatient clinical notes
INDICATOR	4.28 Reasons for depot antipsychotic treatment
MEASURE	Percentage, by specific reason
NUMERATOR	Number of patients with CMHC contact currently on depot antipsychotic treatment, by main reason for depot prescription: <ol style="list-style-type: none"> 1. patient expressing a preference 2. poor treatment adherence 3. other detectable reason (specify the reason) 4. no detectable reason
DENOMINATOR	Number of patients with CMHC contact currently on depot antipsychotic treatment
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes
INDICATOR	4.29 Frequency of adherence to recommended standard dosage ranges and depot preparations interval ranges
MEASURE	Percentage
NUMERATOR	Number of patients currently on depot antipsychotic treatment whose prescription adheres to recommended standard dosage ranges and interval ranges
DENOMINATOR	Number of patients currently on depot antipsychotic treatment
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes
NOTES	<ul style="list-style-type: none"> • Standard dose ranges and interval ranges are set out in the National Formulary
INDICATOR	4.30 Depot antipsychotic treatment monitoring
MEASURE	Percentage
NUMERATOR	Number of patients with CMHC contact currently on depot antipsychotic treatment receiving a psychiatric examination in the last 6 months
DENOMINATOR	Number of patients with CMHC contact currently on depot antipsychotic treatment
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes • DMH information system

4.F TREATMENT-RESISTANT SCHIZOPHRENIA

31. Patients with multiple psychiatric hospitalisations
32. Clinical review of cases with two or more crises per year
33. Shared definition of treatment-resistant schizophrenia
34. Guidelines for frequently relapsing patients and treatment-resistant schizophrenia
35. Pharmacological treatment for frequently relapsing patients and treatment-resistant schizophrenia
36. Switching to an atypical antipsychotic drug in patients unresponsive to conventional antipsychotic therapy
37. Clozapine use in treatment-resistant schizophrenia
38. Psychiatrists' opinions on clozapine use with additional antipsychotic, when clozapine alone proves ineffective

RECOMMENDATION	<p>4.4.5.13 <i>The first step in the clinical management of treatment-resistant schizophrenia is to establish that antipsychotic drugs have been adequately tried in terms of dosage, duration and adherence. Other causes of non-response should be considered in the clinical assessment, such as comorbid substance misuse, poor treatment adherence, the concurrent use of other prescribed medicines, and physical illness</i></p> <p>LEVEL OF EVIDENCE GPP</p>
INDICATOR	4.31 Patients with multiple psychiatric hospitalisations

MEASURE	Percentage
NUMERATOR	Number of patients with two or more psychiatric hospitalisations in the previous year
DENOMINATOR	Number of patients with DMH contact in the previous year (#)
SOURCE	<ul style="list-style-type: none"> DMH information system
NOTES	<ul style="list-style-type: none"> Frequently relapsing patients are considered patients with two or more General Hospital Psychiatric Ward (GHPW) hospitalisations during the previous year. It should be noted that ‘treatment-resistant schizophrenia’ is defined by NICE as ‘a lack of a satisfactory clinical improvement despite the sequential use of the recommended doses for 6 to 8 weeks of at least two antipsychotics, at least one of which should be an atypical’
INDICATOR	4.32 Clinical review of cases with two or more crises per year
MEASURE	<p>Rate the indicator based on the percentage of cases with two or more relapses in the last 12 months and for which multidisciplinary staff meetings have been held with the aim of identifying possible reasons and of reviewing the care programmes:</p> <p>0 = less than 10% of cases 1 = 10%-25% of cases 2 = 26%-50% of cases 3 = 51%-75% of cases 4 = more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group
NOTES	<ul style="list-style-type: none"> Frequently relapsing patients are considered patients with two or more General Hospital Psychiatric Ward (GHPW) hospitalisations during the previous year.
INDICATOR	4.33 Shared definition of treatment-resistant schizophrenia
MEASURE	<p>Ratings:</p> <p>0 = a shared definition does not exist and nearly all psychiatrists appear to have different definitions 1 = less than 26% of psychiatrists substantially share the same definition 2 = 26%-50% of psychiatrists substantially share the same definition 3 = 50%-75% of psychiatrists substantially share the same definition 4 = more than 75% of psychiatrists substantially share the same definition</p>
SOURCE	<ul style="list-style-type: none"> Specialist focus group
NOTES	‘Treatment-resistant schizophrenia’ is defined by NICE as ‘a lack of a satisfactory clinical improvement despite the sequential use of the recommended doses for 6 to 8 weeks of at least two antipsychotics at least one of which should be an atypical’.

RECOMMENDATION	<p><i>4.4.5.13 The first step in the clinical management of treatment-resistant schizophrenia is to establish that antipsychotic drugs have been adequately tried in terms of dosage, duration and adherence. Other causes of non-response should be considered in the clinical assessment, such as comorbid substance misuse, poor treatment adherence, the concurrent use of other prescribed medicines, and physical illness</i></p> <p>LEVEL OF EVIDENCE GPP</p> <p><i>4.4.5.14 If the symptoms of schizophrenia are unresponsive to conventional antipsychotic therapy, the prescribing clinician and service patient may wish to consider an atypical antipsychotic in advance of a diagnosis of treatment-resistant schizophrenia and a trial of clozapine</i></p> <p>LEVEL OF EVIDENCE C</p> <p><i>4.4.5.15 In individuals with evidence of treatment-resistant schizophrenia, clozapine should be introduced at the earliest opportunity</i></p> <p>LEVEL OF EVIDENCE NICE 2000</p> <p><i>4.4.5.17 The addition of a second antipsychotic drug to clozapine may, however, be considered for people with treatment-resistant schizophrenia in whom clozapine alone has proved insufficiently effective</i></p>
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	<i>LEVEL OF EVIDENCE C</i>
INDICATOR	4.34 Guidelines for frequently relapsing patients and treatment-resistant schizophrenia
MEASURE	<p>Rate the indicator by considering whether guidelines address the following recommendations or not:</p> <ul style="list-style-type: none"> • availability of an operational definition of ‘treatment-resistant schizophrenia’ (lack of a satisfactory improvement despite at least 6 weeks of antipsychotic therapy) • if the symptoms of schizophrenia are unresponsive to conventional antipsychotic therapy, the prescribing clinician and service patient may wish to consider an atypical antipsychotic for at least 6-8 weeks at recommended • in individuals with evidence of treatment-resistant schizophrenia, clozapine should be introduced at the earliest opportunity • the addition of a second antipsychotic drug to clozapine may, however, be considered for people with treatment-resistant schizophrenia in whom clozapine alone has proved insufficiently effective <p>0 = no specific guidelines on this topic have been adopted 1 = no specific guidelines on this topic have been adopted, but are scheduled to be adopted 2 = the adopted guidelines are generic and address only a part of the recommendations 3 = the adopted guidelines address most of the recommendations 4 = the adopted guidelines address nearly all the recommendations</p>
SOURCE	<ul style="list-style-type: none"> • DMH Direction
INDICATOR	4.35 Pharmacological treatment for frequently relapsing patients and treatment-resistant schizophrenia
MEASURE	<p>Ratings:</p> <p>0 = the option of switching to an atypical antipsychotic first and subsequently to clozapine is offered to less than 10% of patients with frequent relapses and treatment-resistant schizophrenia 1 = the option of switching to an atypical antipsychotic first and subsequently to clozapine is offered to 10%-25% of cases 2 = the option of switching is offered to 26% -50% of cases 3 = the option of switching is offered to 51%-75% of cases 4 = the option of switching is offered to more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> • Specialist focus group
INDICATOR	4.36 Switching to an atypical antipsychotic drug in patients unresponsive to conventional antipsychotic therapy
MEASURE	<p>Ratings:</p> <p>0 = atypical antipsychotic treatment for at least 6-8 weeks at recommended dosages is prescribed in very few cases (less than 10%) of patients who are unresponsive to conventional antipsychotic therapy 1 = atypical antipsychotic treatment is prescribed in 10%-25% of cases 2 = atypical antipsychotic treatment is prescribed in 25%-50% of cases 3 = atypical antipsychotic treatment is prescribed in 51%-75% of cases 4 = atypical antipsychotic treatment is prescribed in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> • Specialist focus group
INDICATOR	4.37 Clozapine use in treatment-resistant schizophrenia
MEASURE	Percentage

NUMERATOR	Number of patients with frequent relapses or with evidence of treatment-resistant schizophrenia who have been prescribed clozapine in the previous year
DENOMINATOR	Number of patients with frequent relapses or with evidence of treatment-resistant schizophrenia in the previous year
SOURCE	<ul style="list-style-type: none"> Outpatient clinical notes DMH information system
INDICATOR	4.38 Psychiatrists' opinions on clozapine use with additional antipsychotic, when clozapine alone proves ineffective
MEASURE	Ratings: 0 = no/ very few psychiatrists (less than 10%) believe that adding a second antipsychotic drug to clozapine is useful in cases for which clozapine alone has proved insufficiently effective 1 = 10%-25% of psychiatrists believe that supplementation is useful in cases for which clozapine alone has proved insufficiently effective 2 = 26%-50% of psychiatrists believe that supplementation is useful 3 = 51%-75% of psychiatrists believe that supplementation is useful 4 = more than 75% of psychiatrists believe that supplementation is useful
SOURCE	<ul style="list-style-type: none"> Specialist focus group

RECOMMENDATION	4.4.5.16 <i>Antipsychotic drugs, atypical or conventional, should not be prescribed concurrently, except for short periods to cover changeover</i> LEVEL OF EVIDENCE C
INDICATOR	This practice is assessed by indicator 3.16

4.G EMPLOYMENT

- 39. Motivations and work potential assessment
- 40. DMH-promoted work-related activities
- 41. Patients participating in DMH-promoted work-related activities

RECOMMENDATION	4.4.6.1 <i>People with schizophrenia experience considerable difficulty in obtaining employment and many remain unemployed for long periods. The assessment of people with schizophrenia should include assessment of their occupational status and potential. This should be recorded in their notes and care plans</i> LEVEL OF EVIDENCE GPP
INDICATOR	4.39 Motivations and work potential assessment
MEASURE	Rate the indicator based on the percentage of unemployed working-age patients (18-55 years) being assessed on their motivations and work potential in the last 12 months 0 = less than 10% of cases 1 = 10%-25% of cases 2 = 26%-50% of cases 3 = 51%-75% of cases 4 = more than 75% of cases
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group
NOTES	Assessment of patients' motivations and work potential can be conducted in specific staff meetings and/or via interviews with social workers or other mental health workers; the results should be recorded in patients' clinical notes and care plans.

RECOMMENDATION	4.4.6.2 <i>Supported employment programmes should be provided for people with schizophrenia who wish to return to work or gain employment. However, it should not be the only work-related activity offered when individuals are unable to work or are</i>
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	<i>unsuccessful in their attempts to find employment</i> LEVEL OF EVIDENCE C
INDICATOR	4.40 DMH-promoted work-related activities
DEFINITION OF THE INDICATOR	DMH-promoted interventions focussed on the development of employment skills and opportunities for patients
MEASURE	<ol style="list-style-type: none"> 1. DMH service-provided prevocational training programmes (YES – NO) 2. prevocational training programmes provided by social and health agencies external to the DMH (YES – NO) <ol style="list-style-type: none"> 1. “job grants” (YES – NO) 2. placement as associates in cooperative societies 3. (YES – NO) 4. competitive employment (YES, NO)
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
INDICATOR	4.41 Patients participating in DMH-promoted work-related activities *
MEASURE	Percentage, by type of DMH-promoted intervention: <ol style="list-style-type: none"> 1. patients referred to DMH services providing prevocational training programmes 2. patients referred to social and health agencies external to the DMH and providing prevocational training programmes 3. patients receiving “job grants” 4. patients placed as associates in cooperative societies 5. patients placed in competitive employment
NUMERATOR	Number of unemployed patients aged 18-55 receiving work-related interventions in the previous year, by DMH-promoted activity
DENOMINATOR	Number of unemployed patients aged 18-55 with DMH contact in the previous year
SOURCE	<ul style="list-style-type: none"> • Outpatient clinical notes • DMH information system
NOTES	* <i>This indicator also assesses recommendation 4.4.6.3</i>

RECOMMENDATION	<i>4.4.6.3 Mental health services, in partnership with social care providers and other local stakeholders, should enable people to use local employment opportunities, including a range of employment schemes to suit the different needs and level of skills, for people with severe mental health problems, including people with schizophrenia</i> LEVEL OF EVIDENCE GPP
INDICATOR	This practice is assessed by indicator 4.41

5.THE EMERGENCY: MANAGEMENT OF VIOLENT BEHAVIOUR AND RAPID TRANQUILLISATION

1. Environmental factors increasing the likelihood of aggression
2. Staff training in the prevention and management of violent behaviour
3. Procedures for the prevention and management of violent behaviour
4. GHPW practices in violent behaviour prevention and management
5. Training in the use of rapid tranquillisation
6. Staff knowledge of the risks associated with rapid tranquillisation
7. Training on the causes of psychomotor agitation
8. Pharmacological guidelines for rapid tranquillisation
9. Practices in rapid tranquillisation
10. Care procedures for patients receiving rapid tranquillisation
11. Care practices for patients receiving rapid tranquillisation
12. GHPW availability of resuscitation equipment and flumazenil
13. Discussion with patients receiving rapid tranquillisation on their experiences

Note. This Section contains the indicators pertaining to all the NICE Guideline recommendations for Schizophrenia, with the exception of recommendation 4.5.4.8 concerning the opportunity for patients to write their own account of the experience of rapid tranquillisation in their notes, as it is considered not applicable to the Italian mental health service context.

RECOMMENDATION	4.5.1.1 <i>Health professionals should identify and take steps to minimise the environmental and social factors that might increase the likelihood of violence and aggression during an episode, particularly during periods of hospitalisation</i> LEVEL OF EVIDENCE C
INDICATOR	5.1 Environmental factors increasing the likelihood of aggression
MEASURE	Availability, over the last three years, of at least one 8-hour-long session, meeting, or training session in which General Hospital Psychiatric Ward (GHPW) staff had an opportunity to discuss environmental factors leading to an increase in the likelihood of inpatient aggression (YES – NO)
SOURCE	<ul style="list-style-type: none"> • DMH Direction

RECOMMENDATION	4.5.2.1 <i>Staff who use rapid tranquillisation should be trained in the assessment and management of service patients specifically in this context</i> LEVEL OF EVIDENCE C <i>Specifically, health professionals should to:</i> <ul style="list-style-type: none"> • <i>be able to assess the risks associated with rapid tranquillisation</i> • <i>understand the cardiorespiratory effects of the acute administration of these drugs</i> • <i>recognise the importance of nursing</i> • <i>be familiar with the use of resuscitation equipment</i> • <i>undertake annual retraining in resuscitation techniques</i> • <i>understand the importance of maintaining an unobstructed airway</i> LEVEL OF EVIDENCE C
INDICATOR	5.2 Training in the use of rapid tranquillisation
MEASURE	Percentage
NUMERATOR	Number of GHPW staff receiving at least 8 hours of training addressing the aims, risks, and management of rapid tranquillisation
DENOMINATOR	Number of staff working in the GHPW at 31/12
SOURCE	<ul style="list-style-type: none"> • Local Health Unit CME Office • DMH Direction
NOTES	This indicator provides also a measure for recommendation 4.5.3.2 (<i>health professionals should be as familiar with the properties of benzodiazepines as they are with those of antipsychotics</i>)

RECOMMENDATION	4.5.3.1 <i>Staff need to be trained to anticipate possible violence and to de-escalate the situation at the earliest opportunity</i> LEVEL OF EVIDENCE C 4.5.3.2 <i>Training in the use and the dangers of rapid tranquillisation is as essential as training in de-escalation and restraint</i> LEVEL OF EVIDENCE C
INDICATOR	5.3 Staff training in the prevention and management of violent behaviour
MEASURE	Percentage, by professional category
NUMERATOR	Number of GHPW staff receiving at least 8 hours of training in developing violent behaviour management skills, over the last three years,
DENOMINATOR	Number of staff working in the GHPW as of 31/12, by professional category
SOURCE	<ul style="list-style-type: none"> • Local Health Unit CME Office

	<ul style="list-style-type: none"> DMH Direction
INDICATOR	5.4 Procedures for the prevention and management of violent behaviour
DEFINITION OF THE INDICATOR	Availability of written procedures to prevent and manage violent behaviour
MEASURE	<p>Ratings:</p> <p>0 = written procedures to prevent and manage violent behaviour are unavailable</p> <p>1 = written procedures are unavailable, but are scheduled to be produced</p> <p>2 = written procedures are available, but are generic</p> <p>3 = written procedures are available, detailed (rules and responsibilities are specified), but their availability is ignored by staff working in facilities where the risk of violent behaviour is higher</p> <p>4 = written procedures are available, detailed (rules and responsibilities are specified), and known by the staff working in facilities where the risk of violent behaviour is higher</p>
SOURCE	<ul style="list-style-type: none"> DMH Direction
INDICATOR	5.5 GHPW practices in violent behaviour prevention and management
DEFINITION OF THE INDICATOR	Clinical routine prevention and management practices for violent behaviour occurring in GHPWs
MEASURE	<p>Ratings:</p> <p>0 = no structured indications are available: the prevention and management of violent behaviour in routine practice depend exclusively on individual staff members' conduct</p> <p>1 = service staff meetings have been held occasionally over the past year to discuss the prevention and management of violent behaviour, but specific interventions aimed at preventing and managing on-the-ward violence have never been implemented</p> <p>2= service staff meetings are held periodically to discuss the prevention and management of violent behaviour (e.g., meetings focussed on clinical case management), but specific interventions aimed at preventing and managing on-the-ward violence are seldom implemented</p> <p>3 = service staff meetings are held periodically to discuss the prevention and management of violent behaviour (e.g., meetings focussed on clinical case management), and specific interventions aimed at preventing and managing on-the-ward violence are implemented in less than one half of cases</p> <p>4 = service staff meetings are held periodically to discuss the prevention and management of violent behaviour (e.g., meetings focussed on clinical case management), and specific interventions aimed at preventing and managing on-the-ward violence are implemented in the majority of cases</p>
SOURCE	<ul style="list-style-type: none"> Multidisciplinary focus group

RECOMMENDATION	<p>4.5.3.3 Health professionals should:</p> <ul style="list-style-type: none"> be able to assess the risks associated with rapid tranquillisation, particularly when the service patient is highly aroused and may have been misusing drugs or alcohol, be dehydrated or possibly be physically ill; understand the cardiorespiratory effects of the acute administration of these drugs and the need to titrate dosage to effect; recognise the importance of nursing, in the recovery position, people who have received these drugs and also of monitoring pulse, blood pressure and respiration; be familiar with, and trained in, the use of resuscitation equipment; this is essential, as an anaesthetist or experienced 'crash team' may not be available.
INDICATOR	5.6 Staff knowledge of the risks associated with rapid tranquillisation
MEASURE	Percentage, by professional category

NUMERATOR	Number of GHPW staff reporting sufficient knowledge of the risks associated with rapid tranquillisation, by professional category
DENOMINATOR	Number of staff working in the GHPW as of 31/12, by professional category
SOURCE	<ul style="list-style-type: none"> • Specific research conducted on GHPW staff • Multidisciplinary focus group
NOTES	<p>The focus group should address the following topics:</p> <ol style="list-style-type: none"> 1. the cardiorespiratory effects of the acute administration of these drugs 2. the importance of nursing 3. the use of resuscitation equipment 4. annual retraining in resuscitation techniques 5. the importance of maintaining an unobstructed airway

RECOMMENDATION	<p>4.5.4.1 <i>The psychiatrist and the multi-disciplinary team should, at the earliest opportunity, undertake a full assessment, including consideration of the medical and psychiatric differential diagnoses</i> LEVEL OF EVIDENCE C</p>
INDICATOR	5.7 Training on the causes of psychomotor agitation
MEASURE	Percentage
NUMERATOR	Number of psychiatrists receiving, over the last five years, at least 8 hours training in differential diagnoses for medical vs. psychiatric conditions that can cause agitation
DENOMINATOR	Number of psychiatrists working in the GHPW as of 31/12
SOURCE	<ul style="list-style-type: none"> • Local Health Unit CME Office • DMH Direction
NOTES	Include in the denominator both psychiatrists working predominantly in the GHPW and those on call.

RECOMMENDATION	<p>4.5.4.6 <i>Violent behaviour can be managed without the prescription of unusually high doses or “drug cocktails”. The minimum effective dose should be used</i> LEVEL OF EVIDENCE C</p> <p>4.5.5.1 <i>Oral medication should be offered before parenteral medication</i> LEVEL OF EVIDENCE C</p> <p>4.5.5.2 <i>If parenteral treatment proves necessary, the intramuscular route is preferred to the intravenous one from a safety point of view. Intravenous administration should be used only in exceptional circumstances</i> LEVEL OF EVIDENCE C</p> <p>4.5.6.1 <i>The intramuscular (IM) preparations recommended for use in rapid tranquillisation are lorazepam, haloperidol and olanzapine.</i> LEVEL OF EVIDENCE C</p> <p>4.5.6.2 <i>When rapid tranquillisation is urgently needed, a combination of IM haloperidol and IM lorazepam should be considered</i> LEVEL OF EVIDENCE C</p> <p>4.5.6.3 <i>Intramuscular diazepam is not recommended for the pharmacological control of behavioural disturbances in people with schizophrenia.</i> LEVEL OF EVIDENCE C</p> <p>4.5.6.4 <i>Intramuscular chlorpromazine is not recommended for the pharmacological control of behavioural disturbances in people with schizophrenia</i> LEVEL OF EVIDENCE C</p> <p>4.5.6.5 <i>When using IM haloperidol as a means of behavioural control, an</i></p>
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	<p><i>anticholinergic agent should be given to reduce the risk of dystonia and other extrapyramidal side-effects</i></p> <p><i>LEVEL OF EVIDENCE C</i></p>
INDICATOR	5.8 Pharmacological guidelines for rapid tranquillisation
MEASURE	<p>Rate the indicator by considering whether or not guidelines address the following recommendations:</p> <ul style="list-style-type: none"> • an oral preparation should be offered first, and if parenteral treatment proves necessary, the intramuscular (IM) route is preferred to the intravenous one • the prescription of “drug cocktails”, diazepam and chlorpromazine is not recommended • the IM preparations recommended for use in rapid tranquillisation are lorazepam, haloperidol and olanzapine • when rapid tranquillisation is urgently needed, a combination of IM haloperidol and IM lorazepam is recommended • when using IM haloperidol, an anticholinergic agent should be given <p>0 = no specific guidelines on this topic have been adopted 1 = no specific guidelines on this topic have been adopted, but they are scheduled to be adopted 2 = the adopted guidelines are generic and address only a part of the recommendations 3 = the adopted guidelines address most of the recommendations 4 = the adopted guidelines address nearly all the recommendations</p>
SOURCE	<ul style="list-style-type: none"> • DMH Direction
INDICATOR	5.9 Practices in rapid tranquillisation
MEASURE	<p>Rate the indicator based on the frequency with which recommendations on rapid tranquillisation are followed:</p> <p>a) oral preparations should be offered first, and if parenteral treatment proves necessary, the intramuscular (IM) route is preferred to the intravenous one: 0 = oral preparations are preferred for use in rapid tranquillisation, and if parenteral treatment proves necessary, the IM route is preferred over intravenous injection in less than 10% of cases 1 = oral preparations are preferred for use in rapid tranquillisation, and if parenteral treatment proves necessary, the IM route is preferred over intravenous injection in 10%-25% of cases 2 = oral preparations are preferred for use in rapid tranquillisation, and if parenteral treatment proves necessary, the IM route is preferred over intravenous injection in 26%-50% of cases 3 = oral preparations are preferred for use in rapid tranquillisation, and if parenteral treatment proves necessary, the IM route is preferred over intravenous injection in 51%-75% of cases 4 = oral preparations are preferred for use in rapid tranquillisation, and if parenteral treatment proves necessary, the IM route is preferred over intravenous injection in more than 75% of cases</p> <p>b) “drug cocktails”, diazepam and chlorpromazine are not recommended 0 = the recommendation is never followed or is followed in very few cases (less than 10%) 1 = the recommendation is followed in 10%-25% of cases 2 = the recommendation is followed in 26%-50% of cases 3 = the recommendation is followed in 51%-75% of cases 4 = the recommendation is followed in more than 75% of cases</p> <p>c) the IM preparations used in rapid tranquillisation are lorazepam, haloperidol and olanzapine</p>

	<p>0 = IM preparations of lorazepam, haloperidol, and olanzapine are preferably used for rapid tranquillisation in less than 10% of cases</p> <p>1 = IM preparations of lorazepam, haloperidol, and olanzapine are preferably used for rapid tranquillisation in 10%-25% of cases</p> <p>2 = IM preparations of lorazepam, haloperidol, and olanzapine are preferably used for rapid tranquillisation in 26%-50% of cases</p> <p>3 = IM preparations of lorazepam, haloperidol, and olanzapine are preferably used for rapid tranquillisation in 51%-75% of cases</p> <p>4 = IM preparations of lorazepam, haloperidol, and olanzapine are preferably used for rapid tranquillisation in more than 75% of cases</p> <p>d) when rapid tranquillisation is urgently needed, a combination of IM haloperidol and IM lorazepam is used</p> <p>0 = when urgently needed, a combination of IM haloperidol and IM lorazepam is preferably used in less than 10% of cases</p> <p>1 = when urgently needed, a combination of IM haloperidol and IM lorazepam is preferably used in 10%-25% of cases</p> <p>2 = when urgently needed, a combination of IM haloperidol and IM lorazepam is preferably used in 26%-50% of cases</p> <p>3 = when urgently needed, a combination of IM haloperidol and IM lorazepam is preferably used in 51%-75% of cases</p> <p>4 = when urgently needed, a combination of IM haloperidol and IM lorazepam is preferably used in 75% of cases</p> <p>e) when using IM haloperidol, an anticholinergic agent should be given</p> <p>0 = an anticholinergic agent is given with IM haloperidol in less than 10% of cases</p> <p>1 = an anticholinergic agent is given with IM haloperidol in 10%-25% of cases</p> <p>2 = an anticholinergic agent is given with IM haloperidol in 26%-50% of cases</p> <p>3 = an anticholinergic agent is given with IM haloperidol in 51%-75% of cases</p> <p>4 = an anticholinergic agent is given with IM haloperidol in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> • Specialist focus group

RECOMMENDATION	<p>4.5.4.3 <i>Resuscitation equipment and drugs, including flumazenil, must be available and easily accessible where rapid tranquillisation is used</i> LEVEL OF EVIDENCE C</p> <p>4.5.4.4 <i>Because of the serious risk to life, service patients who are heavily sedated or using illicit drugs or alcohol should not be secluded</i> LEVEL OF EVIDENCE C</p> <p>4.5.4.5 <i>If a service patient is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously</i> LEVEL OF EVIDENCE C</p> <p>4.5.4.7 <i>Because of growing awareness that involuntary procedures produce traumatic reactions in the recipient, following the use of rapid tranquillisation, service patients should be offered the opportunity to discuss their experiences and should be provided with a clear explanation of the decision to use urgent sedation. This should be documented in their notes</i> LEVEL OF EVIDENCE GPP</p> <p>4.5.5.3 <i>Vital signs must be monitored after parenteral treatment is administered. Blood pressure, pulse, temperature and respiratory rate should be recorded at regular intervals (agreed by the multi-disciplinary team) until the service patient becomes active again. If the service patient appears to be or is asleep, more intensive monitoring is required</i> LEVEL OF EVIDENCE C</p> <p>4.5.4.2 <i>Drugs for rapid tranquillisation, particularly in the context of restraint, should</i></p>
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	<p><i>be used with caution because of the following risks:</i></p> <ul style="list-style-type: none"> • <i>loss of consciousness instead of sedation</i> • <i>oversedation with loss of alertness</i> • <i>possible damage to the therapeutic partnership between service patient and clinician</i> • <i>specific issues in relation to diagnosis.</i> <p>LEVEL OF EVIDENCE C</p>
INDICATOR	5.10 Care procedures for patients receiving rapid tranquillisation
MEASURE	<p>Rate the indicator by considering whether or not the procedures for the care of patients receiving rapid tranquillisation address the following aspects:</p> <ul style="list-style-type: none"> • vital signs must be frequently monitored after parenteral treatment is administered: blood pressure, pulse, temperature and respiratory rate should be recorded at regular intervals (agreed by the multi-disciplinary team) until the service patient becomes active again • regular frequent monitoring of vital signs is recommended and therapy of potential complications of rapid tranquillisation should be specified • if the service patient appears to be or is asleep, more intensive monitoring is required • resuscitation equipment and drugs, including flumazenil, must be available and easily accessible • because of the serious risk to life, service patients who are heavily sedated or using illicit drugs or alcohol should not be secluded • following the use of rapid tranquillisation, service patients should be offered the opportunity to discuss their experiences and should be provided with a clear explanation of the decision to use urgent sedation <p>0 = specific procedures for the care of patients receiving rapid tranquillisation have not been adopted 1 = specific procedures on this topic have not been adopted, but they are scheduled to be adopted 2 = the adopted procedures are generic and address only a part of the above mentioned aspects 3 = the adopted procedures address 2 or 3 of the above mentioned aspects only 4 = the adopted procedures address at least 4 of the above mentioned aspects</p>
SOURCE	<ul style="list-style-type: none"> • DMH Direction
INDICATOR	5.11 Care practices for patients receiving rapid tranquillisation
MEASURE	<p>Rate the indicator based on the frequency with which recommendations on care for patients receiving rapid tranquillisation are followed:</p> <p>a) regular frequent monitoring of vital signs after parenteral treatment is administered: blood pressure, pulse, temperature and respiratory rate should be recorded at regular intervals (agreed by the multi-disciplinary team) until the service patient becomes active again</p> <p>0 = regular frequent monitoring of vital signs after parenteral treatment is undertaken in less than 10% of cases 1 = regular frequent monitoring of vital signs after parenteral treatment is undertaken in 10%-25% of cases 2 = regular frequent monitoring of vital signs after parenteral treatment is undertaken in 26%-50% of cases 3 = regular frequent monitoring of vital signs after parenteral treatment is undertaken in 51%-75% of cases 4 = regular frequent monitoring of vital signs after parenteral treatment is undertaken in more than 75% of cases</p>

	<p>b) if the service patient appears to be or is asleep, more intensive monitoring is required</p> <p>0 = if the service patient is asleep, more intensive monitoring is undertaken in less than 10% of cases</p> <p>1 = if the service patient is asleep, more intensive monitoring is undertaken in 10%-25% of cases</p> <p>2 = if the service patient is asleep, more intensive monitoring is undertaken in 26%-50% of cases</p> <p>3 = if the service patient is asleep, more intensive monitoring is undertaken in more than 75% of cases</p> <p>c) because of the serious risk to life, service patients who are heavily sedated or using illicit drugs or alcohol should not be secluded</p> <p>0 = the recommendation is never followed or is followed in very few cases (less than 10%)</p> <p>1 = the recommendation is followed in 10%-25% of cases</p> <p>2 = the recommendation is followed in 26%-50% of cases</p> <p>3 = the recommendation is followed in 51%-75% of cases</p> <p>4 = the recommendation is followed in more than 75% of cases</p>
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
INDICATOR	5.12 GHPW availability of resuscitation equipment and flumazenil
MEASURE	<p>Ratings:</p> <p>0 = resuscitation equipment and flumazenil are unavailable in the GHPW</p> <p>1 = both resuscitation equipment and flumazenil are available in the GHPW, but staff ignore their availability and are not trained in their use</p> <p>2 = both resuscitation equipment and flumazenil are available in the GHPW, but only a minority of the staff are trained in their use</p> <p>3 = both resuscitation equipment and flumazenil are available in the GHPW and most of the staff are trained in their use</p> <p>4 = both resuscitation equipment and flumazenil are available in the GHPW, most of the staff are trained in their use and a training has taken place during the last year</p>
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group
INDICATOR	5.13 Discussion with patients receiving rapid tranquillisation on their experiences
MEASURE	<p>Ratings:</p> <p>0 = less than 10% of service patients receiving rapid tranquillisation are offered the opportunity to discuss their experiences</p> <p>1 = 10-25% of service patients receiving rapid tranquillisation are offered the opportunity to discuss their experiences</p> <p>2 = 26%-50% of service patients receiving rapid tranquillisation are offered the opportunity to discuss their experiences</p> <p>3 = 51%-75% of service patients receiving rapid tranquillisation are offered the opportunity to discuss their experiences</p> <p>4 = more than 75% of service patients receiving rapid tranquillisation are offered the opportunity to discuss their experiences</p>
SOURCE	<ul style="list-style-type: none"> • Multidisciplinary focus group