Schizophrenia Needs and Deserves Continuity of Care

Schizophrenia is a chronic life time disease that requires a combination of treatments, including medication, psychological counseling and social support. The foundation of treatment is medication of which there are numerous types but it also requires psychosocial treatments which are essential. These treatments are not given instead of medications; they are given in addition to medications.

Focusing on only one treatment modality as typically done for the majority of cases, helps no one. Not the victim. Not the family. Not society. It is analogous to applying a band aid to someone who has just suffered a major trauma.

Family members can all attest to the fact that very few of these required treatments are made available to our ill relatives. In compiling the treatment modalities required for schizophrenia , I used artificial intelligence to amalgamate all that has been recommended.

As has been pointed out many times by very credible organizations, Canada lacks sufficient professionals, beds, community resources and funding to do what experts consider to be best practices. Other OECD countries do much better than we do and we simply need to look at the numbers of homeless souls living in the streets of our cities and towns with untreated mental illness to realize how bad things are.

Sadly, instead of determining why people are homeless living on the streets (UNTREATED MENTAL ILLNESSES IN MANY CASES), politicians and policy makers ignore the reason while many municipal mayors talk of jail, fines and moving them somewhere less visible.

While medication is the cornerstone of treatment, many approaches are needed and are useful:

Psychotherapy. Cognitive behavior therapy (CBT) can reduce symptoms and distress in schizophrenia. CBT in schizophrenia is conducted differently from CBT for depression. When treating schizophrenia, the therapist puts a heavy emphasis on understanding the person's experience, developing a relationship, and explaining psychotic symptoms in realistic terms to defuse their distressing effect.

Assertive Community Treatment. A community-based team with a variety of caregivers (for example, a psychiatrist, psychologist, nurse, social worker, and/or case manager) makes frequent contact with patients, monitors treatment adherence, and assesses psychosocial and health needs. The team may also provide emotional support to families. Some patients do well living in housing where staff can monitor progress and provide practical assistance.

Assuring Treatment

In many cases, people require hospitalization in specialized hospital beds to become stafilized but our problem is that we do not have sufficient beds for those who can benefit. People are often discharged far too early before they are sufficiently stabilized so we do not to increase the availability of beds.

Then there are those who suffer from anasognosia which is a symptom of their schizophrenia. This is a lack of understanding that prevents them from realizing they are sick. For this group, involuntary hospitalization is required so they do not relapse.

Supported Employment. Such programs rely upon rapid job placement rather than an extensive training period before employment. Programs work hard to honour the person's preferences regarding work. They integrate on-the-job support and mental health services into the program. Most careful studies have found such an approach to be more effective than traditional vocational services.

Family Education. Schizophrenia profoundly affects families. Education about the illness and practical advice can reduce relapse rates of patients as well as reduce family distress and help family members support the person suffering with the illness.

Substance Abuse Treatment. Substance abuse, which is a common problem in schizophrenia, can make the illness worse. Such treatment is essential when substance problems emerge.

General Health. Patients with schizophrenia have a higher incidence of smoking and overweight leading to reduced longevity. Thus, a comprehensive program may include a way to help patients with these problems. Examples are smoke-ending advice, weight-loss programs or nutritional counselling.

The overall goal of psychosocial treatment is to provide ongoing emotional and practical support, education about the illness, perspective on the symptoms of the illness, advice about managing relationships and health, skills for improved functioning and orientation to reality. There may be an emphasis on sustaining motivation and solving problems. All of these efforts can help a patient stick with treatment. The longer and more trusting the relationships (with a therapist or case manager), the more useful it will be for the person affected by this illness.

These are the core principles shared across guidelines and the most important updates clinicians emphasize today:

1.Shared decision-making

- •Patients should be involved in treatment choices as early as possible.
- •Clinicians should discuss benefits, risks, side-effects, and psychosocial options.
- •Family involvement is encouraged when appropriate.

2. Individualized treatment

- •Medication choice depends on symptom profile, side-effect sensitivity, comorbidities, and patient preference.
- •Factors like age, sex, smoking, metabolic risk, and drug interactions matter.
- •Guidelines emphasize using the lowest effective dose.

3. Act early

- •Early assessment of response (often within 1–2 weeks) is recommended.
- •If response is inadequate, adjust dose or switch medications promptly.

Medication initiation

- Start antipsychotics after ≥1 week of psychotic symptoms causing distress or impairment.
- Delay only if symptoms are clearly substance-induced and not dangerous.

Preferred first-line options

- Antipsychotics with lower metabolic burden, e.g., aripiprazole.
- Avoid prolactin-raising agents in young women when possible.

If using higher-risk agents (e.g., olanzapine)

- Offer lifestyle interventions and consider metformin to reduce weight gain risk (per INTEGRATE consensus).

Monitoring

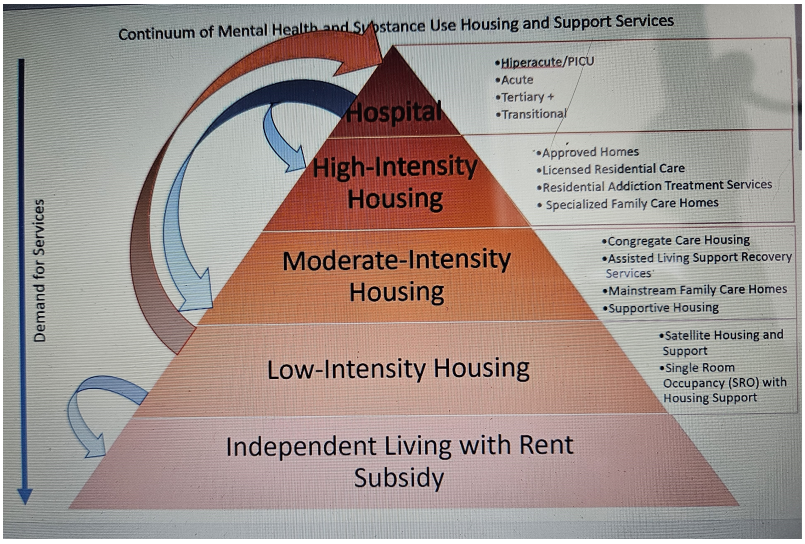
- Reassess within 1 week and titrate based on response and tolerability.

The Guidelines above synthesized by AI leave out two crucial aspects of life with schizophrenia that should be included – supportive housing and income.

As mentioned, schizophrenia is a chronic life long condition and many who suffer need housing and may be sufficiently disabled to require supportive housing. Many can also not work or work full time particularly with relapses that do occur. Schizophrenia is a disease that strikes males about 18-25 before they have completed schooling and developed maturity and social skills. Age of onset is later for females which may be why female prognosis is better than it is for males.

Many parents do what they can to help their kids who often live with their immediate family for years but not all can manage that. And parents get old and the kids outlive them so this is not a tenable long range solution.

Supportive housing guidelines for schizophrenia that is most relevant comes from the 2025 Canadian scoping review on high-support housing for serious mental illness and the Mental Health Commission of Canada's quality standards. Dr Daniel Vigo, the chief medical examiner for British Columbia presented a hierarchy of housing when he addressed the Family Alliance on Severe Mental Illnesses AGM last fall with hospitals at the top.



The Core Principles for Housing Are:

Stable, safe, permanent housing

- •Housing stability is one of the strongest predictors of improved outcomes.
- •Residents with schizophrenia benefit from predictable, long-term accommodation.

Flexible, recovery-oriented support

- •Supports should promote independence, not custodial dependence.
- •Recovery-oriented models show better outcomes than purely custodial ones.

Integrated mental-health services

- •Access to case management, medication support, and crisis response.
- •Staff trained in psychiatric rehabilitation (not just custodial care).

Community integration

- •Opportunities for social connection, meaningful activity, and employment/education.
- •Supported housing models emphasize autonomy and community participation.

Choice and autonomy

- •Evidence shows that resident control, privacy, and choice improve satisfaction and emotional well-being.

Integrated mental-health care:

- •Easy access to psychiatry, case management, and crisis support
- •Help with medication (reminders, blister packs, injections if needed)
- •Support for physical health (appointments, labs, lifestyle coaching)
- •Community inclusion: Housing should be in regular neighborhoods, not isolated “mini-institutions.” Programs should actively support social connection, leisure, volunteering, and employment.

Common models (and when they fit)

High-support / congregate housing:

- 24/7 staff on-site, shared or small units
- Best for people with very high needs, frequent crises, or severe functional impairment
- Should still be recovery-focused, not just "hotel + meds"

Supportive housing (on-site supports):

- Apartment or group home with staff present part-time or full-time
- Good for people who need regular help with daily living and meds
- Supported housing (independent units + mobile supports):
    - Tenant has their own apartment; support team visits as needed
    - Highest autonomy; strong evidence for satisfaction and quality of life
    - Works well when symptoms are somewhat stable and basic skills are present or can be built

Most modern guidelines lean toward supported housing + flexible supports as the ideal, with high-support housing reserved for those who truly need that level of structure.

Minimum standards a program should meet

If you're evaluating or designing a supportive housing program for schizophrenia, it should at least:

- Guarantee tenancy rights similar to other renters (leases, privacy, due process)
- Have clear, written care plans co-created with the resident
- Offer regular check-ins (not just "call us if you need us")
- Monitor mental and physical health (weight, metabolic risk, substance use, suicidality, relapse signs)
- Provide crisis pathways that don't automatically mean eviction
- Coordinate with hospitals and community mental-health teams for smooth transitions in and out of hospital

Supportive housing best practice involves:

- Partners with early psychosis or community mental-health teams
- Uses a recovery-oriented framework (e.g., Housing First principles plus clinical support)
- Avoids large, institutional settings in favour of small, community-based homes or scattered-site apartments

All of this is strictly theoretical as we have very few if any standards and a complete lack of a system or organizational structure.

Income Support

Unless you come from a wealthy family, chances are that you have little disposable income to pay for what you require. Income support for those who cannot work due to disabilities has always been the

responsibility of the provinces and the amounts given vary. Artificial intelligence had difficulty finding rates of allowances for all provinces but this is what came out:

Province/Territory	Monthly Amount (Single Adult)	Source
Ontario	$1,408	
British Columbia	$1,535.50	
Alberta	Not provided in search results	
Saskatchewan	$1,159 (Tier A)	
Manitoba	$1,166–$1,205	
Québec	$1,318	
Nova Scotia	Not provided	
New Brunswick	Not provided	
PEI	No fixed income amount	
Newfoundland & Labrador	$400	
Yukon	Not provided	
Northwest Territories	Not provided	
Nunavut	$1,302 (derived from $15,629/year)	

How much income and individual needs to survive in Canada depends on the area but that amount is greater than the disability payments for any province. In 2023, the low income cutoff for single individuals it ranged from $16,548 to $25,297 depending on size of the community.

Income below the above amounts make it difficult to impossible for people to live but that is what we give to the disabled.

There has been an active movement in Canada to create a universal basic income for people but it has been watered down to the point of absurdity. For those who can prove their disability, they now get an extra $200 a month.

Treatment for schizophrenia is not perfect but with the medication we have now and the other evidence based modalities along with proper social and income supports, the victims should be able to live reasonably good lives. They do not have to end up on the street homeless or revolve in and out of jail and/or hospital. But that is what we give them.

It needs to stop.