Schizophrenia Diagnosis in the Post-Acute & Long-Term Care (PALTC) Setting

Context

AMDA – The Society for Post-Acute and Long-Term Care Medicine (AMDA) is concerned that there may be some PALTC clinicians, as well as other clinicians, using the diagnosis of schizophrenia to justify the use of antipsychotics for patients in their facility that do not have schizophrenia.

Schizophrenia is a lifelong and progressive illness that occurs in approximately 1% of the general population. At the same time, due to medical comorbidities associated with schizophrenia, increased life expectancy and a lack of resources, persons with schizophrenia may be increasingly overrepresented in LTC settings. The typical presentation of schizophrenia involves the emergence of symptoms in late teens or early twenties with another small bump in the 50-60 age group. Epidemiology studies, show that the incidence of schizophrenia in late life – over the age of 75 - is rare.

Because the development of schizophrenia is uncommon in older adults over the age of 75, which constitutes many of the residents and patients in nursing homes, it is AMDA's policy that a diagnosis of new onset schizophrenia in a post-acute and long-term care (PALTC) setting should only be made by health professionals familiar with the diagnosis and management of mental health issues. Health professionals should utilize widely accepted diagnostic criteria such as the current DSM criteria. The term schizophrenia should never be used solely to justify the use of an antipsychotic.

Background

In recent years, there has been an increase in the diagnosis of schizophrenia in elderly persons, especially on the MDS among residents of PALTC facilities. Some of this increase reflects the increased life expectancy of individuals with schizophrenia and also reflects more attention paid documenting the diagnosis in the medical record or MDS among those with a diagnosis prior to admission. While the development of very late onset schizophrenia like psychosis (VLOSLP) is possible, epidemiology studies show that is generally regarded as a rare incidence. In one study, among 1,767 unique individuals admitted to psychiatric facilities for schizophrenia, 23 (1.3%) developed their first psychotic symptoms at the age of 40-59 years old (Late onset - LOS), and 13 (0.7%) at the age of 60 years and above (VLOSLP).[1] There is limited good quality data on the development of schizophrenia on the very old (over the age 75 years). Most studies indicate incidence declines with age and is a fraction of that found in younger adults.[2,3]

At the same time, one of the fastest growing segment of the PALTC population is that of younger adults, particularly those with mental health issues, which may reflect another reason for the increase in persons diagnosed with schizophrenia in PALTC. However, while the increase in schizophrenia diagnoses can be accounted for by the changing populations in PALTC and better documentation, anecdotal stories have indicated that the misdiagnosis of schizophrenia to justify medication use may be a contributing factor.

Clinicians may be challenged when separating the psychotic symptoms of VSLOP from similar symptoms in patients with neurodegenerative disorders.[4] Of note, patients with VLSOP schizophrenia do not tend to have dementia or cognitive deficits on common cognitive screening measures at the time of VSLOP

onset.[5,6] That is, the symptoms of VSLOP schizophrenia predate the onset of dementia. Developing dementia followed by a new onset schizophrenia appears to be extremely unusual.[6] Thus, when a person in the PALTC setting has a history of a progressive dementia and subsequently develops psychoses, they are much more likely to have the psychoses as a result of their underlying dementia rather than a new diagnosis of schizophrenia.

Protocol

The diagnosis of schizophrenia is one that requires thorough evaluation of the patient and history. While DSM criteria provide the diagnostic framework, it is imperative that clinicians use other information to support the diagnosis, especially in individuals with cognitive impairment who reside in PALTC facilities, since distinguishing the features of schizophrenia and dementia can be difficult. Evaluating the patient holistically and obtaining proper diagnostic rule-outs for similar disease processes can help assure an accurate diagnosis. It is also important to know that schizophrenia can co-occur with other illnesses including dementia and delirium.

Particularly as it relates to the diagnosis of schizophrenia, it is recommended that the following approach to patient presentation occur:

1. ***Follow standardized diagnostic criteria using DSM criteria for schizophrenia:*** Schizophrenia is a clinical diagnosis (e.g. there are no laboratory or radiologic tests to establish the diagnosis). The DSM criteria are an accepted standard set of clinical criteria used to diagnose schizophrenia. DSM diagnostic criteria are listed in Table 1 below. Key features of these criteria are the need to have at least two characteristic symptoms for more than 6 months and not to have other causes such as substance abuse, pharmacologic or clinical diagnoses that may explain the symptoms. When assessing residents, it should include an evaluation for symptoms including delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms including diminished emotional expression. Such symptoms cause impairment in major areas of functioning including activities, interpersonal relationships, or self-care. Additionally, some of the symptoms must last continuously for a period of at least six months and cannot be explained by other diagnoses such as Alzheimer's disease or other types of dementia.
2. ***Obtain collateral information***: Efforts should be made to obtain a thorough psychiatric history from the patient and family or caregivers. Given that schizophrenia is normally a lifelong illness, validation of the existence of symptoms in the past supports the diagnosis of schizophrenia. Especially helpful is information related to past diagnosis, treatment, participation in outpatient day treatment, and hospitalizations. The past use of long-acting injectables can be suggestive or supportive of a possible schizophrenia diagnosis. Documentation of previous impairment in functioning including work, relationships, and self-care can also support the diagnosis but must also be distinguished from progressive forms of dementia, particularly those impacting executive function.
3. ***Rule out other possible diagnoses:*** There are multiple other diagnoses that can, for short or long periods of time, mirror the symptoms of schizophrenia. These can become more frequent or likely in the aging adult. A true diagnosis of schizophrenia should not be made in the context of another medical or psychiatric diagnosis that has similar symptoms, such as bipolar disorder or schizoaffective disorder as well as those with different forms of dementia (e.g. Alzheimer's dementia, Lewy body dementia, Fronto-Temporal Dementia (FTD), etc). Additionally, in the PALTC setting it is crucial to consider the following commonly encountered conditions in the differential diagnosis of schizophrenia:

a. *Delirium* – Delirium is a common and often unrecognized condition among PALTC residents. Delirium tends to have an acute onset following a medical or surgical event and represents a significant change from the patient's prior baseline status. Two types of delirium are recognized: hyperactive and the more common hypoactive delirium. Both types of delirium may present with symptoms also experienced by patients with schizophrenia, such as hallucinations, delusions, withdrawal, psychomotor retardation.

b. *Dementia* – The hallmark features of dementia are a general decline in memory, cognitive functioning and reasoning that impairs a person's overall daily functioning. Some people with dementia will experience behavioral symptoms that mimic schizophrenia, such as agitation, delusions, hallucinations, disinhibitions, and depressive symptoms. While these symptoms can last for weeks or possibly months, they occur in the context of the dementia diagnosis.

c. *Mood Disorders Such As Major Depression with Psychotic Features and/or Bipolar Disorder* – Mood disorders are commonly encountered in the PALTC setting. Persons with mood disorders may experience perceptual disturbances such as paranoid thinking and hallucinations.

Good Clinical Practice

It is a serious violation of good clinical practice and medical ethics to give a diagnosis that a person does not have in order to "justify" the use of a particular type of medication. In the PALTC setting, a new diagnosis of schizophrenia should be rare and when made, should rely on the DMS V criteria and involve a qualified and licensed clinician who has explored and documented the patient history and has ruled out other possible causes of the observed symptomatology. Once the diagnosis has been established, good clinical practice with any patient on antipsychotic medications involves ongoing vigilance to ensure that the patient is on the lowest possible effective dose, using a Gradual Dose Reduction (GDR) protocol where indicated.

Table – DSM 5 Schizophrenia Diagnosis

DSM-5
Disorder Class: Schizophrenia Spectrum and Other Psychotic Disorders
A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
1. delusions
2. hallucinations
3. disorganized speech (e.g., frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior
5. Negative symptoms (i.e., diminished emotional expression or avolition).
Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

DSM-5
B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
C. *Duration*: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).
Specify if: The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria. • First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled. • First episode, currently in partial remission: Partial remission is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled. • First episode, currently in full remission: Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present. • Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse). • Multiple episodes, currently in partial remission • Multiple episodes, currently in full remission • Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

DSM-5
• Unspecified
Specify if: • With catatonia (refer to the criteria for catatonia associated with another mental disorder for definition). • Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizophrenia to indicate the presence of the comorbid catatonia. *Specify* current severity: • Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter "Assessment Measures.") Note: Diagnosis of schizophrenia can be made without using this severity specifier.

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