INVITED COMMENTARY ON
Older people with long-standing mental illness: the graduates

The article by David Jolley and his colleagues (Jolley et al., 2004, this issue) raises a number of issues about older people who have enduring mental illnesses. The following contribution aspires to be a complementary article and attempts to expand on some areas that may be of relevance. These concern the disabilities that ‘graduates’ have (including cognitive deficits), comorbidity, prognosis and management, ending with a note on future research directions.

Social disabilities

Elderly patients with schizophrenia in long-term institutional care are known to suffer from a number of social disabilities. Wing & Furlong (1986) identified five factors that contributed to these disabilities:

- risk of harm to self and others
- unpredictability of behaviour and liability to relapse
- poor motivation and reduced capacity for self-management or performance of social roles
- lack of insight
- low public acceptability.

Different studies have shown social functioning in schizophrenia to both improve and deteriorate over time (Ciompi, 1980; Huber et al., 1980; Harding et al., 1987). Some aspects of daily living such as coping skills and socialisation with family members tend to improve with age (Cohen, 1993; Cook et al., 1994), but most elderly patients with schizophrenia continue to have disabilities in the higher domains of functioning such as finance, transportation, shopping and grooming (Klaplow et al., 1997). These all make community rehabilitation a challenge.

Cognitive impairment

Cognitive deficits are well known to be associated with schizophrenia (Cassens et al., 1990; Goldberg...
et al, 1993). Specific deficits in the areas of executive function (Shallice et al, 1991), use of language (Faber et al, 1983), memory function (Saykin et al, 1994) and visuospatial tasks (Gabrovská-Johnson et al, 2003) have been reported. Cognitive deficits, more than positive symptoms, have been shown to affect the adaptive abilities required for community living (Green, 1996; Harvey et al, 1999) and to be responsible for the failure of rehabilitation even in times of remission of illness (Goldberg et al, 1993).

Several histological studies have reported a lack of Alzheimer-type pathological changes in schizophrenia (Pantelis et al, 1992; Casanova et al, 1993), whereas others have shown a higher prevalence than in the general population (Soustec, 1989; Prohovnik et al, 1993). These findings suggest that currently available anti-dementia drugs might be of value in older people with schizophrenia.

**Physical illness**

Some physical illnesses have higher rates in people with schizophrenia than in the ‘normal’ population (for example, cardiovascular disorders, including coronary artery disease, and diabetes mellitus) (Baldwin, 1979; Tsuang et al, 1983; Harris, 1988). A number of other physical disorders such as peptic ulcers, epilepsy, asthma and cancer have also been associated with schizophrenia, but the consequences of these conditions remain generally unappreciated (Jeste et al, 1996). Recognition of concomitant physical illness in elderly patients with schizophrenia is particularly important, as there is an increased risk of deterioration owing to lack of insight and the chances of non-compliance with treatment are high (Cohen et al, 2000).

**Outcome**

Kraepelin (1913) gave a bleak prognosis for schizophrenia, but a more heterogeneous outcome has since been described (Bleuler, 1974; Carpenter & Kirkpatrick, 1989). Abrahamson et al (1989) found that 25% of patients improved and 10% deteriorated. Cutting (1986) reviewed ten outcome studies and concluded that many patients with chronic schizophrenia continued to have a bad outcome. The five most powerful predictors of poor outcome were:

- social isolation
- having episodes of long duration
- a past history of psychiatric treatment
- being unmarried
- a history of behavioural disturbance in childhood.

**Management**

There are few studies on the use of neuroleptics in elderly patients with schizophrenia, but older people are known to be at greater risk of developing extrapyramidal symptoms and tardive dyskinesia (Jeste et al, 1995). Extrapyramidal symptoms can cause functional disabilities greater than those caused by the disease itself (Jeste et al, 1998), and this usually results in the use of smaller doses of antipsychotics for older patients (Jeste et al, 1995). It also highlights the importance of combining pharmacological treatments with psychosocial approaches such as group activities (Harding et al, 1992). The newer atypical antipsychotics seem to have a reduced tendency to cause extrapyramidal side-effects and to have better effects on negative symptoms (Kumar, 1997).

**Conclusions**

The literature on older people with schizophrenia is sparse and much remains to be studied. Areas for future research highlighted by Cohen et al (2000) include the following:

1. identification of the factors that determine the subjective and objective mental, physical and social well-being of older people who have schizophrenia, with the aim of enabling their optimal functioning in the community;
2. clarification of the factors that predict their levels of positive and negative symptoms, depression and neuropsychological deficits, so that the most effective long-term treatment of these symptoms can be established;
3. identification of the factors that contribute to the burden on the carers of this population and, through comparison with the burden on carers of people with other disorders, the development of models to enhance support systems for older people with schizophrenia;
4. determination of the optimal service mix for older people with comorbid physical and chronic mental illness and development of models of funding their care.

**References**


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