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CASE REPORT

Missing link in community psychiatry: When a patient with schizophrenia was expelled from her home

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Treatment and disposition of homeless patients with schizophrenia represent a great challenge in clinical practice. We report a case of this special population, and discuss the development of homelessness, the difficulty in disposition, their utilization of health services, and possible applications of mandatory community treatment in this group of patients. A 51-year-old homeless female was brought to an emergency department for left femur fracture caused by an assault. She was diagnosed with schizophrenia about 20 years ago but received little help from mental health services over the decades. During hospitalization, her psychotic symptoms were only partially responsive to treatment. Her family refused to handle caretaking duties. The social welfare system was mobilized for long-term disposition. Homeless patients with schizophrenia are characterized by family disruption, poor adherence to health care, and multiple emergency visits and hospitalization. We hope this article can provide information about the current mental health policy to medical personnel. It is possible that earlier intervention and better outcome can be achieved by utilizing mandatory community treatment in the future, as well as preventing patients with schizophrenia from losing shelters.

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Introduction

Homelessness is a serious public health issue that affects a large number of people in both urban and rural areas around the world.[1] Homeless people have poorer health than the general population and often experience a disproportionate burden of acute and chronic health issues, including concurrent mental health and substance use disorders.[2,3] They also have significantly higher mortality rates than the general population.[4–7] However, despite their increased need for care, many homeless people face barriers to primary health care and frequently have unmet health needs.[8] The prevalence of homelessness is high among psychiatric patients. Folsom et al[3] estimated that 15% of the patients treated in a large public mental health system in San Diego County were homeless.

Patients with schizophrenia have greater risk of homelessness than other psychiatric patients.[9,10] It leads to lower quality of life and shorter life span, and poses risk of assault on mentally ill patients.[11,12] Moreover, homelessness of patients with schizophrenia is one of the most important factors associated with longer duration of untreated psychosis and poor prognosis.[13,14]

Although considerable efforts have been devoted to illustrating the negative influence of homelessness on schizophrenia, rather less attention has been paid to the pathway to homelessness and the family's role in it.

Other critical issues for homeless patients with schizophrenia are poor adherence and ineffective response to treatment. There has been growing interest in the use of mental health services and its cost-effectiveness. McNiel and Binder[15] showed that homeless patients accounted for 30% of psychiatric emergency services in San Francisco. They were likely to have multiple emergency visits and subsequent hospitalization. Folsom et al[3] also reported that the odds ratios for utilization of emergency and inpatient services by homeless patients were 3.6 and 2.5, respectively. Previous studies tended to focus on interventions such as treatment of comorbid substance use disorder and assistance of health insurance to improve patients' health care.[3,11,12,15] However, factors contributing to the limited utilization of early community-based psychiatric care in Taiwan remain unclear.

We report a case of a homeless patient with schizophrenia in a rural area of Taiwan and delineate the factors related to homelessness and the important role of the family. We also discuss causes that impede the utilization of community-based psychiatric care, introduce the newly enacted mandatory community treatment, and propose its potential role on preventing homelessness.

Case report

Ms. A, a 51-year-old woman, was found lying beside the road with her left leg swelling and deformed, and was initially sent to her husband by a passerby. However, her husband and sons then dropped her at her brother's house and left. Her brother brought her to the emergency department of a general hospital in middle Taiwan. One witness said that she had stolen some fruit and was beaten by several young people. At the emergency department, poor personal hygiene, disorganized thought, and self-talking were noted. She could not describe what had happened to her and had difficulty reporting her physical problems. The patient then received surgery for the left femur fracture, and was transferred to the psychiatric ward for further treatment.

According to her brother, Ms. A has been a worker in a textile factory after graduation from elementary school. She was forced to marry a man when she was in her 20s, and the marriage was not a happy one.

When disorganized and hallucinatory behaviors developed in her 30s, her husband thought she was controlled by the spirits. She received exorcism and then herbal medicine, but in vain. She began to wander out intermittently. Her husband thought she was unfaithful and rejected her coming home. She then led a vagrant life between fields and shabby shelters for more than 10 years thereafter, until this admission.

Under the treatment consisting of either risperidone (6 mg/day) or subsequent olanzapine (20 mg/day), the persecutory delusion, prominent disorganization, and very poor self-care hardly improved. She was suspicious and hostile to medical staff under delusion of misidentification. She withdrew to a corner most of the time. Throughout the period of her hospitalization, she lacked disease insight and was unwilling to receive treatment.

During her stay at the hospital, her husband and three sons refused to visit her. They also declined further caretaking upon the time of discharge; they accused her of having never played the roles of a wife and a mother. Her parents passed away several years ago, and her sister lost contact after getting married. Her only brother could not care for her further because he was handicapped, and suffered from oral cancer and poor financial condition. Local police tried to contact her husband to urge him to fulfill his statutory obligations. Meanwhile, the social worker of the hospital mobilized administrative and social resources to assign a protector to handle her care and subsidize her long-term disposition. She was finally transferred to a halfway house under her own consent, which we are not sure could last long with her vivid psychotic symptoms, poor insight, limited motivation for treatment compliance, and poor social support. If the patient refuses treatment and insists on discharge from the halfway house when compulsory hospitalization is not yet enforceable, it seems inevitable that she will become homeless again.

Discussion

This case represents a special group of patients who are expelled from home and wander on the fields for most of their lives. Poor personal care, prominent disorganized symptoms with poor treatment response, and difficulty in disposition complicated the quality of care.

Development of homelessness in patients with mental illness and difficulties in treatment and disposition

The prevalence of homelessness among patients treated for serious mental illnesses was reported to range from 15% to