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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

28% in the United States.[3,16] According to the Department of Statistics (http://sowf.moi.gov.tw/stat/year/list.htm) (Fig. 1), the number of listed homeless individuals was around 2200 to 4100 each year after 2001, among a total population of 22.4–23.1 million in Taiwan, and 1.6–8.2% of them were transferred to mental health services for disposition, which were surely underestimated for valid policy making.

The predisposing factors of the patient's homelessness included unhappy or even miserable sex experiences and the conservative social climate. Precipitating factors included the onset of schizophrenia, persecutory delusion, disorganized behavior, damaged social function, and the impaired roles of mother and wife. The perpetuating factors included inadequate treatment of schizophrenia, cognitive impairment, social stigma, rejection from her husband and sons, and poor support from her family-of-origin. These factors are consistent with previous findings that cognitive dysfunction, unemployment, and the diagnosis of schizophrenia are risk factors for homelessness.[3] Furthermore, family disruption, misunderstanding of the disease by the family, and lack of community care drew our attention to this case.

Previous studies showed that if the community tends to have a negative attitude toward psychiatric patients, the community is inclined to be against psychiatric care, and the families also suffer from such negative views. The family might refuse the diagnosis to avoid social stigma, thus delaying proper treatment. The attitude of the family is also important in the development of homelessness. While patients suffer from their family's critical emotional expressions, their psychotic symptoms frequently relapse. Subsequently, the patients are more likely to be rejected by their overburdened families.[17]

Partly due to the uneven distribution of medical resources in the different regions of Taiwan, the long-term care of patients relies mainly on individual families, rather than on public health and welfare system.[18] This is particularly true in rural areas of Taiwan even nowadays. To prevent patients from losing shelters and to lower caretakers' stress, it is crucial to provide psychological, social, and medical support, such as educating the community, training the family for caretaking, and engaging them to form support groups. Taiwan does have a law providing needed shelter and medical services to homeless people after due assessment. Under the supervision of the Department of Social Welfare, the homeless shelters and the district welfare service centers are in charge of the procedures/processes (http://www.dosw.taipei.gov.tw/i/i0300.asp?l1_code=10&l2_code=03&fix_code=1003001&group_type=1). However, there is lack of integration among the social welfare and mental health care systems. If possible, we should draw the administrative authority's attention to the systematic determinants that lead to local poverty and lack of resources. Regarding medical support, subsidization of local mental health facilities may increase accessible resources in the rural areas, and active case management would enhance adherence to community treatment programs. Currently, there are no laws or regulations to provide housing by force to these individuals, as the willingness of homeless patients must also be taken into account.

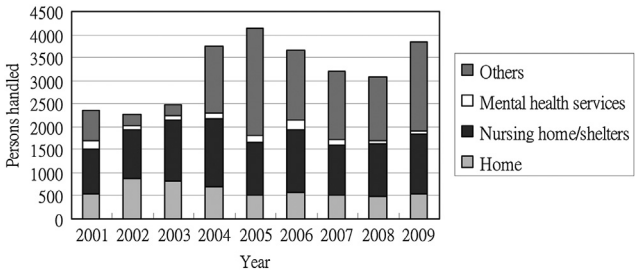

Figure 1 Prevalence of homeless and their handled conditions. (Data from Department of Statistics, Ministry of the Interior).

Utilization of mental health services

The explanatory models of psychiatric disorder may affect the ways caregivers help the patients. Two studies conducted in Taiwan in 1981 and in 1991, have identified different ways people viewed mental illnesses. About 15% of these individuals hold spiritual explanations of mental illnesses, and that attribution to spirits has a strong correlation with belief in folk therapy, limited utilization of psychiatric care, and delayed treatment.[19,20] The psychotic symptoms of our patient were regarded as possession by evil spirits, which might explain why her family avoided letting the community know about her condition, and only took exorcism as the necessary salvation.

Although homeless patients could obtain care and housing from mental health services, their hostility toward medical staff largely influenced treatment. Such a rejection may claim one's competence to protect oneself from invasion in a wild place.[21] This may partly explain why homeless patients often end up being forced to the emergency service only when they are severely disabled, as in the case of our patient. Given that increased emergency services lead to higher expenditure, better care for homeless patients with serious mental illness might be cost-effective, or at least improves patient outcomes with only moderate increases in costs.[3]

The patient's disposition and the mandatory community treatment in Taiwan

The Mental Health Act in Taiwan was recently amended in 2007, with a new provision on mandatory community treatment, which is not seen in other Asian countries. Mandatory community treatment aims to assist and protect patients living in the community, to provide them with health services, and to prevent relapse without sacrificing too much of their autonomy. Those severe cases of patients who have a pattern of refusing treatment and then developing unstable symptoms or deteriorated functions are the target population of the new commitment measure. It is hoped that the less restrictive and more preventive measures adopted in mandatory community treatment through the system of case management could replace compulsory admission as a more humane approach to

empowering the mentally ill and improving their well-being. The Act stipulates that each patient with severe mental illness (like the reported case) shall have a protector selected through the family's mutual agreement from the guardian, legal proxy, spouse, parents, and relatives. The local authority shall assume the responsibility of the protector if no protector could be selected in the family and thus may facilitate social care such as housing. Moreover, through the Act, the protector, the government, and the hospital are obliged to assist patients in obtaining medical care in life-threatening situations, emergent placement, and mandatory hospitalization.

Evidence of the impact of mandatory community treatment is currently wanting but should raise some concerns. It has been reported in Australia and Indonesia that community-based treatment with oral or depot antipsychotics, counseling, and education significantly reduced homeless episodes and improved the quality of life of patients with schizophrenia.[22,23] The strictest scientific evidence from Western countries comparing the effectiveness of compulsory community treatment and standard care shows that people receiving compulsory community treatment were less likely to be victims of violent or nonviolent crime.[24] Nevertheless, there is not much evidence regarding the effectiveness of compulsory community treatment in homeless patients. Although mandatory community treatment may not promise a better outcome in our patient at her current situation, it is possible that by assigning a responsible protector and a competent case manager and offering active treatment earlier, mandatory community treatment might prevent such cases (like our patient) from deteriorating to a point where the family cannot afford as well as extend continuous care after acute inpatient treatments. Additionally, evidence shows that adequate housing is an important step to help homeless patients with mental illness.[25] We suggest that, before adequate housing can be easily accessed, the function of local homeless shelters be enhanced for the mandatory community treatment to deliver the service. This is important for the success of mandatory community treatment. Although housing currently is not accessible in many regions of Taiwan, case managers in mandatory community treatment at least could facilitate the finding of adequate housing for needy patients. With good balance of benefit over cost and risk, mandatory community treatment for homeless persons with severe mental illness, particularly those with schizophrenia, warrants serious consideration. And only when all less restrictive measures that have been adopted in mandatory community treatment fail, should long-term hospitalization be chosen for the patient's care. Further investigations on the influence of mandatory community treatment on the use of long-term hospitalization and the disposition of homeless population are indicated.

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