No fixed abode: a case report highlighting the complexities of schizophrenia and homelessness in the context of diminishing access to psychiatric rehabilitation

Matthew Tennant, Cameron Lacey

In a recent New Zealand Medical Journal editorial, Frizelle highlighted the plight of homeless people in New Zealand, bringing to our attention the growth in homelessness which disproportionately affects Māori, Pasifika and those with major mental illness and addiction. This case highlights some of the complexities of treating people with schizophrenia who are homeless in New Zealand.

Case history

A 41-year-old Māori man (iwi: Ngā Puhi, Ngāti Porou) self-presented to an emergency department because he felt “unsafe”. He described auditory hallucinations and a belief that he was being controlled by an external force, along with insomnia and poor nutrition. He was homeless, estranged from whānau, unemployed and receiving no benefits.

His parents had migrated to the South Island when he was young, and he had since felt disconnected from his iwi.

He had one previous psychiatric admission 7 years earlier and was diagnosed with schizophrenia. After 2 years he was “lost to follow-up”, with no fixed abode, and had no mental health care for 5 years. Over this time, he moved between transient accommodation and living on the street. His whānau had only intermittent contact with him and they described fluctuating psychosis complicated by use of cannabis and synthetic cannabinoids.

Prior to his presentation, whānau attempted to provide support and shelter; however, at the time he experienced paranoia and carried a knife. It soon escalated into a physical altercation with his brother and, as a result, he became estranged from his whānau.

He was admitted voluntarily for 3 weeks. He responded well to risperidone and then to paliperidone depot every 4 weeks. Efforts to arrange suitable accommodation while he was an inpatient were unsuccessful. Due to bed pressure, he was discharged despite having “no fixed abode” and taken to a homeless shelter.

On remission of his psychosis, the man described sudden lucidity regarding his illness, estrangement from family and isolation from society. At this point he developed a depressed mood with suicidality.

For the last 4 months since discharge, he has reported no symptoms of psychosis. He has taken his paliperidone regularly and is not using illicit substances. Despite persistent advocacy, he still has no permanent accommodation and is on a waiting list with Kāinga Ora.

Discussion

This man had 5 years of untreated psychosis perpetuated by homelessness and lack of mental health care.

Approximately 21% of homeless people have psychotic disorders. Māori men are disproportionately affected by schizophrenia and homelessness. Factors likely to have contributed to this disadvantage include colonisation, marginalisation, migration and racism.

Inconsistent or unsafe accommodation is destabilising for those with schizophrenia and limits access to psychiatric case management. Being discharged from a psychiatric hospital to “no fixed abode” adversely impacts one’s health and dignity. Inadequate access to accommodation for those with schizophrenia is arguably a breach of the Code of Health and Disability.
Services Consumers’ Rights, right 4 (3,4,5). Negative stereotypes have been used to justify inaction by viewing accommodation as out of the scope of institutional responsibility.7

Waitaha Canterbury’s psychiatric rehabilitation beds have reduced from 39 beds (over two units) to 16 beds (in one unit), which serve a population of approximately 594,000. This will mean less support is available for those with severe psychotic disorders. Research is needed into how reduced psychiatric rehabilitation impacts on Māori who are discharged to “no fixed abode”.

Alongside assertive pharmacological treatment, stable accommodation, physical health, vocational rehabilitation and cultural support should all be a priority in the treatment of schizophrenia.3
COMPETING INTERESTS
Nil.

AUTHOR INFORMATION
Dr Matthew Tennant: Senior Lecturer, Department of Psychological Medicine, University of Otago, Christchurch, New Zealand.
Dr Cameron Lacey: Associate Professor & Director, Māori/Indigenous Health Institute, University of Otago, Christchurch, New Zealand.

CORRESPONDING AUTHOR
Dr Matthew Tennant: Senior Lecturer, Department of Psychological Medicine, University of Otago, Christchurch, New Zealand.
E: Matthew.tennant@otago.ac.nz

REFERENCES