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Original Article

Psychiatry Section

The Clinical Presentation and Outcome of the Institutionalized Wandering Mentally Ill in India

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ABSTRACT

Introduction: There are estimated 400,000 wandering mentally ill persons in India, found in poor physical state wandering on streets and railway stations; mainly treated either by government run Hospitals for Mental Health (HMH) or Psychiatry units of a Government Medical College (GMC). They require psychosocial rehabilitation along with treatment.

Aim: To study the presentation, clinical profile and rehabilitative outcome of wandering mentally ill admitted in government psychiatric care facilities. The objective was to establish them as a distinct psychiatric inpatient population requiring special attention.

Materials and Methods: The study was a chart review of all wandering mentally ill patients institutionalized during a period of two years in two distinct government facilities. Additionally, clinical staff was interviewed for cross checking the data and for eliciting problems faced in management. The discharged patients were contacted to assess the present status.

Results: Forty seven patients in HMH and 35 patients in GMC were studied. Wandering mentally ill patients were brought to mental health facility by helping person (30) and police (23). Majority of them (61) were picked up from streets and railway station. Most of them (56) belonged to <40 years age group and communication with them was difficult due to language barrier in 51. Diagnosed as Psychosis NOS (45) initially, they presented with poor physical condition, with positive viral markers (25) and pregnancy in females (4). Most common final diagnosis was schizophrenia (45) along with prominent negative symptoms and poor cognitive abilities. Forty three of them showed good improvement on treatment. Forty five gave their address; Relatives were found in 39 through police, post cards and social workers and were rehabilitated back to family.

Conclusion: Wandering mentally ill constitutes a unique patient population with specific challenges different from other inpatients in management and rehabilitation. Provisions to take care of this most vulnerable group of the society and mechanisms to watch for their continuous implementation are required.

Keywords: Homeless, Psychosis, Rehabilitation

INTRODUCTION

About 2-5% of India's population suffers some form of mental or behavioural disorder. Around 1% has a serious form of mental disorder requiring urgent care at any one point of time [1,2]. Homelessness is a serious problem among patients with severe mental illness with a prevalence of 15% [3-5]. There are around 400,000 wandering mentally ill persons in India [3]. They are often seen, in various states of mental distress and physical abuse; around railway stations, bus stands, pilgrim centers and on street corners, especially in urban areas. The wandering mentally ill belong mainly to economically backward and socially marginalized families [6]. Nine out of 10 have diagnosable and treatable mental disorders; four out of five have significant co-morbid physical health problems [3,6]. In India, 80% of our districts do not have even one psychiatrist in public service [2]. Thus, India without a massive mental health movement will see a lot of homeless wandering mentally ill patients [2].

Many studies throughout the world have focused wandering mentally ill most of which pointed out their uniqueness as a group when compared with other psychiatric inpatients [7-10]. They require someone to pick them up from streets and bring them to hospital, their identity has to be determined (name, age, address), no past history is available, psychoses with poor communication skills hinder symptom analysis and finally they need rehabilitation either to their families or shelter homes [7,9-11].

In India a number of organisations like the Banyan foundation and Shradda rehabilitation foundation are doing a commendable job in collecting data as well as in rehabilitation of wandering mentally ill patients [12,13].

This study focuses wandering mentally ill patients who were admitted at two different mental health care facilities i.e., Hospital for Mental Health (HMH) and Government Medical College (GMC). There are 43 HMH and 77 departments of psychiatry in various GMC in India [14].

HMH in this study has a capacity of 400 inpatients, and has staff specifically trained in mental health and has a dedicated Clinical Psychologist, Psychiatric Social Worker team, Occupational Therapy team and social skills trainer, though consultant liaison with other medical specialties is difficult because only a psychiatrist or a MBBS doctor is present there. Physically ill patients are referred to nearby GMC 10 kilometers away. Mostly chronically mentally ill patients requiring long term stay are admitted here and there is no limit for duration of stay.

Department of Psychiatry of the hospital chosen in study has a capacity of 40 beds; the staff is a General Hospital Staff not trained specifically in mental health. The facility lacks services of clinical psychologist, psychiatric social worker, occupational therapist and social skill trainer. As other medical specialties are present in the same building consultant liaison with other departments and easy accessibility to wide range of laboratory investigations is present. The facility mainly admits acute mentally ill patients; chronic patients are generally transferred to HMH and duration of stay is limited to 6 months. The aim of the study is to evaluate the presentation, clinical profile and rehabilitative outcome of wandering mentally ill

admitted in government psychiatric care facilities. The objective is to establish them as a distinct psychiatric inpatient population requiring special attention.

MATERIALS AND METHODS

This was a chart review of institutionalized unidentified wandering mentally ill admitted under psychiatric care. The study was carried out at HMH in Gujarat and Department of Psychiatry, GMC in Gujarat, India. In both institutes all inpatients currently admitted or admitted within past two years fulfilling the following criteria were included in the study. All case files of wandering mentally ill admitted from March 2012 till February 2014 in both the institutes were included for the study.

Ethical clearance for the study was taken from Human Resource Ethics Committee, Government Medical College, Surat.

Inclusion Criteria

All patient found unattended brought to attention by a second person, who were unable to provide reliable address and there were no relatives/friends/caretakers known at the time of admission with apparent mental illness at the time of admission were included in study.

Exclusion Criteria

Patients presenting with above inclusion criteria but having apparent substance intoxication/ gross medical cause on examination at the time of admission (relevant in 11 patients all from GMC) and those who provided complete identity and address within 24 hours of hospital stay (relevant in two cases not included in study) were excluded from the study. Patients with incomplete case records (relevant in 2 cases who absconded after admission) were also excluded. Patient shifted to HMH from GMC were not considered among HMH patients (relevant in 7 cases).

Total of 47 patients in HMH and 35 patients in GMC fulfilled the above criteria.

Method of Data Collection

The case records were retrieved from the hospital record centre. An electronic chart review data sheet (Microsoft Excel Office Worksheet) was prepared based on commonly documented record in case files of these patients. This included socio-demographic data, illness related information available at admission, clinical evaluation/observation and treatment related information, and rehabilitation details. The details of each patient were confirmed with the treating psychiatrist and hospital staff, the improvement in patient condition recorded in files was reconfirmed with the treating psychiatrist. Research team also made an attempt to contact the discharged patients for evaluation of present condition through telephone, letters and personal visits to the address provided. Finally the psychiatrists and hospital staff were interviewed regarding their impression of these patients and their experiences in the management of these patients elicited using open ended questions.

RESULTS

On evaluation following findings regarding the first presentation and diagnosis [Table/Fig-1,2]; sociodemographic, illness [Table/Fig-3,4] and treatment profile were obtained. Finally, data related to improvement, rehabilitative profile and current status of the discharged patients is given [Table/Fig-5,6].

Treatment profile: Most common psychiatric medication prescribed were atypical antipsychotics (most commonly risperidone) in 68 followed by typical antipsychotic (most commonly haloperidol) in 44. More than one antipsychotic were given in 61. Mood stabilizers (most commonly Valproate) were given in 23. Long acting injectable antipsychotic (fluphenazine most common) were given in 21. Clozapine was given in 10 patients (HMH-3, GMC-7) with records documenting marked improvement in 3 patients after starting clozapine. The treating staff at HMH was reluctant to start clozapine because of risk of sudden death, falls due to sedation and convulsions. Electroconvulsive therapy (ECT) was given to 24 patients (HMH-11, GMC-13) without any substantial improvement.

Sr. No.	On Presentation		HMH (N=47)	GMC (N=35)	Overall (N=82)
1	Patient brought to authorities by	Helping person	9	21	30
		Emergency 108	15	10	25
		Police	20	3	23
		NGO	3	1	4
2	Place found at (Street or railway station)	Surat	8	33	41
		Vadodara	20	0	20
		Bharuch	5	0	5
		Bhavnagar	4	0	4
		Kutch	2	0	2
		Vyara	3	0	3
		Vapi	2	0	2
		Tapi	2	0	2
		Bardoli	0	1	1
		Dang Ahwa	1	1	2
3	First admitted/ presented/ stayed in	GMC Surat	8	31	39
		GMC Vadodara	15	0	15
		SMIMER Medical College, Surat	7	0	7
		GMC Bhavnagar	10	0	10
		HMH	6	0	6
		Nari Sanrakshan Gruh	0	3	3
		Dang Ahwa hospital	1	1	2

[Table/Fig-1]: Patient profile on first presentation to a mental health establishment.

Sr. No.	Diagnosis	Given provisionally in	Finally diagnosed in*
1	Psychosis NOS	45	22
2	Schizophrenia	24	45
3	Bipolar mood disorder	10	10
4	Mental retardation	3	7
5	Brief psychotic episode	0	2
6	Substance related	0	5

[Table/Fig-2]: Psychiatric diagnosis made on admission provisionally and after final detailed evaluation.
*some patients may have more than one diagnosis.

Sr. No.	Area		HMH (N=47)	GMC (N=35)	Overall (N=82)
1	Estimated age group(in years)	15-20	2	2	4
		20-30	19	12	31
		30-40	15	10	25
		40-50	8	6	14
		50 and above	3	5	8
2	Sex	Male	28	18	46
		Female	19	17	36
3	Predominant language spoken	Gujarati	21	10	31
		Hindi	11	10	21
		Marathi	3	6	9
		Oriya	1	3	4
		Bengali	1	2	3
		Tamil	2	0	2
		Telugu	3	0	3
		Bhojpuri	1	3	4
		Language not known	4	1	5

[Table/Fig-3]: Sociodemographic profile of patient at the time of admission.

Sr. No.	Parameter	Sign and symptoms	Observed in (N=82)
1.	Negative Symptoms	Blunted affect	52
		Emotional withdrawal	27
		Lack of spontaneity	44
		Poor rapport	48
2.	Positive symptoms	Delusion	11
		Grandiosity	10
		Excitement	21
		Hostility	13
3.	Cognitive symptoms	Poor attention & concentration	41
		Poor social judgement	57
		Impaired memory	21
		Motor retardation	48
4.	Other symptoms	Neglected self care	54
		Absconding tendency	31
		Urinary or fecal incontinence	22
		Self harming behaviour	5
		Sleep disturbance	41
5.	Physical Examination	Abnormal systemic examination	21
		Skin or scalp infection	55
		Open wounds	29
		Injury marks	59
		Pallor & malnutrition	64
		Pregnancy (in females)	4
6.	Investigations	Abnormal CBC, LFT, RFT, Chest X Ray or ECG	33
		Viral markers (HBsAg, HCV, HEV, HIV)	25 (HBs Ag – 15)
		CT scan or MRI abnormality*	16 (out of 41 scans)

[Table/Fig-4]: Illness profile of patient during the course of inpatient stay. *Abnormal findings mainly comprising of diffuse cerebral atrophy and lacunar infarcts.

Outcome: A consistent address was given by 45 on improvement. Relatives were found in 39 patients. Common mode of information to relatives were through local police with whom treating team was able to establish contact, through post cards send to patient's address, through hospital social worker/resident doctor going to the address provided and through telephonic conversation on the number provided by patient.

Impressions and experiences of Psychiatric care team (Psychiatrists, nursing staff, ward attendants and hospital social worker) in management of unidentified wandering mentally ill:

- On asking how is an unidentified wandering mentally ill different from other patients both centers opined that major problem is that relatives of these patients are not available, there is no adequate history, proper diagnosis cannot be made as duration and extent of illness is not clear, mental retardation cannot be ruled out and they are poor responders to drugs. The main difference in opinion between the two centers was that at GMC staff considered them as needing special attention and extra time as compared to other patients, they have longer duration of stay and that they disturb during night time while HMH staff had no such complaints.
- On asking the reasons why this patient population end up on street they opined worsening of illness; running away tendency and physical, verbal abuse by relatives as main reasons. While additionally poor cognitive abilities and female exploitation leading to wandering mentally ill status were also reported.
- On asking the problems that they face in treating such patients both centers commonly reported language barrier as the major problem. Migrant population from other states with low education levels and speaking other than local language

Sr. No.	Improvement	HMH (N=47)	GMC (N=35)	Overall (N=82)
1	0% to 10%	4	3	7
2	10%- 30%	20	6	26
3	30%-70%	9	11	20
4	70%-100%	11	12	23
5	Early to comment (<2 months of stay)	3	3	6

[Table/Fig-5]: Improvement in patient condition after treatment as per case record and treating psychiatrists opinion.

Sr. No.	Event	HMH (N = 47)	GMC(N = 35)
1.	Shifted to HMH	Not applicable	7
2.	Shifted to NGO	none	3
3.	Shifted to narisanrakshan (Government shelter home)	5	4
4.	Handed over to relatives	21	13
5.	Patient absconded	1	7
6.	Still staying in institution	20	2
	Present status of patients discharged		
	At Follow up	HMH (of 27 patients discharged)	GMC (of 33 patients discharged)
1.	Worsened	4	3
2.	Status quo	14	11
3.	Off drug	6	8
4.	Unable to contact	3	11

[Table/Fig-6]: Final rehabilitative outcome of the study population and the present status of discharged patients.

are more likely to end up on street after developing mental illness. Other problems were in process of rehabilitation and uncooperativeness of police and relatives. In some cases relatives refuse to accept the patient and some patient especially females are again left back on street after rehabilitation. HMH also reported difficulty in management of medically ill as emergency medical services are not available there. Process of rehabilitation especially to other states is difficult as transfer of patient requires chain of permissions and the funds to rehabilitate patients are not allocated in time. At GMC untrained nursing staff and ward attendants is also a major problem. Need of medication and food under supervision, difficulty in maintaining hygiene, inappropriate behaviour like moving naked and danger of abuse by other inpatients are other problem areas.

- On asking suggestions for their betterment they opined that need for simplification of transferring process especially to other states and NGO co-operation with more awareness regarding wandering mentally ill is required. Providing a pen and paper constantly with patient and reconfirming the details many times is useful. HMH insisted for complete medical check-up before admission and timely and adequate allocation of social worker funds during rehabilitation while staff at GMC demanded separate ward for such patients.

DISCUSSION

Similar results have been obtained by studies done on wandering mentally ill worldwide. In India only a few studies have focused on wandering mentally ill of which notable is study done in a psychiatry hospital of north Indian medical university regarding sociodemographic and illness profile of homeless mentally ill (2013) which concluded that after treatment of mental illness, it was possible to reintegrate about 70% of the patients into their families. Families were willing to accept and support them. Untreated/inadequately treated mental illness was the most common reason for homelessness [7]. In a descriptive study done in Goa, India by

Rane and Nadkarni in patients admitted with reception order (of which unknown patients are part) compared with those admitted voluntarily, those admitted by reception order tended to be single, middle aged (40–60-year-old) and non-Goan; on average they had a significantly longer hospital stay than voluntarily admitted patients. Non-affective psychosis and substance use disorders were the more common diagnoses [8].

In a study done by Onofa et al., in Nigeria, Africa comparison between vagrant and non-vagrant psychiatric population was done and it was concluded that clinical profile and treatment outcome were poorer in the vagrant population [9]. Another study in Madrid, Spain by Gonzalez et al., showed similar picture [10].

Study done by Koegel et al., in Los Angeles reported rates of major mental illnesses were disproportionately high in homeless mentally ill. Substance abuse was more highly prevalent among older individuals and Native Americans, while schizophrenia was most highly prevalent among those subjects between 31 and 40 years of age. It was estimated that 28% of subjects in this inner-city homeless sample were chronically mentally ill; they also reported that there is a need for simultaneous attention to the social welfare and mental health requirements of homeless mentally ill individuals [11].

As reflected from the findings of this and other studies mentioned wandering mentally ill constitute a unique patient population as they frequently are victims of physical/sexual abuse (injury marks, viral markers positive and pregnancy); they require someone to take them to hospital; due to language barrier, predominant negative symptoms, poor cognition, neglected self care and absconding tendency they need continuous supervision by staff; poor physical state requires consultation liaison with other branches and finally efforts have to be done to locate their families or rehabilitate them to shelter homes.

Provisions to take care of this most vulnerable group of the society and mechanisms to watch for their continuous implementation are required. Currently, there are no separate guidelines by the government for identification or management of this population and they are treated just like other mentally ill. For identification a nationwide unique identification number (AADHAR card) with biometric database of all persons resident in India linked to hospitals can be an answer to the problem [15]. The current national mental health policy stresses on deinstitutionalization and community care (section 4.7) which is not possible without addressing this inpatient group. The transferring process especially to other states should be simplified. There is a need for guidelines regarding ethical treatment of this group especially as they are unable to provide informed consent [16]. Hospitals for Mental Health can function more efficiently if specialists from other medical sciences regularly visit these facilities. Finally as psychiatry units of Government Medical Colleges play a major part in management of these patients there is a need to upgrade them in terms of infrastructure and manpower so that they can function at par with HMH.

LIMITATION

Standardized symptom rating scales were not used in assessing patients. The time point of improvement was chosen based on the subjective assessment of the consultant psychiatrists and their management team. For some of the patients, their age may not be exact.

CONCLUSION

Wandering mentally ill in India is a big emerging problem which requires immediate and effective intervention. Language barrier is a major limiting factor in diagnosis and rehabilitation of these patients. They frequently are victims of physical and sexual abuse. They mostly suffer from resistant schizophrenia, with prominent negative symptoms, with poor cognitive abilities and poor treatment outcome. Their treatment requires effective liaison among various departments in hospitals, police and NGOs. If efforts are done in right directions many of them can be rehabilitated into the society.

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