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Prevalence of Homeless Mentally Ill Patient along with their Clinical Presentation at Government Setup in Western Uttar Pradesh State of India

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Abstract

Context: Homeless persons lack socioeconomic support which is instrumental in affecting both their physical as well as psychological health. A number of destitute persons are often brought to specialized psychiatric centres in view of their dilapidating physical and psychological health.

Aim: To study the prevalence and clinical presentation among the destitute persons admitted to a specialized psychiatric care centre.

Materials & Methods: A total of 100 destitute persons admitted to a specialized psychiatric care centre were included in the study as a retrospective chart review. Demographic profile and clinical presentations were noted. The classification of psychiatric illnesses was done as per international classification of diseases (ICD)-10 classification. Data has been represented in frequencies (number) and percentages.

Results: Age of patients ranged from 15 to 75 years. Mean age of patients was 40.70 ± 13.99 years. Majority (62%) were males and Hindus (57%). Poor personal hygiene (79%), abnormal behavior (52%) and self-muttering (44%) were the most common presenting complaints. On mental status examination, irrelevant speech (85%), restricted/perplexed affect (93%), impaired judgement (98.8%), impaired attention and concentration (90.7%) and impaired memory (80%) were the major findings. CNS and GI abnormalities were seen in 9% and 2% patients. Almost all (99%) had non-cooperative attitude, inadequate skin/nail care (94%). Majority (56%) had thin to very thin built and psychomotor agitation (55%). Unspecified nonorganic psychosis (44%) was the most common psychiatric illness followed by paranoid schizophrenia (10%) and organic delirium (6%). In 28% cases, the psychiatric illness could not be established clearly, and were kept under observation.

Conclusion: Destitute persons have a huge burden of psychiatric illness that had affected their physical health too.

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Introduction

Homeless persons are those who don't own home. They are also known as wandering person. Homelessness, defined as house-less-ness is a state in which persons live in places other than a house with a roof. They usually live

in open places such as footpath, under staircases, flyovers and places of worship, or railway platforms. They are high prone to stress, psychiatric disorders, Vancouverrt from it drug abuse, alcoholism, are also dominantly evident in these subjects.[1,2] There is widespread variation in occurrence of psychiatric disorders among Homeless individuals worldwide. High prevalence is seen among developing countries such as Pakistan, Bhutan, Tibet, India etc.[3,4] In India, they are often seen around bus stands, railway station, temples, gurudwaras, churches, street corner, pilgrim centres.[5] Most of them have mental illness. In India, there is lack of mental health care specialist and Mental health care facility in many remote areas so in our country without a massive mental health care interventions will see a number of destitute patients with mental illness.[1,5] They are belonging to poor background and are under privileged. Nine out of 10 destitute patients have mental disorders of diagnosable and treatable type; 4 out of 5 have considerable co-morbid physical health situations.[5]

There is provision for homeless mentally ill (HMI) persons for rehabilitation and treatment management under Mental Health Act. Services for these HMI persons are also provided by few non-government organisations (NGOs).[6] Most of these NGOs are active in South India whereas in northern India lack most of these facilities. Organisations such as 'Shradda rehabilitation foundation' and 'Banyan foundation' are active in India and providing services for HMI patients.[7]

There are number of studies worldwide focused on HMI patients most of which distinguish these patients as a separate unique group compared with other mentally ill inpatients.[8-11] The present study was conducted with the aim to evaluate the frequency of various psychiatric disorders among homeless patients admitted in destitute wing of psychiatry ward at our setup as these population need special care and attention.

Methodology

Study Design

This study was a retrospective chart review of a total of one hundred HMI patients age ranged 15 to 80 years, admitted in destitute ward in LLRM Medical College, Meerut, Uttar Pradesh, India from January 2017 to January 2020

Ethical Approval Status

Approval from institutional ethical and review committee was sorted beforehand.

Inclusion Criteria

All destitute patients who were admitted in past 3 years in destitute ward of medical college in age ranged 15 to 75 years of either gender with assumed psychiatric illness at the time of admission was included.

Exclusion Criteria

Person with incomplete case files (in which more than 50% of data are missing).

Sampling Techniques

All destitute patients who were admitted in past 3 years in destitute ward of medical college in age ranged 15 to 75 years of both the gender with assumed psychiatric illness were included as a sample.

Data Collection Method

The case files were taken from the records section of destitute ward. Parameters such as age, gender, religion, clinical information, physical /general/ mental status examination details, investigations and diagnosed illness were recorded in case sheet. These HMI patients were brought to our setup by police as they found on streets, or by helping person. They were admitted at our facility in destitute ward as a case of acute mental illness and the patients requiring long term care and management were transferred to Bareilly or Agra mental hospital, UP, India.

Psychiatric facilities including consultant psychiatrist, psychiatric social worker, occupational therapist, and other medical specialties were present at our setup, so that accessibility of consultant liaison with other departments was made. Each patient's detailed record was retrieved for the study was confirmed with the treating psychiatrist, residents (currently working in same facility) and also with the nursing staff who were posted that time in the destitute ward. Results of the study were clubbed

and spread along MS excel sheet. Data has been represented in frequencies (number) and percentages.

Results

The Table 1 belonging to Socio demographic characteristics of patients shows that age <20 years comprised of 4, 21 to 30 Years had 30, 31 to 40 Years had 25, 41 to 50 Years had 22, 51 to 60 Years had 11, 61–70 Years had 7 and 71 to 80 Years had 1 patient. The mean age ± SD (Range) in years was 40.70 ± 13.99 (15–75).

There were 62 males and 38 females. Religion was Hindu in 57, Muslim in 9, Sikh in 1 and unknown in 33. Presenting complaints were abnormal behaviour in 52, aggressive/abusive in 31, poor hygiene in 79, self- muttering in 44, suspiciousness in 8, unable to speak in 7, injury/fracture in 28, abnormal limb movements in 5, fever/headache/vomiting in 7 and generalised weakness in four patients (Table 1).

Table 1: General Characteristics and Presenting Complaints (n = 100)

SN	*Characteristic*	*No. & %*
1.	Age	
	≤20 Years	4
	21–30 Years	30
	31–40 Years	25
	41–50 Years	22
	51–60 Years	11
	61–70 Years	7
	71–80 Years	1
	Mean Age ± SD (Range) in years	40.70 ± 13.99 (15-75)
2.	Sex	
	Male	62
	Female	38
3.	Religion	
	Hindu	57
	Muslim	9
	Sikh	1
	Unknown	33
4.	Presenting complaints	
	Abnormal behavior	52
	Aggressive/abusive	31
	Poor hygiene	79
	Self muttering	44
	Suspiciousness	8
	Unable to speak	7
	Injury/fracture	28
	Abnormal limb movements	5
	Fever/headache/vomiting	7
	Generalized weakness	4

Table 2 shows mental status examination findings, in that speech was irrelevant in 85, output decreased in 6, output increased in 2, slurring in 2, volume high in 3 and no output in 3 patients. Delusions was seen in 25, hallucinations in 32, impaired judgement (n = 86) in 85 (98.8%), partial/Impaired insight (n = 87) in 23 (26.4%), impaired memory (n = 90) in 72 (80%) and impaired attention and concentration (n = 97) in 88 (90.7%).

Table 3 of systemic examination findings shows that there was CNS abnormality in 9 and GI abnormalities in 2.

Table 4 for general appearance shows that inadequate skin and nail care was seen in 94, open wounds in 28 and injury marks in 26. Body built

Table 2: Mental status examination (data is mutually inclusive)

SN	*Characteristic*	*No. & (%)*
1.	Speech	
	Irrelevance	85
	Output decreased	6
	Output increased	2
	Slurring	2
	Volume high	3
	No output	3
2.	Affect	
	Restricted	47
	Perplexed	46
	Excitation	3
	Constricted	2
	Labile	1
	Flat	1
3.	Delusions	25
4.	Hallucinations	32
5.	Impaired judgement (n = 86)	85 (98.8)
6.	Partial/Impaired insight (n = 87)	23 (26.4)
7.	Impaired memory (n = 90)	72 (80)
8.	Impaired attention and concentration (n = 97)	88 (90.7)

(In mse fluctuation in "n" occur due to incomplete mse findings in some cases,)

Table 3: Systemic examination findings

SN	*Finding*	*No. & (%)*
1.	CNS abnormality (not oriented to time/place/ person/drowsy)	9
2.	GI abnormalities (Tenderness)	2
3.	Respiratory abnormalities	0
4.	CVS abnormalities	0

Table 4: General appearance

SN	Finding	No. & (%)
1.	Inadequate skin and nail care	94
2.	Open wounds	28
3.	Injury marks	26
4.	Pregnancy	-
5.	Body built	
	Very thin	1
	Thin	55
	Average	44
6.	Non-cooperative attitude	99
7.	Abnormal movements	5
8.	Psychomotor agitation	55

Table 5: Psychiatric illness

SN	Finding	No. & (%)
1.	Unspecified nonorganic psychosis	44
2.	Paranoid schizophernia	10
3.	Organic delirium	6
4.	Bipolar affective disorder	2
5.	Organic hallucinosis	2
6.	Seizure disorder with altered behaviour	2
7.	Alcohol intoxication	2
8.	Bipolar disorder with seizure disorder	1
9.	Seizure disorder with post-ictal confusion	1
10.	Post-ictal confusion	1
11.	Intellectual disability with behavior problems	1
12.	Under observation (Diagnosis could not be established clearly)	28

was very thin in 1, thin in 55 and average in 44. Non-cooperative attitude was present in 99, abnormal movements in 5 and psychomotor agitation in 55.

Table 5 for diagnosed psychiatric illness shows that common psychiatric illness was unspecified nonorganic psychosis in 44, paranoid schizophrenia in 10, organic delirium in 6, bipolar affective disorder in 2, organic hallucinosis in 2, seizure disorder with altered behavior in 2, alcohol intoxication in 2, bipolar disorder with seizure disorder in 1, seizure disorder with post-ictal confusion in 1, intellectual disability with behavior problems in 1 and under observation (Diagnosis could not be established clearly) in 28.

Discussion

HMI people are an extremely susceptible and socially deprived group. Homeless people with mental illness face numerous health and social tribulations.[12] The homelessness may result into some mental health concern or vice versa.[2] The prevalence of psychiatric disorders in this population ranges from 3–42%, in comparison to general population with 1%.[13] Serious mental illnesses can disturb people's cVancouvercity to perform necessary part of daily life, for example self-care and household supervision, due to this they are more likely to turn into homeless than the general population. Due to mental illness negligence in self-care may resulting into disrupted general physical health too.

Tripathi *et al.* assessed the 140 socio-demographic and clinical outlines of Homeless mentally ill patients. They observed that most of them were illiterate with mental illness. There was 4.3% co-morbid substance abuse, 38.6% with intellectual disabilities and 75.4% with physical problems.[8] Similar to our findings, Parks *et al* from systemic review observed impaired cognitive functions among the study participants. One study there was lower language deprivation and learning difficulties among 80% of the participants; in subgroups 11% of children had mild retardation and had learning difficulties in 35%.[14] In our study, we found very small no of intellectual disability cases and no cases of learning disability as compare to other studies, it may be because we mostly had adult population in our sample and we did not find any features of low intelligence on clinical assessment in most of the cases.

Burra *et al.* from systemic review found global cognitive deficits with focal deficits in verbal and attention, visual memory, executive functions, and speed of cognitive processing among 4 to 7% of homeless people.[15] Ennis *et al* from their systemic review observed, 18 to 55.4% general cognitive deficits, 33 to 78% had visual memory impairments and 33 to 69% had verbal memory impairments among homeless participants.[16] While in our study, we found 80% of memory impairment and 90.8% impairment in attention and concentration. Hodgson *et al,* from systemic review found the 48.4 to 98% prevalence of mental disorders.

Homeless people had high rates of depression (17.6–28.1%), conduct disorder (36–76.7%), anxiety (32%), bipolar disorder (26.9%), mood disorders (12.2–41.3%), attention deficit hyperactivity disorder (4.4%), substance or alcohol use disorder (11–43.7%), suicidal ideation (22–36.8%), self-harm (69%).[17] While in our study we found the rates of psychiatric illness are Unspecified nonorganic psychosis (44%) was the most common psychiatric illness followed by paranoid schizophrenia (10%), organic delirium (6%) and substance abuse disorder (2%). The increased number of psychotic cases in our sample may be due to homeless individual had lack of awareness and affordability for psychiatric treatment. Schreiter *et al.* systemic review found 77.5% prevalence of mental illness. The prevalence rates for substance-related disorders (60.9%, 95% CI: 53.1–68.5), alcohol dependency (55.4%, 95% CI: 49.2–61.5), anxiety disorders (17.6%, 95% CI: 12.9–22.8), drug dependence (13.9%, 95% CI: 7.2–22.2), affective disorder (15.2%, 95% CI: 9.8–21.5), psychotic illness (8.3%, 95% CI: 5.4–11.8), major depression (11.6%, 95% CI: 4.4–21.3), personality disorders (29.1%, 95% CI: 5.6–59.5), cognitive impairment (11.7%, 95% CI: 6–18.9) . in our study alcohol intoxication was found in 2% population which was low as compared to other studies it may be due to lack of money and poor financial status for using alcohol or other substance.[18] Singh *et al,* evaluated the clinical profile and rehabilitative outcome of wandering mentally ill subjects. Most commonly they had schizophrenia and poor cognitive abilities.[5] Which is similar to our study as we had two most common mental illness found in our sample was nonorganic psychotic disorder and paranoid schizophrenia. Gowda *et al.* assessed the sociodemographic and clinical profiles of HMI patients with mean age of 34.6 years.[19] In our study, the mean age for the homeless patient was 40 years.

At present, there are no separate government guidelines for recognition or management of mentally ill homeless patients and they are treated similar to other mentally ill.[5] Police personnel and volunteers if motivated effectively could play a significant role in recognizing homeless persons with mental disorder and referring them. The most common reason for the patients' becoming homeless and residing on the street was that patients left away from their home due to mental illness that was not treated in time.[8]

Limitations of the Study

The study was based on case records therefore data on some variables was not covered and missing, treatment aspect was not included.

Future Implications

Large scale studied to highlighting the role of NGOs in better management of mentally ill homeless patients should be studied.

Conclusion

Destitute persons are more vulnerable group of population, and they have a huge burden of psychiatric illness that had affected their physical health too. These HMI patients need special attention and with effective management they can live with dignity and reintegrate into society as well.

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