

Varied Presentation of Wandering Mentally Ill and Homeless Patients Presenting to a Psychiatry Setup: A Case Series

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ABSTRACT

Mental illness has been gaining attention in recent times for variety of reasons. The case series aims to assess the presentation, symptoms, and treatment outcome of one such category of who are forcibly admitted to government psychiatric hospitals as they are homeless and found wandering on the streets. They need to be established as a discrete category in the psychiatric inpatient setting as they require special attention and treatment. This case series studies the diverse presentation of wandering mentally ill and homeless patients presenting to Psychiatry setup. Three male and three female patients are reported. The final diagnosis in the males included Unspecified psychosis, Encephalitis, and Alcohol Dependence Syndrome. The female patients were diagnosed with Unspecified psychosis, Bipolar Affective disorder, and Intellectual Disability. All the patients in this case series showed improvement in their symptoms after treatment. Systematic studies of hurdles faced by them for access to psychiatric services and strategies to surmount them would be beneficial.

Key Words: Wandering mentally ill, Schizophrenia, Bipolar affective disorder, Major depressive disorder, Psychotic illness, Substance use, Alcohol, Mental and Behavioural illnesses.

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Introduction

In recent times mental illnesses have become the centre of concern. Earlier community-based epidemiological research carried out in India on Psychiatric illnesses have shown prevalence rates, varying from 9.5 to 102 per 1000 population [1]. However, it was found that currently, 2-5% of Indians have some type of psychiatric disorder. Approximately 1% suffer from a serious variety of mental illnesses needing urgent care at some stage. Thus, the numbers are on the increase [2]. Around 15% of the patients with severe mental illness are homeless [3,4]. At present an estimated 400,000 psychiatric patients are homeless and living on the streets in India [3]. These wandering persons with psychiatric disorders

are found at places like bus and railway stations, on the streets usually in a dishevelled state. A disproportionate number of them belong to economically deprived and socially marginalized families [5].

About 90 percent of the persons found wandering on the streets suffer from a treatable mental illness. Around 25% to 33% of homeless persons have major psychiatric disorders. The psychiatric disorders found in homeless persons are Schizophrenia, Bipolar affective disorder, and Major depressive disorder [6,9,10]. Most suffer from physical illness along with psychiatric problems [3,6]. When we look at the statistics for patients first hospitalized with psychotic illness almost 15% had an episode of homelessness. Earlier studies

have shown that the risk of homelessness was more in males when compared to females [7]. Homelessness was seen to be associated with substance use [8].

Homelessness leads to further problems like decreased quality of life, risk of physical harm or violence, and early mortality [9,10]. Despite having so many physical and mental problems [11], homeless people have difficulty accessing healthcare services [12]. It is very unfortunate that they are unable to get regular health care. It may be because their daily efforts are more focussed on procuring food and shelter, thus mental health care is not their main focus [13]. With the ever-increasing rent in urban areas, the number of homeless people increase [14]. Patients suffering from serious psychiatric disorders who were homeless were found to have more psychiatric hospital use [15] and more mental health treatment costs [16] when compared to patients who were not homeless. The case series aims to assess the presentation, symptoms, and treatment outcome of one such category of who are forcibly admitted to government psychiatric hospitals as they are homeless and found wandering on the streets.

Case Reports

Case 1

A young adult male was brought to the Psychiatric Outpatient Department (OPD) by the local police with a history of inappropriately touching females on the streets, shouting at strangers, picking garbage, and getting irritable without provocation. Detailed history could not be obtained. The patient was telling multiple different addresses whenever inquired about his whereabouts. He had a dishevelled appearance. He was gesturing continuously, and smiling without reason at times along with the increased psychomotor activity. He was minimally cooperative, communicative, and oriented to time, place, and person. Attention was ill-sustained, rapport could not be established, eye to eye contact was not maintained. He had delusion of persecution. Affect was irritable. Judgment and insight were impaired. In view of poor social support, the patient was admitted to an inpatient psychiatric facility. Relevant investigations were normal. With a diagnosis of Unspecified psychosis, he was treated with olanzapine 15 mg at night. He showed improvement in symptoms and was able to tell the address and phone number of his relatives. The social worker traced them, and the patient was discharged and sent back home after a month with the advice of regular follow-up. Discharge counselling was given to the patient and attendants, drug compliance was emphasised, supervision of medication, engaging the patient in work activities, and reporting for regular follow-ups in outpatient department.

Case 2

A middle-aged male was sent to Psychiatric OPD by the police as he was trying to enter people's homes, talking in an irrelevant manner, and refusing to talk to police during questioning. The patient was unable to give the history himself. On mental state examination, he was ill-kempt and was not responding to the external environment. Intermittently he was seen doing repetitive and seemingly meaningless movements. He refused to speak. He would hold his body in unusual positions and would resist people who try to move his body and would get agitated. For further management, the patient was admitted to an inpatient psychiatric facility. After admission, he developed fever and drowsiness. CT scans showed hypodensity in the temporal lobes bilaterally. Cerebrospinal fluid (CSF) findings revealed mild mononuclear pleocytosis. Glucose levels were normal and protein concentration was increased. He was transferred to a neurology unit for further management of encephalitis. The police were able to trace his relatives as there was a missing report registered. He was discharged after treatment and with the advice to follow-up in neurology.

Case 3

A 30-year-old male was sent to the Psychiatric emergency by the police with a history of wandering on the streets, irrelevant talking, and trying to break an ATM machine. He had been consuming alcohol in excessive amounts for over five years, with no periods of abstinence. His daily consumption was 3-4 litres of country liquor. He denied any other substance use. On examination, he was thin-built and ill-kempt. He had abrasions over his left arm and forearm. The patient was restless and sweating with mild tremors. He had mild fever (37.6°C), tachycardia (109 beats/minute), his blood pressure was 160/90 mm Hg. The mental status revealed the patient was cooperative, increased psychomotor activity. Speech was relevant and coherent. No delusions or hallucinations. Insight was unimpaired. A diagnosis Alcohol-related disorder was made. Urine drug testing was positive for alcohol and negative for other substances. An electrocardiogram was notable for sinus tachycardia. A chest radiograph and a computed tomographic (CT) scan of the head revealed no abnormalities. He was detoxified and after 3 days was symptom free. A brief intervention in the form of psychoeducation and motivation enhancement therapy was administered. The patient had been homeless for the past few years and would do odd jobs wherever possible. Since the family members could not be traced, the patient was shifted to a halfway home after a month.

Case 4

A middle-aged female was brought to the Psychiatric emergency by the police with a history of shouting and

screaming on the streets, throwing stones at people passing by, wandering aimlessly on the street, and talking irrelevantly. The patient was not able to provide proper history. On examination, pallor and malnutrition were found. Her hair had a lice infestation. On mental state examination, she was observed to be scanning the room suspiciously. Attention was ill-sustained, rapport could not be established, eye to eye contact was not maintained. Her speech had a lack of spontaneity and low rate, tone, and volume. The affect was blunted with emotional withdrawal. Judgment was impaired and insight was absent. A diagnosis of Unspecified psychosis was made and she was hospitalized. Radiological, urine, and blood tests were normal except for low haemoglobin. She was started on Olanzapine 20 mg along with iron and folic acid during the day. She was also treated for lice infestation. The relatives were traced with the help of police and social workers but refused to come to the hospital to accept the patient. She showed minimal improvement in symptoms in a month after which she was shifted to a government shelter home for women with the advice of monthly follow-up at the hospital.

Case 5

A young female was brought to the Psychiatry emergency by members of NGO and local police with irritability and agitation. They had received complaints about her dancing in the middle of the street. On arrival, she was loudly expressing her desire to leave the hospital. She complained of disturbances in sleep and loss of appetite. She denied any other complaints. There was no reliable informant for a detailed history. On mental status examination, she was noticed to be over-groomed. There was increased psychomotor activity. Her speech was under increased pressure with flight of ideas, and a grandiose delusion (she is having the power of God). Mood elevation was prominent. Judgment and insight were impaired. The patient was admitted to an inpatient psychiatric facility. Radiological, urine, and blood tests were normal. She was started on valproic acid 500 mg and olanzapine 5 mg. The symptoms gradually improved during the hospital stay. Her relatives were traced, and they provided a history of psychiatric illness in the patient for the past 1 year presenting with depression, remaining aloof and neglecting her personal hygiene. No treatment was given at this time. After 6 months she developed excessive talkativeness, irritability, and decreased sleep for which they consulted a psychiatrist. She was started on medication, but she stopped the drugs after two weeks as she felt normal, she stopped taking drugs since then. She was diagnosed with Bipolar Affective Disorder, current episode mania. The patient and relatives requested that she take treatment from another hospital and hence was discharged.

Case 6

A 30-year-old female was brought to Psychiatric OPD by the police as she was found screaming at strangers on the street. She was referred for evaluation of aggressive behaviour. Detailed history could not be obtained. General and systemic examination were normal. The patient was intellectually disabled, hyperactive, and displayed repetitive behaviour such as hand flapping, eye blinking, and screaming irrelevant words. In view of poor social support and for further evaluation, she was admitted to an inpatient psychiatric facility. Radiological, urine, and blood tests were normal except for low haemoglobin. IQ tests revealed Severe Mental Retardation. She was unable to perform self-care activities such as bathing and eating. She exhibited frequent anger outbursts. She was started on Olanzapine 5 mg at night. The local police and social workers were unable to trace the relatives. She showed minimal improvement in behaviour in a month after which she was shifted to a government shelter home for women with the advice of monthly follow-up at the hospital.

Discussion

Homelessness has been defined in various forms ranging from living on the street or in a homeless shelter. This case series studies the diverse presentation of wandering mentally ill and homeless patients presenting to Psychiatry setup. 3 male and 3 female patients were evaluated. Earlier researchers found higher rates of homelessness in men when compared to women [17]. The diagnosis found in the males included Unspecified psychosis, Encephalitis, and Alcohol Dependence Syndrome. The female patients were diagnosed with Unspecified psychosis, Bipolar Affective disorder, and Intellectual Disability. Previous research studied the admission rates to public shelters during the period 1990 to 1992 among patients who received treatment from mental health services in Philadelphia from 1985 to 1993 was 7.5 %, which was almost 2.7 times higher than the rate of shelter use by the general population which was found to be 2.8 percent. They also found that 9.7% of patients with Schizophrenia utilized a public shelter while 6.7% of those with affective psychosis used it [18]. However, another study reported that there was no difference in rates of homelessness among patients with Schizophrenia, bipolar disorder with psychosis, or depression with psychosis [19]. An investigation studying the veterans admitted to the psychiatric wards of Department of Veterans Affairs [VA] facilities showed that around 18% were homeless when they were admitted to the hospital [20]. Homelessness has been found to be associated with substance use disorders [21]. Treating substance abuse was shown to improve the outcome in homeless patients having serious psychiatric illnesses along with substance abuse [22]. Nevertheless, attaining treatment is much more problematic

for homeless patients with serious mental illnesses when compared to other homeless persons [23]. It was also seen that homeless persons having psychotic symptoms have difficulty gaining access to and maintaining entitlement benefits than homeless persons without psychotic disorders [24].

All the patients treated in the above case series showed improvement in their symptoms after treatment. A few of the research done studying the interventions in homeless persons with psychiatric disorders have shown that the persons who obtained the interventions had lesser inpatient hospitalizations. In two of these studies, the total expenditures were found to be lesser for the intervention group. However, another study found that the improvement in patient outcomes required larger costs [25].

Conclusion

Wandering mentally ill patients are one of the most vulnerable and deprived segments of the population and are a big emerging problem in India that requires immediate and effective intervention. Their successful treatment requires effectual liaison among psychiatric hospitals, police, and NGOs. With efforts done in the right direction, several of them can be rehabilitated into society. The mental and physical health care of homeless patients with serious mental illness should be one of the top societal priorities.

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