Reintegration of Homeless Patients with Mental Illness (HPMI) in the Community—Challenges Faced During COVID-19 Pandemic

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Homelessness is a major challenge during public health emergencies. Viewing from a sociopolitical scenario, COVID-19 pandemic and its prevention strategies, such as social distancing, stay at home, and personal hygiene measures, highlighted the helplessness of the homeless population and the violations of their rights. According to the *2011 Census Report*,[1] there are 1.77 million homeless people in India, which constitute 0.15% of the country's total population. Furthermore, there is a high proportion of mentally ill and street children in the homeless population.[1–3] The National Mental Health Survey (NMHS) guestimates the number of homeless patients with mental illness (HPMI) across various states to be "nil" or "almost minimal" to "1% of mentally ill." The NMHS estimates the number of HPMI in some states to be as high as "15,000." The estimates of HPMI varied across districts, cities, and states across India, according to the NMHS. Approximately one-fifth of this population has diagnosable severe mental disorders, which are severely incapacitating and result in a very poor quality of life.[4] In the background of the pandemic spread, the combination of mental illness and homelessness adds to the pre-existing stigma and marginalization. HPMI are considered to be one of the most affected populations in this regard. The possibility of contracting COVID-19 is higher among persons with medical or psychiatric comorbidities. Homeless persons are often malnourished and have comorbidities that compromise their immunity and make them more susceptible to COVID-19.[5] In Spain, a specialized onsite visit program for HPMI was initiated during the COVID-19 lockdown period. This resulted in continued psychiatric care during the emergency, prevention of drug default and relapse, reduced emergency hospital admission, and better utilization of state mental health resources.[6]

During the COVID-19 lockdown from March 24, 2020, to May 3, 2020, wandering HPMI were brought by police personnel, for admission, to the Emergency Psychiatry and Acute Care services of National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru a tertiary care hospital. HPMI were admitted under Section 89 of the Mental Healthcare Act 2017,[7,8] with each admission reviewed "by the Institute Mental Health Review Committee due to the lack of implementation of Mental Health Review Board (MHRB) by the State Government." With case illustrations, this article draws attention to how the COVID-19 pandemic and lockdown affected the HPMI and the challenges in providing care and protection and in reintegrating them back to the community. The article also provides certain guidelines for providing care and protection to HPMI during the pandemic.

Case 1

Mr M, a 35-year-old male, was brought by police as he was found wandering in the street. On observation, he was not interacting and was found muttering to himself. Immediately after admission to the observation ward, an RT-PCR test was done for COVID-19 screening, and he tested positive. He was shifted to the

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COVID-19 ward in NIMHANS. He was diagnosed with psychosis, and treatment was initiated. The patient understood Hindi; however, when interacted, he was responding through gestures and failed to provide any information regarding his family, place of work, or residence. Multiple efforts to trace the family through various sources failed. The patient was treated and tested negative for COVID-19. The team had difficulty in placing the patient due to the lack of rehabilitation centers for men in Bengaluru. Further, there was extreme pressure from the hospital administration to send the patient back to the community due to the COVID-19-pandemic-related issues in keeping the patient in the ward for a longer duration. The hospital administration wanted to prevent overcrowding in the ward, so that social distancing measures could be followed to curb the spread of COVID-19 to other chronically ill elderly patients in the ward. Many government organizations and non-governmental organizations (NGOs) refused to admit him in their centers as they were not equipped to handle mentally ill patients. With continued efforts, the team placed the patient in a long-term shelter care and facilitated arrangements for free treatment and medications and follow-up services through telepsychiatry care. The patient is currently on regular medication and doing well in the organization.

Case 2

Mr MN, a 25-year-old male, unmarried, educated up to pre-university college, hailing from Odisha, presented along with police personnel under court order. He was found wandering in the street, with poor self-care and disruptive behavior, in the Mysore district of Karnataka. He was diagnosed with Intellectual Developmental Disorder and psychosis. After a few days of treatment, his illness started improving and he gave some information about family details and village name in Nayagarth, Odisha. He was referred to a multidisciplinary team (i.e., psychiatrists, psychiatric social workers, psychologists, and psychiatric nurses) for tracing the family and rehabilitation. With the available information, the team contacted the District Superintendent of Police to help trace the family and in reintegration.

Subsequently, the family was traced and contacted through the police. A family member revealed over the phone that the patient had run away from home two years ago, and the family had filed a missing case in the local police station. The family members were emotionally attached to him, and they were very eager to know about the patient's health condition. The family members were willing to take him back to Odisha. Due to the COVID-19 pandemic, there were no train or bus services available for the family members to travel from Odisha to Bengaluru. Moreover, the family was not in a financial position to come to Bengaluru. Currently, the patient is staying in the hospital's closed ward, functioning well and engaging in the ward activities. The team is facilitating regular interaction between the patient and family members over the telephone. The family members have assured to take back the patient home after the resumption of the train services.

Case 3

Mr PK, a 43-year-old male, divorced, graduate in law, currently unemployed, was brought by police personnel. He was found wandering and sleeping in public places, showing inappropriate and abusive behavior towards the public, and causing damage to public property, during the lockdown period. On observation, he was found to have irritability, aggressive behavior, muttering to self, poor self-care, and decreased sleep, leading to bio-psychosocial dysfunction. With treatment, he started recovering and gave some information about personal and family details. The team was able to trace the family with the help of Chikmagalur police. His brother informed over the telephone that the patient had received treatment from a tertiary care hospital in the past. Apparently, he stopped medicine a year ago, in the background of interpersonal issues with his wife regarding divorce and the custody of children, and property-related legal issues with siblings. Assessment revealed that he had a history of mental illness for the past 12 years and had taken treatment in several hospitals. He have had multiple episodes of drug default "due to strained" interpersonal issues with his wife and family members. Initially, the brother was hesitant to take him back as there was an ongoing property-related issue between them. After multiple attempts of supportive work with the brother over the telephone, the patient was reintegrated back with the family. The patient was also referred to the local district mental health hospital for further follow-ups. The patient is currently staying with his brother, adhering to medication and maintaining well.

Discussion

The case illustrations clearly indicate the issues of HPMI during the COVID-19 pandemic. These patients were admitted to Emergency Psychiatry and Acute Care Services at NIMHANS, Bengaluru. The institute had prepared separate protocol and guidelines to address all patients' COVID-19 risk status.[8] A pragmatic approach was adopted by modifying the testing criteria to suit the needs of these patients as they are unable to fit to Indian Medical Council Medical Research (ICMR) testing protocol guidelines for COVID-19.[9] Mandatory testing was recommended and done on all the patients when they were brought by the police personnel. Consent is essential for COVID-19 testing and the mandatory quarantine before admission, provided by the nominated representative of the "Institute Mental Health Review Committee." Following the consent from the nominated representative, an RT-PCR test was done, and patients were quarantined in designated wards for two weeks. Patients who tested positive for COVID-19 were treated as per the ICMR protocol. Those patients who tested negative were shifted to the regular ward, and health care workers ensured that the patients used face masks during the incubation period. HPMI are more vulnerable to getting the infection, as they are homeless; they also have the highest risk of getting affected within the shortest possible time due to lack of protective measures, poor self-care, and wandering tendency. HPMI are more vulnerable to acquire and spread COVID-19 due to multiple factors like inadequate sanitation, poor self-care, comorbid health conditions, roaming tendency, lack of knowledge about COVID-19, low level of immunity and nutrition, and lack of access to healthcare services.[10]

One of the challenges the health workers faced during the management of these patients during their stay in the ward was making them understand public health measures (understanding of COVID-19, wearing face masks, following physical distancing while interacting with other residents, and importance of hand hygiene). It was quite difficult due to poor comprehension and limited cognitive ability of the patients. The health workers had to repeatedly guide them and ensure the safety protocol norms in the ward. Another challenge the treating team faced was community rehabilitating of patients as there was extreme pressure from the administration. In Karnataka, there is no government psychiatric rehabilitation center for HPMI in the community. The Nirashrithara Parihara Kendra (Beggar Home), which provides short-term shelter care only for homeless males, stopped admitting the patients as it was already overwhelmed with a larger number of residents. Moreover, NGOs were also faced with similar problems and were not well equipped to handle psychiatric patients. There is a need to have more government community-based psychiatric rehabilitation homes for recovered HPMI. In India, we do not have government-run free community-based rehabilitation centers, day care, or halfway homes for recovered patients.[11–13] A few NGOs with limited capacity admit patients who are psychiatrically stable. Another reason for not taking patients was that the staffs were ill-equipped to handle psychiatric patients during any exacerbations. This concern was addressed by providing frequent follow-up through teleconsultation. The treating team's contact detail was provided to the NGO staff to call in case of exacerbation of symptoms.

The government should make provision for temporary facilities for handling HPMI during the pandemic. During the lockdown period, in India, issues of homeless populations were not given adequate consideration. Considering the vulnerability factors and the mode of COVID-19 transmission, there is an alarming need to initiate multiple strategies to improve the condition of HPMI. Some of the strategies to mitigate the problems during the COVID-19 pandemic are outlined further.

Awareness Creation

Even though there is a spreading message that our fight is against coronavirus, not against those who are infected, there is a high amount of stigma and discrimination in the community. In the case of HPMI, the discrimination and human rights violations turn into their worst forms. The public should be equipped with awareness so that they can help any wandering person to meet their basic and health-related needs by networking with different stakeholders such as police, panchayat authorities, and healthcare workers.

Testing and Treatment Centres for HPMI

Testing and screening of this population needs to be increased. There is a need for adequate screening and treatment for HPMI who tested positive for COVID-19 in the community. Designated hospitals should be made available in the community for adequate testing and treatment of HPMI, so that working for HPMI seems ethically appropriate, feasible, and legally mandatory too. These centers should take care of the availability, accessibility, and affordability aspects of the services.

Training Shelter Care Staff

During the lockdown, many formal and informal shelter care homes refused to provide shelter care. Many of them were ill-prepared to handle the COVID-19 crisis and had limited resources and facilities to handle the HPMI. There is also a need to have proper SOPs to handle HPMI at governmental and non-governmental shelter homes. It is also important to sensitize the NGO personnel and provide the needed resources in the prevention of COVID-19.

Continuity in Mental Health Care

Adequate and continuous mental health treatment of HPMI helps improve their condition, which may aid them in following the precautionary measures needed for their health safety during this pandemic. Mental health services in shelter homes need to be ensured through teleconsultation in liaison with the district mental health psychiatrist services. Further, the district mental health team should also extend their services in the shelter care homes and ensure continuity of care during the COVID-19 pandemic.

Policy Level Interventions—Multisectorial Approach

There should be networking and coordination between different stakeholders for tackling challenges associated with the treatment and reintegration of HPMI. Advocacy can be considered as one of the strongest tools. Different sectors such as health, education, law, technology, and other infrastructures need to work in association for a better outcome in this regard.

Conclusion

The Indian Pandemic Act 1897 has not given importance to the marginalized homeless population and HPMI. Policy implications and administrative measures need to ensure that the HPMI are rehabilitated with basic dignity, empowered, and helped against the infections, just like others, instead of punishing them under the Epidemic Disease ACT 1987 for not adhering to the lockdown measures.

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