



Letter to the Editor

Use of newer technologies with existing service for family reintegration of unknown psychiatric patients: A case series



ARTICLE INFO

Keywords:

Homeless Mentally Ill
Family reintegration
India
Newer technologies

ABSTRACT

Homeless Mentally Ill (HMI) patients pose a challenge in treatment, management and rehabilitation services. HMI patients are often difficult to engage in treatment, and associated with relapse and rehospitalization, even after recovery. Family plays an important role in treatment engagement and care of the mentally ill person in India. Here, we report two unknown psychiatric patients who were reintegrated to their families using newer technologies with existing service. Newer technologies have helped in early identification of HMI families and reintegration into them. The early reintegration reduced the unnecessary detention of HMI patients inside the hospital after recovery.

1. Introduction

Homeless Mentally Ill (HMI) patients are often found near railway stations, bus stands, pilgrim centres, and beggars' home. This special population pose a challenge in treatment, management and rehabilitation services (Singh et al., 2016; Gowda et al., 2017a,b). HMI patients have psychological, physical and social problems, and they often present to health care with complex issues (Crystal and Ladner, 1985). HMI patients are often difficult to engage in treatment and associated with relapse and rehospitalization even after recovery. Community Treatment Order and Assertive Community Treatment may have some role in treatment engagement. However these legal provisions are not there in Indian mental health care act of 2017 (Killaspy et al., 2006; Rugkåsa, 2016; MHCA 2017). In Indian Context, family plays an important role in treatment engagement and care of the mentally ill person (Gowda et al., 2016). So reintegrating HMI patients into their family has added advantage over placing in social service complex run by a government agency. The existing studies on HMI patients have shown that family reintegration is possible with collaborative, multidisciplinary approach (Gowda et al., 2017b; Tripathi et al., 2013). Here, we report two unknown psychiatric patients who were reintegrated to their families using newer technologies like Google Map, Google database, electronic record and What App messenger services with existing service for the sole purpose of reintegration.

2. Case – 01

Mr Unknown (U), a 36-year-old male, was staying at a government-run beggars' rehabilitation centre for past 6 months as per records. 3 days prior to psychiatric admission at our centre, he allegedly assaulted a co-resident following which he succumbed to death. So he was sent to our centre along with police for treatment and evaluation under the reception order (chapter – 3, section - 27 of the MHA-1987).

Serial mental status examination and behaviour observation had shown that he was grossly oriented, alert, active, dishevelled, disorganised and rapport was difficult to establish. He also had hallucinatory behaviour, formal thought disorder, impaired social and personal judgment, and absent insight. Diagnosis of Schizophrenia (F20) was made as per the International Classification of Diseases – 10 (ICD – 10), 10th edition. He was started on Tablet Risperidone 2 mg and was increased to 8 mg per day along with Tablet Trihexyphenidyl 2 mg per day. He had shown improvement and was able to recall details of his native place (XXXXX) at the end of 8 weeks of inpatient care.

Then using Google maps, it was noted that his alleged native place (XXXXX) belonged to Telangana State. The local police station number was obtained using Google search and the police officials in the station were contacted. The police officials were requested for any other details of him that would help in easier identification and hence patient's photo (picture was taken using a cell phone) was shared using Whats App after taking informed consent about the same. The police officials were able to identify family members of the patient at the earliest of one week through our details.

As per family, he was reportedly working in Mumbai for the television industry and has worked as an assistant director too for few serials. He was found to be having schizophrenia eight years ago and reportedly went missing after he took a bus to go to his relatives place about 5 years ago. Mr. U's family accepted him and were extremely happy, expressed pleasure when he was reintegrated into their family. His family reported that they were very much concerned about the disappearance and they filed a missing complaint at a police station.

3. Case – 02

Mr. U, 40 years male, was brought to emergency psychiatric care by a social worker. He was admitted for treatment and evaluation under the

reception order (chapter –3, section –20) of the MHA, 1987 issued by a judicial magistrate. Serial mental status examination and behaviour observation had shown that he was dishevelled, withdrawn and was unable to take care of self. He also had formal thought disorder, impaired social and personal judgment, and absent insight. Diagnosis of Schizophrenia (F20) was made as per the International Classification of Diseases – 10 (ICD – 10), 10th edition. He had shown improvement with Tablet Risperidone 8 mg per day and Tablet Trihexyphenidyl 4 mg per day.

He was able to consistently recall information about his native at the end of six weeks of inpatient care that he was from (MMMMMM) Village. Then using Google maps, it was noted that his alleged native place called (MMMMMM) Village located was in northern part of Karnataka. A letter along with photo was sent to the same police station to trace the family through the post and however to facilitate the early reintegration of patient, the local police station number was obtained using police station telephone record through Google search. After liaison with police officers, patient's photo (picture was taken using a cell phone) with a letter was shared using Whats App to police officers, after taking informed consent about the same. The police officers were able to identified family members of the patient through missing complaint record at the earliest of one day.

As per family, he was reportedly working as a farmer and taking care of agriculture work. He was found to be having schizophrenia with poor compliance to treatment for last ten years and reportedly went missing about three years ago without any apparent reason. Mr. U's family accepted him and were happy, expressed pleasure when he was reintegrated into their family. His family filed a missing complaint at a police station, published in media and newspaper about missing of a family member.

4. Discussion

Family reintegration of unknown psychiatric patients represents a unique problem and poses a challenge with existing infrastructure in India (Gowda et al., 2017a, b). The existing collaborative, multidisciplinary approach like postal letter, home visit, sending a letter to nearest police station, publishing in media, newspaper, have made it possible to reintegrate the patients into their family, but took very long period (15 weeks). It is also noted that they stayed for a long period inside the hospital due to the judicial dilemma about care and delayed reintegration (Gowda et al., 2017b).

There are community resources and technology, which help in early reintegration into their family like a) Liaison with District Mental Health Programme multidisciplinary team, b) Local Non Governmental Agencies, c) Children's/Women's/Elders Helpline number d) contacting local Temple, Mosque, Church and e) newer technologies like Google Map, Google database, electronic record, Fax and What App messenger.

The patients in our case series were reintegrated to their families using newer technologies like Google Map, Google database, electronic record and What App messenger with existing multidisciplinary health service for the sole purpose of reintegration. Newer technologies have helped in early identification of unknown psychiatric patient's family and reintegration. The duration required for reintegration in our case series is 8 weeks, compared to 15 weeks in HMI patients who were reintegrated through older existing method. So it reduced the unnecessary detention of HMI patients inside the asylum, even though improved with respect to mental illness due to judiciary dilemma (Gowda et al., 2017b). AADHAAR number is a 12-digit random number issued by the UIDAI to the residents of India. It provides unique demographic and biometric information. So linking biometric database information with that of health sector (hospital) will help in early identification of person through biometric database and facilitates family reintegration. It can also be used for strategic policy planning, reformation of the public health sector and to address the unmet need of HMI (The Unique Identification Authority of India, 2016).

The National Mental Health Program (NMHP) in India was operationalized in 1982. Under this, District Mental Health Program (DMHP) was launched with huge fanfare, however the program failed to gain the desired momentum, and progress has been very slow and many institutes have been established to treat mentally ill people. One of the objectives of National Mental Health Policy – 2014 (NMHP, 2014) of India is to increase access to mental health services for vulnerable groups like homeless persons. In spite of this, service and provisions remains to a limited special group of population and majority of the HMI patient group does not have satisfactory access to mental health facilities in public sectors (Thirunavukarasu, 2011; NMHP, 1983; NMHP, 2014). In last few decades in India, a number of NGOs like the Chittadhama in Karnataka, The Banyan Foundation in Tamil Nadu, Paripurnata in West Bengal, Navachetana in Guwahati and Shraddha rehabilitation Foundation in Maharashtra are providing care, protection and rehabilitation of HMI. This was the practical beginning of the residential rehabilitation centre for HMI patients in India (Rao, 2004; Singh et al., 2016; Swaminath, 2015). Moreover, services provided by NGOs may be difficult to sustain over time and on larger scales. The collaboration from government and nongovernmental agencies may help in long-term, self-sustaining models of psychosocial rehabilitation for the management of HMI patients. Along with that, there is a need for effective provisions in a national plan, guidelines and policies are required to care for the homeless and wandering mentally ill individuals, whose plight is borne out of a combination of health, socioeconomic and human right issues (Thara and Patel, 2010).

5. Conclusion

Integrating AADHAAR and newer technologies with existing health services will help in early identification of unknown psychiatric patients' family and reintegration, there by reducing the duration of hospital stay of HMI in the future.

Author contribution

All the authors have contributed and approved the final manuscript.

Conflict of Interest

The authors declare no conflict of interest.

References

- Crystal, S., Ladner, S., 1985. Multiple impairment patterns in the mentally ill homeless. *Int. J. Ment. Health* 14, 61–73. <http://dx.doi.org/10.1080/00207411.1985.11449010>.
- Gowda, G.S., Noorthoorn, E.O., Kumar, C.N., Nanjegowda, R.B., Math, S.B., 2016. Clinical correlates and predictors of perceived coercion among psychiatric inpatients: a prospective pilot study. *Asian J. Psychiatry* 22, 34–40. <http://dx.doi.org/10.1016/j.ajp.2016.04.004>.

- Gowda, G.S., Gopika, G., Manjunatha, N., Kumar, C.N., Yadav, R., Srinivas, D., Bharath, R., Math, S.B., 2017a. Socio-demographic and clinical profiles of homeless mentally ill admitted in mental health institute of South India: know the unknown project. *Int J Soc Psychiatry* 63 (6), 525–531. <http://dx.doi.org/10.1177/0020764017714494>. Epub 2017 Jun 27.
- Gowda, G.S., Gopika, G., Kumar, C.N., Manjunatha, N., Yadav, R., Srinivas, D., Bharath, R., Math, S.B., 2017b. Clinical outcome and rehabilitation of homeless mentally ill patients admitted in mental health institute of South India: know the unknown project. *Asian J. Psychiatry* 30, 49–53. <http://dx.doi.org/10.1016/j.ajp.2017.07.001>.
- Killaspy, H., Bebbington, P., Blizard, R., Johnson, S., Nolan, F., Pilling, S., King, M., 2006. REACT: a randomised evaluation of assertive community treatment in North London. *BMJ* 332, 815–819. <http://dx.doi.org/10.1136/bmj.38773.518322.7C>.
- Mental Health Act, 1987. Ministry of Health & Family Welfare Department, Govt. of India. Retrieved February 20, 2017, from <http://www.wbhealth.gov.in/download/MENTAL%20HEALTH%20ACT%201987.pdf>.
- The Mental Health Care Act 2017 (MHCA, 2017), Ministry of Health & Family Welfare Department, Govt. of India. Retrieved July 20, 2017, from <http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20Healthcare%20Act,%202017.pdf>.
- National Mental Health Program (NMHP), 1983. Government of India, Retrieved February 20, 2017, from http://mohfw.nic.in/sites/default/files/9903463892NMHP%20detail_0.pdf.
- National Mental Health Policy of India 2014, Government of India, Retrieved February 20, 2017, from mohfw.nic.in/WriteReadData/1892s/9903463892NMHP%20detail.pdf.
- Rao, P.N., 2004. Rehabilitation of the wandering seriously mentally ill (WSMI) women—the banyan experience. *Soc. Work Health Care* 39, 49–65.
- Rugkása, J., 2016. Effectiveness of community treatment orders: the international evidence. *Can J Psychiatry* 61, 15–24. <http://dx.doi.org/10.1177/0706743715620415>.
- Singh, G., Shah, N., Mehta, R., 2016. The clinical presentation and outcome of the institutionalized wandering mentally ill in India. *J. Clin. Diagnostic Res.* 10, VC13–VC16. <http://dx.doi.org/10.7860/JCDR/2016/19497.8681>.
- Swaminath, G., 2015. Indian psychiatric society-south zone: innovations and challenges in providing psychiatric services to disadvantaged populations: a pilgrim's progress. *Indian J. Psychol. Med.* 37, 122–130. <http://dx.doi.org/10.4103/0253-7176.155607>.
- Thara, R., Patel, V., 2010. Role of non-governmental organizations in mental health in India. *Indian J. Psychiatry* 52, S389–95. <http://dx.doi.org/10.4103/0019-5545.69276>.
- The Unique Identification Authority of India (UIDAI). uidai.gov.in. (Homepage on the internet). Last accessed on 12/04/16. Available from: <https://uidai.gov.in>.
- Thirunavukarasu, M., 2011. Closing the treatment gap. *Indian J. Psychiatry* 53, 199–201. <http://dx.doi.org/10.4103/0019-5545.86803>.
- Tripathi, A., Nischal, A., Dalal, P.K., Agarwal, V., Agarwal, M., Trivedi, J.K., Gupta, B., Arya, A., 2013. Sociodemographic and clinical profile of homeless mentally ill inpatients in a north Indian medical university. *Asian J. Psychiatry* 6, 404–409. <http://dx.doi.org/10.1016/j.ajp.2013.05.002>.

Guru S. Gowda*, Ashay Telang, Chandra Reddy Sharath, Thomas Gregor Issac, Chintala HariPriya, Praveen Shivalli Ramu, Suresh Bada Math
Department of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, 560029, India
E-mail address: drsgowda@gmail.com

* Corresponding author.