Title page

**Title:** Rehabilitation of homeless females with mental illness after implementation of the Mental Healthcare Act, 2017 in India: A case series

**Short Title:** Rehabilitation of females with MI through MHCA, 2017

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**Title:** Rehabilitation of homeless females with mental illness after implementation of the Mental Healthcare Act, 2017 in India: A case series

**Abstract:**

Background: In India, rehabilitation services for homeless persons with MI, especially females, are mainly rudimentary. Mental Healthcare Act (MHA), 2017 focuses mainly on the community based living of the patients with mental illness with more defined roles of the police system.

Aim: In this paper, the authors have tried to highlight the role of the police helping in the treatment and rehabilitation of homeless females with mental illness through demonstration of 4 cases.

Methodology: In all the 4 cases described, police had found the patients with mental illness on street, brought to the hospital and got them involved in a treatment net. After showing improvement in mental illness, patients could be rehabilitated back in the community setting with the help of police.

Results: In the four cases described, Section 100 of MHA 2017, defining the specific role of police, had guided them to work in collaboration with the treating team and help with the patient’s overall well being.

Conclusion: People have their negative perceptions of homeless persons with psychiatric disorders. Proper utilization of available resources can help in up-gradation of this neglected group.

**Introduction:**

Rehabilitation services for the homeless persons with mental illness (MI), though existent on papers in 63% of mental hospitals in India (1), these are mainly rudimentary (2). As per 2011 census of India, 1.7 million people are homeless in the country (3), around 100,000 homeless persons are with mental illness (4) and the number is increasing exponentially. To add to the woes, the condition is far worse for the females.

Mental Health Act,1987 in India was replaced in 2017 by Mental Healthcare Act (MHA), 2017 and it focuses mainly on the rights of the patients with mental illness and their community based living. This act is mainly patient centric and involves more active involvement of the police system with a full separate section assigned to define their duties in respect of persons with mental illness. In this paper, the authors have tried to highlight the role of the police helping in the rehabilitation of homeless females with mental illness in shelter living through illustration of four success stories.

Different sections of MHA, 2017 (5) involved in rehabilitation of these patients are:

*Section 100:* in which the police has been legally bound to safely take the persons with MI to the hospital for treatment and thereafter rehabilitate the patient to his/her home or if homeless, the to the Government establishment.

*Section 89:* which defines the procedure for the supported admission of patients with MI

*Section 14:* which defines the Appointment and revocation of nominated representative (NR).

The nominated representative in these cases is hospital appointed NGO as per section 14 provisio of MHA, 2017.

**Case summaries**

Case 1

Ms. T, 25 year old female was found on the streets, misbehaving with people, in a disheveled state, wearing torn clothes, when people around had called police who brought the patient to the psychiatric institute of the state. The patient was assessed at the hospital by psychiatrists and it was decided to admit the patient. On assessment and ward observation, the patient had hallucinatory behavior, well formed systemized delusion of reference, persecution and grandiosity, irritability, unprovoked anger outbursts and disturbed sleep. She was diagnosed with psychotic illness with a probable diagnosis of Schizophrenia and was started on oral haloperidol. The patient showed improvement over next 3-4 weeks on the medication by nearly 50-60%. But she still could not tell the details of her exact whereabouts. Though she would say that she had an account in a bank, the details of which were given by the treating team to the investigating police officer (IO). Also, the IO of the patient could trace her aadhar card details (country’s biometric identification card) from her biometrics. The patient’s address could finally be traced. But she was found to be from another state. The station house officer (SHO) of the police station from where the patient belonged was contacted by the IO and address of the patient was confirmed. The patient was subsequently shifted to her home by the concerned IO and restoring her to her family members.

Case2

Ms.P, 19 years old female was found on the streets talking excessively, with disheveled state, getting into easy fights with people because of easy irritability. People around had contacted the police who brought the patient to the state psychiatric hospital. The patient was assessed and need for admission was considered because of the potential risk of harm to others and damage to property. She was admitted to the hospital after the consent of appointed NR as she was not able to tell the details of her whereabouts and her own mental health capacity was found impaired. On ward observation and serial assessment, she was diagnosed as Mania with Psychotic symptoms and started on psychotropics. After 10-14 days of treatment, she showed improvement by 80-90% and could tell the details of her whereabouts. IO concerned was informed and her residential details were confirmed and the patient was rehabilitated back with the family.

Case 3

Ms.L, a 21 year old female was found on the streets talking irrelevantly, throwing stones at people. Police was contacted by people around seeing her disheveled state and she was brought to the psychiatric hospital. The patient was assessed in the hospital emergency setting by psychiatrists. No meaningful conversation with the patient was possible. She was shouting, hitting people, was appearing fearful and hallucinatory behaviour was present. The patient’s urine drug screen was found positive for cannabinoids. Probable diagnosis of Substance intoxication was kept. Emergency treatment was initiated and psychotropics were given in loading dose. The patient slept for the next 12-14 hours. Her vitals were monitored simultaneously. After coming out of the sedation, she could tell her contact details. IO of the patient was informed and she could be rehabilitated back with her family. Her further treatment was continued from outpatient basis.

Case 4

Ms.D, a female seeming to be in her twenties was found lying on the roadside, as reported by people for the previous 2 days, in a bad state wearing torn clothes, smeared with her urine and feces, malnourished state. As such, people around contacted the police who brought the patient to the hospital. On assessment, no meaningful conversation was possible, the patient was smiling to self, making gestures in the air. Biofunctions were poor. She would require assistance in urination and defecation. Contractures in body were present. Her admission was advised. She was admitted with the consent of appointed NR. During her admission, her hygiene would be ensured, dietary intake would be monitored along with her vitals. She would have regular physiotherapy sessions for contractures. Patients built improved over next 2 months. But she continued to smile to self, biofunctions remained poor, meaningful conversations were not possible. Her IQ assessment showed Moderate intellectual impairement. Over 3 months, no family details could be traced for the patient by IO. She did not have any aadhar card when her details were tried to be traced using her biometrics. As such, the patient was transferred to the state government run welfare home for women by IO. She was enrolled in aadhar card identification system by her IO. She is following up thereafter on a regular outpatient basis for a refill of her prescription.

**Discussion**

People with psychiatric disorders, especially if long term, find it difficult to adjust in the community setting mainly due to the stigma associated with these disorders. But many a times, they themselves are not able to do basic activities of daily living, have difficulty in communication, occupational and social dysfunctions that might be attributed to neurocognitive deficits developing secondary to the long term psychiatric disorders. In such patients, rehabilitation in community setting becomes important as institutional setting on a long term basis might be further detrimental because of decreased environmental stimulation. Long term institutionalization further devoids the patient of their right to live freely in the community setting. Patel et al., 2007 reported that females with mental illness usually are victims of long term institutionalization than men, especially in LAMIC countries mainly due to factors of stigma, discrimination, financial issues. (6).

Rehabilitation helps in reintegrating patients in mainstream society and improving their quality of life. But, rehabilitation in India is in very poor state of being for patients with mental illness. And if the patient with mental illness is homeless female, the situation is still more poor. Dean *Klinkenberg and Calsyn, 1998* (7), reported clear-cut gender difference in reintegration with family or community in females. Homelessness is a societal and global concern affecting the countries throughout the world and more of a bigger problem in people with mental illness(8). Research has shown that homelessness may contribute to mental illness and vice versa, i.e. the people having poor mental health conditions are more than twice as likely to experience homelessness in their lifetime, compared with people who are not (9,10).

Females are already a vulnerable group of the society. Trauma, sexual abuse, stigma victimization are far much more common in females than males. Gender disparity is the reality still persisting worldwide and in the developing countries, like India, it is not hidden from anyone. Other factors like legislative rules regarding ownership of the house, socially acceptable remarriages in spouses of females with mental illness, make them more vulnerable to homelessness. All these factors make the fairer gender more at risk of developing psychiatric disorders than males. And homeless females with mental illness are much more at risk of victimization, abuse, exploitation, unwanted pregnancies and other psychosocial adversities.

In all the above 4 case illustrations, patients were found on the streets and with the involvement of police, were brought to hospital, could engage in treatment net, improvement was possible and through law agency could be rehabilitated in the community setting. Case 1 and case 2 were rehabilitated in their homes after varying lengths of treatment; case 1 after 3 months and case 2 after 15 days of admission to hospital. Case 3 could be rehabilitated after treatment in < 24 hours. It was possible to rehabilitate case 4 in a community care setting. Probable diagnosis were Psychotic illness, Mania with psychotic symptoms, Substance intoxication and Moderate intellectual impairment in Case 1, 2, 3, 4 respectively. Thus, in all 4 cases, across the spectrum of clinical conditions in mental health, independent of the diagnosis, rehabilitation was possible.

In MHA,2017, the role of police personnels is more clearly defined in sec 100 of MHA, 2017 and the role of judicial bodies has been decreased to section 101, 102 and 108 of MHA, 2017, resulting in faster expedition of cases. Homeless persons already have poor access to governmental schemes, treatment plans and other care facilities. And if the person is mentally ill along with being homeless, then the reach to these facilities become still more difficult or almost negligible. Hence, the role of society, police and other judicial bodies become more important in such scenarios. Section 100 (7) mandates it to police bodies to file the First Information Report (FIR) for the missing persons. In the four cases described, Section 100 of MHA 2017, defining the specific role of police, guided them to work in collaboration with the treating team and collaboratively help in the patient’s overall well being.

**Conclusion**

Failure to provide adequate resources to homeless females with mental illness is a sign of failure of the system of the country. Though the steps have been taken towards this section of society, but still a lot needs to be done. The need of social care homes and dedication of different organizations towards this section of the society is huge. This topic is already little researched. People have their own negative perceptions about homeless persons and persons with psychiatric disorders. Different states can prepare Police manuals with proper SOPs (Standard Operating Procedures) in collaboration with mental health establishments for more clearly defined roles and work required at each level. Also, in order to protect the rights of these patients, hospital authorities and police personnel should consider providing legal services aid to the patients wherever necessary and required. Media, scientific papers and society itself can help in upgradation of this neglected group of the society and proper utilization of available resources for development as a whole.

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**Declaration of Interest**

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