

Family Reintegration among homeless persons with mental illness in India— A systematic review and Meta-analysis

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Systematic Review

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Abstract

Background

In India, Homeless persons with mental illness (HPMI) constitute extremely vulnerable group of population. Many HPMI lose their identity due their mental illness and thus become “unknown” patient in hospitals. Tracing and reintegrating such patients family is a challenging task. Family reintegration is one of the key outcomes of the rehabilitation. However, systematic evidence regarding its effectiveness, barriers, and facilitating factors is limited.

Methods

A systematic review was conducted in accordance with the PRISMA 2020 guidelines and registered prospectively in PROSPERO with the registration number CRD420261450704. Databases such as PubMed, Scopus, Web of Science, and Google Scholar were searched for studies published up to 2025. Case reports, case series and retrospective chart reviews describing family reintegration among homeless persons with mental illness in India were included. Narrative synthesis was performed for case reports and case series. In addition, a random-effects meta-analysis was performed for retrospective studies to estimate the pooled prevalence of successful family reintegration of HPMI in India.

Results

a total of 1560 records were retrieved, among which twenty-two studies met the eligibility criteria for the review. These records consisted of retrospective studies ($n = 6$), case series ($n = 10$) and case reports ($n = 6$). Family reintegration involved a multistage process including psychiatric treatment, identity restoration, family tracing, verification and reunification. Meta-analysis showed that a pooled family reintegration prevalence of 51% (95% CI 36%–66%), with considerable heterogeneity ($I^2 = 87.7\%$).

Conclusions

Available evidence suggests that family reintegration is feasible for many homeless persons with mental illness in India when supported by multidisciplinary rehabilitation, coordinated inter-agency collaboration, and technology-assisted tracing.

Introduction

Homelessness among persons with mental illness is a major issue of concern. Homelessness and mental illness is bi-directional and so it can be a cause and a result of mental illness. (Nagavarapu et al, 2019; Pophaim et al, 2021). This condition leads multiple forms of problems such as poor physical health, social exclusion, victimisation and inadequate access to healthcare facility and limited opportunities for recovery and leading a normal life (Kim et al, 2007; Floris, G., 2025; Sherman et al, 2025; Macatangay et al, 2026; Henderson et al, 2026). This is not different in Indian scenario, lack of social support, stigma and discrimination, family disruption, poverty, inadequate community-based mental health services and many more factors may contribute to not adherence to treatment and sometimes maybe a direct cause of homelessness (Swaminath et al, 2019; Bhattacharya, 2026; Bukhari, 2026).

Homeless persons with mental illness (HPMI) are commonly brought to psychiatric hospitals by police personnel. If they find people wandering on streets, railway stations, bus terminals, marketplaces, or other public places in severely neglected physical and mental health conditions. In India, they rescue them and produce in front of the magistrate of the district court and admit them to a hospital through the reception order (Gowda et al, 2017; Moorkath et al, 2018; Swaminath et al, 2019; Sanadi et al, 2020; Bharadwaj et al, 2024). Due to their severe psychiatric condition, many individuals are unable to provide reliable personal information making them to remain “unknown” for a long period. (Gowda et al, 2017).

Family reintegration is widely considered as one of the most important rehabilitation outcomes of psychiatric rehabilitation for HPMI. Beyond restoring family relationships, successful reintegration promotes social inclusion, improves continuity of psychiatric care, enhances quality of life, reduces long-term institutionalisation, and supports recovery-oriented mental healthcare. (Fisk et al, 2000; Hoffman & Rosenheck, 2001; Gowda et al, 2019). There is a transition in tracing the family members in the recent years due to the technological advancement and digital revolution (Garg et al, 2025). Use of Aadhaar-based identity verification (Gowda et al, 2019), Google Maps (Kumari, D., & Parkash, R., 2021), online electoral list which is publicly available in the election commission website (Bharadwaj et al, 2024), mobile communication, police information systems, and social media platforms made it easy in locating family members and verifying patient identity (Garg et al, 2025). Despite these developments, considerable variability exists across institutions regarding tracing methods, stakeholder involvement, legal procedures, and reintegration outcomes. In addition, there is no single policy or guidelines nation-wide to follow in India. Usage of these technologies in helping to reintegrate may also has legal complications as there is violation of rights of privacy. Thinking about these legal complications, the usage of technology in family reintegration has not still gained wide acceptance in India (Bharadwaj et al, 2024).

Over the last decade, several Indian academic based hospital settings have published retrospective chart reviews, case series and case study reporting the innovative approaches they adapted to trace the family of HPMI. These studies collectively demonstrate the feasibility of family reintegration while highlighting numerous clinical, administrative, technological and legal challenges encountered during process of rehabilitation. However, the available evidence remains fragmented across different geographical regions in India. To the authors’ knowledge, till date no systematic review has synthesized the available evidence regarding family reintegration among homeless persons with mental illness in India. Specifically, there has been no attempt to integrate evidence describing institutional rehabilitation pathways, multidisciplinary collaboration, technology-assisted family tracing to successful reintegration or to estimate the prevalence of family reintegration of HPMI in India. Such synthesis is essential for informing evidence-based clinical practice and guiding to

draft policy exclusively for HPMI and adapting technology assisted reintegration component into it. Therefore, this systematic review and meta-analysis aimed to synthesise available evidence on family reintegration among homeless persons with mental illness in India. The research question was as follows- What is the available evidence regarding family reintegration among homeless persons with mental illness in India, and what is the pooled prevalence of successful family reintegration reported in retrospective observational studies?

Methods and Materials

Review Protocol

This systematic review and meta-analysis was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-2020) statement (page et al, 2021). For the transparency, the protocol was registered in PROSPERO (CRD420261450704) before the commencement of data extraction.

Inclusion and Exclusion Criteria

Component	Eligibility for Inclusion
Population	Homeless persons with mental illness in India
Intervention	Family tracing or family reintegration or family reunification
Outcomes	Family reintegration, tracing strategies, barriers, facilitators
Study designs	Retrospective studies, case series, case reports
Language	English
Country	India
Period	Till 2025

[Table 1- Inclusion criteria]

Because the literature on family reintegration among HPMI is limited, case reports and case series were included to capture novel rehabilitation approaches, technology-assisted tracing methods, and complex clinical scenarios that are unlikely to be represented in larger observational studies. However, these studies were included only in the narrative synthesis and were not pooled quantitatively (see table 1).

Studies were excluded if they focused solely on homeless persons without explicitly mentioning about mental illness or without addressing the 'unknown' aspect. Studies that discussed reintegration only in non-Indian contexts were also excluded. Opinion pieces, editorials, or commentaries that did not present original data or systematic case analysis were not considered. Finally, purely theoretical or conceptual papers without any empirical were excluded.

Study Identification

To identify relevant literature, we searched 3 electronic databases: PubMed, Web of Science, Scopus, and Google Scholar search engine was also searched based on the relevance search option. PubMed was selected for its comprehensive coverage of biomedical and public health literature, which is central to the health-related aspects of homelessness and mental illness. Web of Science and Scopus were chosen for their broad interdisciplinary scope, capturing studies from social sciences, psychology, and policy research. Google Scholar was used as a supplementary search engine to capture grey literature, and non-peer-reviewed case studies that are often critical in this field but may not be indexed in traditional databases. Synonyms of the keywords “homeless mentally ill” and “family reintegration” were used and appropriately utilised as subject headings. Boolean operators such as ‘AND’ and ‘OR’, were used in conjunction with search terms across all three databases. The complete search strategy for each database is presented in Table 2.

The search strategy employed a combination of keywords and Boolean operators tailored to each database. The core search string was: ("homeless mentally ill" persons" OR "unidentified homeless mentally ill" OR "unknown homeless mentally ill") AND ("family reintegration" OR "family reunification" OR "family tracing" OR "reconnection" OR "rehabilitation" OR "Reintegration") AND ("India" OR "Indian").

Database/ Search engine	Search Strategy	Records Retrieved (n)
PubMed	(("Homeless Persons"[Mesh] OR homeless[tiab]) AND ("Mental Disorders"[Mesh] OR "mental illness"[tiab] OR psychiat*[tiab] OR psychosis[tiab] OR schizophrenia[tiab]) AND ("family reintegration"[tiab] OR "family reunification"[tiab] OR "family tracing"[tiab] OR rehabilitation[tiab] OR reintegration[tiab]) AND ("India"[Mesh] OR India[tiab] OR Indian[tiab]))	12
Scopus	("homeless mentally ill persons" OR "unidentified homeless mentally ill" OR "unknown homeless mentally ill") AND ("family reintegration" OR "family reunification" OR "family tracing" OR "reconnection" OR "rehabilitation" OR "Reintegration") AND ("India" OR "Indian")	42
Web of Science	TS=("(homeless mentally ill" OR "homeless mentally ill persons" OR "unknown homeless mentally ill" OR "unidentified homeless mentally ill" OR "wandering mentally ill") AND TS=("family reintegration" OR "family reunification" OR "family tracing" OR reconnection OR rehabilitation OR reintegration) AND TS=(India OR Indian))	6
Google Scholar	"Homeless Mentally Ill" And "India" (initial 75 pages)	1500

[Table 2- Database and keyword search strategy]

Study Selection Process

All the retrieved records were imported into the Covidence software. Two reviewers (YB and IM) independently screened the titles and abstracts of all retrieved records against the inclusion criteria. Disagreements were resolved through discussion. Full-text articles of potentially relevant studies were assessed independently by two reviewers (SM and RP) and any disagreements regarding study eligibility were resolved through discussion with a third reviewer (YB) until consensus was reached.

Data Extraction, Synthesis & Risk of bias (Rob) assessment

The quality of the included studies was assessed using a modified version of the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Case Reports and Case Series and retrospective study. This tool evaluates studies on criteria such as clear description of the patient's demographic characteristics, clinical history, diagnostic methods, intervention, post-intervention outcomes, and adverse events. The risk of bias was assessed by two reviewers independently (YB and SM) and any discrepancies were resolved through the discussion. The data extraction template was prepared by the reviewers after multiple discussions. The extracted case study and case series data were reported using narrative synthesis and retrospective chart review were reported using meta-analysis. The reviewers performed Meta-analysis of prevalence of family reintegration, prevalence of psychotic disorders among unknown homeless mentally ill in India and prevalence of substance use disorder were analysed. The Meta-analysis was performed using Meta package in the R-Studio software. The pooled prevalence and corresponding 95% confidence intervals (CIs) were estimated using a random-effects model. Forest plots were generated to display individual study estimates and the pooled prevalence. Separate risk of bias assessments was done for case studies and case series/retrospective chart review. The details of are given in table 2 for case studies and table 3 for case series and table 4 for retrospective chart review respectively.

Results

The search across all the three databases yielded a total 1560 records. After removing 40 duplicate records, 1520 records remained for title and abstract screening. During this initial screening, 1485 records were excluded as they did not meet the inclusion criteria. The full texts of the remaining 35 reports were sought for retrieval. Of these, 2 reports could not be retrieved due to unavailability of full text or lack of response from authors. The remaining 33 reports were assessed for full-text eligibility. During this assessment 11 reports were excluded among which there was a relevant study (Gowda et al, 2019), it was a retrospective study. However, the study was the extension of a study published in 2017 by the same author which had similar data. Hence, 2019 study was not considered for our review since it was an extension of 2017 study (Gowda et al, 2017). Hence, 22 studies were included in the review. The study selection process is illustrated in the PRISMA flowchart (Fig. 1).

[Figure 1- PRISMA flow diagram of studies included family reintegration of HPMI in India].

[Table 2- risks of bias of case studies]

Author (Year)	Q1 Demographics	Q2 History & Timeline	Q3 Clinical Condition	Q4 Diagnostics	Q5 Intervention	Q6 Post-intervention	Q7 Adverse Events	Q8 Takeaway Lessons	Overall Appraisal
Kumar P. et al. (2021)	Y	Y	Y	Y	Y	Y	N	Y	Include
Singh A.R. & Sidana A. (2020)	Y	Y	Y	Y	Y	Y	N	Y	Include
Gopika G.G. et al. (2021)	Y	Y	Y	Y	Y	Y	N	Y	Include
Kalyanasundaram J.R. et al. (2023)	Y	Y	Y	Y	Y	Y	N	Y	Include
Sriramulu et al. (2021)	Y	Y	Y	Y	Y	Y	N	Y	Include
Gotewal S. (2022)	Y	Y	Y	Y	Y	Y	N	Y	Include

[Table 3- risk of bias assessment for case series]

Author (Year)	Were there clear criteria for inclusion in the case series?	Was the condition measured in a standard, reliable way for all participants included in the case series?	Were valid methods used for identification of the condition for all participants included in the case series?	Did the case series have consecutive inclusion of participants?	Did the case series have complete inclusion of participants?	Was there clear reporting of the demographics of the participants in the study?	Was there clear reporting of clinical information of the participants?	Were the outcomes or follow-up results of cases clearly reported?	Was there clear reporting of the presenting site(s)/clinic(s) demographic information?
Sharma M. et al. (2023)	Y	Y	Y	U	U	Y	Y	Y	Y
Sanadi R. et al. (2020)	Y	Y	Y	U	U	Y	Y	Y	Y
Somanna M et al. (2024)	Y	Y	Y	U	U	Y	Y	Y	Y
Bhanu P et al. (2020)	Y	Y	Y	U	N	Y	Y	Y	Y
Bharadwaj Y et al. (2024)	Y	Y	Y	U	U	Y	Y	Y	Y
Gowda G.S. et al. (2019)	Y	Y	Y	U	U	Y	Y	Y	Y
Sanjeevani G. et al. (2019)	Y	Y	Y	U	U	Y	Y	Y	Y
Sharma P. et al. (2024)	Y	Y	Y	U	U	Y	Y	Y	Y
Ali A. et al.	Y	Y	Y	U	U	Y	Y	Y	Y
Garg S. et al. (2025)	Y	Y	Y	U	U	Y	Y	Y	Y

[Table 4- risk of assessment for retrospective chart review]

Author (Year)	Were there clear criteria for inclusion in the case series?	Was the condition measured in a standard, reliable way for all participants included in the case series?	Were valid methods used for identification of the condition for all participants included in the case series?	Did the case series have consecutive inclusion of participants?	Did the case series have complete inclusion of participants?	Was there clear reporting of the demographics of the participants in the study?	Was there clear reporting of clinical information of the participants?	Were the outcomes or follow-up results of cases clearly reported?	Was there clear reporting of the presenting site(s)/clinic(s) demographic information?
Kumar P. et al. (2019)	Y	U	U	Y	Y	Y	Y	Y	Y
Tripathi A. et al. (2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gowda G.S. et al. (2017) (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y
Singh S. et al. (2023)	Y	Y	Y	Y	Y	Y	Y	Y	Y
Singh G. et al. (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y
singla. et al. (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y

Research Trends

[Figure 2 represents included studies by publication year]

Initially the dataset had twenty three studies for review. However, Gowda et al (2017) and Gowda et al (2019) have published two studies with the research question slightly changed, but their data was the same. Keeping in mind about the anticipated discrepancy while analysing data, one of the study was excluded (Gowda et al, 2019), while keeping the study Gowda et al (2017). Hence, finally twenty two studies were included in this systematic review. The earlier empirical study was conducted by Tripathi et al, (2013), where the authors examined the socio-demographic and clinical profile of homeless mentally ill admitted in a north Indian medical university. This was followed by Singh et al (2016), Gowda et al (2017). In 2019, a notable inflation occurred, where five studies were published, however as Gowda et al, 2019 (retrospective study) was excluded, remaining four studies are kumar et al (2019), Singla et al (2019), Gowda et al (2019- case series) and Sanjeevani et al (2019) respectively. In 2020 there were three articles published, two were case series published by Banu et al (2020) and Sanadi et al (2021). Another was a case report by (Singh AR & Sidana A, 2020). In 2021, three studies, two as case studies (Sriramulu et al, 2021; Kumar et al, 2021), one in the form of letter to editor was published (Gopika et al, 2021). Sangeetha Gotewal has published a case study in 2022. In 2023, three studies have been reported (Sharma et al, 2023; Singh et al, 2023; Kalyanasudaram et al, 2023). Similarly in 2024 three articles have published (Somanna et al, 2024; Bharadwaj et al, 2024; Sharma et al, 2024). In 2025, two studies were conducted (Garg et al, 2025; Ali et al, 2025). The Fig. 2 denotes the annual publications.

Study characteristics

Among the twenty two studies included, six studies were case reports (Singh & Sidana, 2020; Kumar et al, 2021; Gopika et al., 2021; Sriramalu et al., 2021; Kalyanasundaram et al., 2023; and Gotewal et al, 2022), ten studies were case series (Sanjeevani et al., 2019; Gowda et al, 2019; Sanadi R et al., 2020; Banu et al. 2020; Sharma et al., 2023; Somanna M et al. 2024; Bharadwaj YHS et al., 2024; Sharma et al., 2024; Ali et al., 2025; and Garg et al, 2025). Remaining six studies were retrospective studies (Tripathi et al, 2013; Singh et al, 2016; Gowda et al, 2017; Kumar et al, 2019; Singla & Aggarwal, 2019; and Singh et al, 2023). Out of six case reports which has only one case each, ten case series had the sample size ranging from 2 to 6 (Gowda et al, 2019; Sanadi et al, 2020). The sample size of six retrospective studies ranging from 23 to 127 (Singh et al., 2023; Tripathi et al., 2013). Details of the studies are represented in table 5. The geographical distribution of family reintegration studies among homeless persons with mental illness in India shows that nine studies were conducted in Karnataka (eight studies from NIMHANS, Bengaluru, one study from DIMHANS, Dharwad), six studies from Delhi (IHBAS), two studies from Haryana (one from State Institute of Mental Health and one from Pt. B. D. Sharma Postgraduate Institute of Medical Sciences each). One study each was conducted in Uttar Pradesh, Gujarat, Punjab, Telangana and Chandigarh. Studies and the HPMI conditions at the time of admission are detailed in table 5,6,7 respectively.

[Table 5- Included Studies Investigating Family Reintegration among Unknown Homeless Persons with Mental Illness]

Author (Year)	Study Design	Study Population	Institution/s	Sample Size	Intervention/Reintegration Process	Reintegration Outcome
Tripathi et al. (2013)	Retrospective chart review	HPMI	King George Medical University, Lucknow	127 (out of 140)	Psychiatric treatment, family tracing and rehabilitation	Approximately 70% reintegrated with families
Singh et al. (2016)	Retrospective chart review	HPMI	HMH in Gujarat and Department of Psychiatry, GMC in Gujarat	82	Treatment, police/social worker-assisted family tracing	39 patients reunited with families
Gowda et al. (2017)	Retrospective chart review	HPMI	NIMHANS, Bengaluru	78	Multidisciplinary treatment and rehabilitation	40 (51.3%) family reintegration
Kumar et al. (2019)	Retrospective study	HPMI	SIMH, Rohtak, Haryana	46	Aadhaar, Google Maps, ICT, police and Panchayat collaboration	31 community reintegration; 23 family reintegration
Singla & Aggarwal (2019)	Retrospective file review	HPMI	Christian medical College & Hospital, Ludhiana, Punjab	67	Treatment, NGO rehabilitation and family tracing	15 reunited with families
Singh et al. (2023)	Retrospective study	HPMI during COVID-19	IHBAS, Delhi	23	Treatment and rehabilitation during lockdown	Nearly half rehabilitated
Gowda et al. (2019)	Case series	HPMI	NIMHANS, Bengaluru	2	Google Maps and digital technologies	Successful family reintegration
Sanjeevani et al. (2019)	Case series	HPMI	IMH, Hyderabad, Telangana	2	Google Maps, Aadhaar, teamwork	Successful reunification
Sanadi et al. (2020)	Case series	HPMI	NIMHANS, Bengaluru	6	Police, Panchayat, media and social networks	Successful reintegration
Banu et al. (2020)	Case series	MPMI (with IDD)	NIMHANS, Bengaluru	5	Technology-assisted family tracing	Five successfully reintegrated
Sharma et al. (2023)	Case series	HWMI	IHBAS, Delhi	3	Police-assisted rehabilitation under MHCA 2017	Successful rehabilitation
Somanna M et al. (2024)	Case series	HPMI	NIMHANS, Bengaluru	4	Multidisciplinary stakeholder involvement	Family reintegration achieved
Bharadwaj YHS et al. (2024)	Case series	HPMI	DIMHANS, Dharwad	4	Technology-assisted family tracing	Successful family reintegration
Sharma et al. (2024)	Case series	HWMI (adolescents)	IHBAS, Delhi	3	Child welfare, police and psychiatric care	Family reintegration
Garg et al. (2025)	Case series	HWMI	IHBAS, Delhi	3	Google Maps, community contacts	Successful reintegration
Ali et al. (2025)	Case series	HPMI	IHBAS, Delhi	4	Psychosocial interventions, counselling, vocational referral	Reintegration/NGO rehabilitation
Kumar et al (2021)	Case report	HPMI	PGIMS, Rohtak, Haryana	1	Google Maps and Aadhaar-assisted tracing	Successful family reintegration
Gopika et al. (2021)	Case report	HPMI	NIMHANS, Bengaluru	1	Police coordination and family tracing during COVID-19 lockdown	Successful family reintegration
Sriramalu et al. (2021)	Case report	HPMI	(Community mental health centre),NIMHANS, Karnataka	1	Case management approach	Successful family reintegration
Gotewal (2022)	Case report	HPMI	IHBAS, Delhi	1	Multidisciplinary rehabilitation	Successful rehabilitation
Kalyanasundaram et al. (2023)	Case report	HWMI (sexual abuse history)	NIMHANS, Karnataka	1	Psychosocial intervention, identity tracing, family intervention	Successful family reintegration
Singh & Sidana (2020)	Case report	HPMI	Government Medical College & Hospital (GMCH), Chandigarh (UT)	1	Multidisciplinary team approach	Successful rehabilitation
*HPMI = Homeless persons with mental illness; HWMI= Homeless women with mental ill						

Condition of HPMI at the time of admission

[Table 6 – patient characteristics and Condition of HPMI across case report/case series at the time of admission]

Author (Year)	No. of Cases	Patient Characteristics	Condition at Presentation to Hospital
Ali et al. (2025)	4	• Age range: 22 to 47 years • Sex: 2 males, 2 females • Diagnosis: Schizophrenia, Psychosis, Poly-substance dependence; untreated psychosis	• Found homeless or wandering • With untreated psychosis, persecutory delusions, suicidal ideation, aggression, poor insight, severe psychosocial vulnerability • Inability to identify or contact family. • Admitted under reception orders.
Banu et al. (2020)	5	• Age range: 14 to 18 years • Sex: Male adolescents • Diagnosis: mild–moderate intellectual developmental disorder (IDD), bipolar disorder, or psychosis	• Found Homeless • impaired cognition and impaired communication, • Fragmented autobiographical memory • Inability to establish identity or return home independently. • Admitted under reception orders.
Bharadwaj et al. (2024)	4	• Age range: 19 to 40 years • Sex: 2 males, 2 females • Diagnosis: Adults with psychosis, mania, & neurological co-morbidity	• Found wandering or creating public nuisance • Poor self-care, agitation, psychotic symptoms • Inconsistent identity & information • Admitted under reception orders.
Garg et al. (2025)	3	• Age range: 30–35 years • Sex: females • Diagnosis: schizophrenia, acute transient psychosis, bipolar affective disorder	• Found wandering in public places with poor hygiene, hallucinations, delusions, disorganised behaviour, impaired judgment and absent insight. • Admitted under reception orders.
Gopika et al. (2021)	1	• Age: 25 years • Sex: Young adult male • Diagnosis: Schizophrenia and mild IDD	• Wandering, irritability, poor communication • Unable to identify family because of psychiatric illness and intellectual disability. • Admitted under reception orders.
Gotewal (2022)	1	• Age: 25 years • Sex: Young adult female • Diagnosis: Subnormal intelligence and severe psychosocial adversity with psychotic symptom	• Homeless, confused, violent, socially withdrawn, • unable to communicate identity; • history of trafficking & sexual abuse • Admitted under reception orders.
Gowda et al. (2019)	2	• Age range: 36 to 40 • Sex: male • Diagnosis: schizophrenia	• Homeless, wandering, hallucinatory behaviour • poor judgment, absent insight • Admitted under reception orders.
Kalyanasundaram et al. (2023)	1	• Age: 37 years • Sex: female • Diagnosis: chronic schizophrenia	• Prolonged homelessness • Survivor of sexual assault • Mutism • severe psychosocial dysfunction, inability to communicate identity • Admitted under reception orders.
Kumar et al (2021)	1	• Age: not known • Sex: male • Diagnosis: Paranoid schizophrenia	• Wandering, aggressive behavior • hallucinations • persecutory delusions • Poor hygiene, • Unable to identify himself • Admitted under reception orders
Sanadi et al. (2020)	6	- Age range: 23 to 65 years - Sex: male - Diagnosis: schizophrenia, psychosis NOS, catatonia, and intellectual disability	• Wandering • Disorganised behavior • Hallucinations • catatonic symptoms

Author (Year)	No. of Cases	Patient Characteristics	Condition at Presentation to Hospital
			• poor self-care • Admitted under reception orders
Sanjeevani et al. (2019)	2	Age range: NA Sex: both male and female Diagnosis: schizophrenia	• Homeless, aggression, • Socially inappropriate behavior • poor hygiene, • inability to provide identifying information • Admitted under reception orders
Sharma et al. (2024)	3	Age range: Sex: female adolescents Diagnosis: psychosis and manic symptoms	• Found wandering • Aggressive • Hallucinations • grandiose behavior • Communication difficulties, unable to provide identity. • Admitted under reception orders
Sharma et al. (2023)	3	Age range:14–16 years Sex: females Diagnosis: with psychosis, mania, and substance use	• Found homeless • Aggression • Hallucinations • Grandiose and persecutory delusions • Poor self-care • Behavioural disturbances, impaired judgment. • Communication difficulties, unable to provide identity • Admitted under reception orders
Singh & Sidana (2020)	1	Age: 42 years Sex: male Diagnosis: psychosis and severe physical illness	• Extreme self-neglect • maggot-infested wounds • poor hygiene • Muttering • Uncooperative behaviour, multiple medical co-morbidities. • Communication difficulties, unable to provide identity • Admitted under reception orders
Somanna M et al. (2024)	4	Adults with schizophrenia, schizoaffective disorder, psychosis, and tuberculosis	Found wandering, begging, aggressive, poor self-care, socially inappropriate behaviour, admitted through police or NGOs.
Sriramalu et al. (2021)	1	Older homeless widow with severe depression with psychotic symptoms	Long-term homelessness, malnutrition, poor self-care, hallucinations, multiple medical co-morbidities, severe psychosocial deprivation.

[Table 7- Characteristics of homeless mentally ill persons across six retrospective studies]

Variable	Tripathi et al. (2013)	Singla & Aggarwal (2019)	Singh et al. (2023)	Singh et al. (2016)	Kumar et al. (2019)	Gowda et al. (2017)
Age	34.6 ± 12.4 years	Majority of them between 46–60 years (36%)	Mean age was 37.5 years (20–50)	Majority < 40 years (68.3%)	nearly 50% aged 30–50 years	x
Gender	Male 82.9% Female 17.1%	Male 87% Female 13%	Male 95.7% Female 4.3%	Male 56.1% Female 43.9%	Male 60% Female 40%	Female 53.8% Male 46.2%
Marital status	Never married 68.6%; Separated/divorced 31.4%	Unmarried 55%; Married 45%	x	x	x	x
Education	Uneducated 39.3%; Up to primary 35%	Illiterate 60%; Literate 40%	x	x	x	x
Psychiatric illness present	127 (90.7%) out of 140 homeless people	All participants	Majority (~74%)	All participants	All participants	All participants
Multiple psychiatric diagnoses	55.7%	Present in some participants	x	Present in some participants	x	Present
Psychotic disorders	65%	Predominant diagnoses (psychosis NOS, schizophrenia spectrum)	Predominant diagnoses (psychosis NOS, schizophrenia)	Psychosis NOS and schizophrenia most common	Psychosis NOS (85%)	Schizophrenia/psychotic disorders 65.4%
Substance use disorders	44.3%	x	Cannabis-induced psychosis (2 cases)	5 patients	x	23 (29.5%)
Physical/medical problems	75.4%	Epilepsy and dementia-related conditions reported	Organic causes in 2 participants	Common physical morbidity	Physical morbidity affected rehabilitation	Medical co-morbidity common
Common medical problems	Anaemia (37.9%), skin diseases (32.9%), pulmonary disorders (18.6%)	Epilepsy with psychosis; dementia	x	Pallor, malnutrition, injuries, skin infections, wounds	Chronic physical morbidity and functional disability	Injuries, malnutrition, infections, neurological problems
Treatment/Rehabilitation outcome	x	x	x	Good improvement in 43; family reintegration in 39	Community reintegration in 69%	Family reintegration 51.3%; NGOs/state homes for remaining patients

Family reintegration of HPMI using Digital technology

[Table 8-Family reintegration strategy used across the studies using digital technology]

Study	Technology/Tools Used	Family Tracing Strategy	Key Stakeholders Involved
Tripathi et al. (2013)	No digital technology reported	Patient recovery followed by family tracing using police support and available address information	Psychiatric team, police, family members
Singh et al. (2016)	No digital technology reported	Family tracing through psychiatric social workers and police	Psychiatric social workers, police, family members
Kumar et al. (2019)	Aadhaar, Google Maps, mobile phones, internet, ICT	Identity verification and address tracing using digital tools with local administrative support	Psychiatric social workers, police, Gram Panchayat, Zila Parishad, family members
Singh et al. (2023)	E-Travel Pass, ZIPNET, Aadhaar database, telephonic communication	Photographs circulated through police network; Aadhaar verification; relatives contacted by phone	Psychiatric social workers, police, helpline staff, nodal officers, government volunteers, family members
Gowda et al. (2019)	Google Maps, Aadhaar biometric authentication	GPS-based address verification and biometric identity confirmation	Psychiatric social workers, police, family members
Sanjeevani et al. (2019)	Google Maps, Aadhaar	Digital identity verification and geolocation-assisted tracing	Multidisciplinary team, police, family members
Sanadi et al. (2020)	Mobile phones, social media, local media	Community-based tracing through media and social networks	Police, Panchayat, media personnel, psychiatric social workers
Banu et al. (2020)	Technology-assisted tracing (specific tools not detailed)	Digital-assisted identification of persons with intellectual disability	Multidisciplinary rehabilitation team
Somanna et al. (2024)	Online electoral (voter) database, digital communication	Technology-enabled tracing integrated with multidisciplinary rehabilitation	Multidisciplinary team, government agencies
Bharadwaj et al. (2024)	Emerging digital technologies (not specified)	Technology-assisted tracing integrated with rehabilitation services	Psychiatric social workers, rehabilitation team
Sharma et al. (2024)	Digital communication with child protection services	Family tracing coordinated through child welfare mechanisms	Child Welfare Committee, police, psychiatric team, family
Garg et al. (2025)	Google Maps, community contacts	Geospatial verification combined with local community tracing	Community members, psychiatric social workers
Ali et al. (2025)	Google Maps, Aadhaar biometric authentication	Digital identity verification followed by psychosocial rehabilitation	Psychiatric social workers, police, rehabilitation team
Kumar et al. (2021)	Google Maps, Aadhaar	Technology-assisted family tracing	Psychiatric social workers, police, family members
Gopika et al. (2021)	Telephone communication during COVID-19	Police-assisted tracing during lockdown	Police, psychiatric team, family members
Sriramalu et al. (2021)	No specific technology reported	Case-management-based family tracing	Community mental health team, family
Gotewal (2022)	No specific technology reported	Multidisciplinary rehabilitation	Psychiatrist, psychiatric social worker, rehabilitation team
Kalyanasundaram et al. (2023)	Identity verification (tools not specified)	Psychosocial intervention with identity tracing and family intervention	Psychiatric team, family members
Singh & Sidana (2020)	No digital technology reported	Conventional multidisciplinary rehabilitation	Multidisciplinary team

Meta-analysis

Among the twenty two studies, six studies were retrospective studies. Remaining were case report and case series. Hence, the research team decided to conduct a Meta analysis for the six retrospective studies to estimate the pooled prevalence of family reintegration among homeless persons with mental illness (HPMI) in India. [See Fig. 3]

[Figure 3 pooled prevalence of family reintegration of HPMI]

Six studies involving 423 homeless persons with mental illness were included in the meta-analysis. The pooled prevalence of successful family reintegration was 51% (95% CI: 36%–66%) using a random-effects model. Considerable between-study heterogeneity was observed ($I^2 = 87.7\%$, $p < 0.001$), indicating substantial variability in reintegration rates across studies.

Discussion

This systematic review focused on case based family reintegration of homeless person with mentally illness (HPMI). Twenty two studies were included in the review, which included six retrospective studies, six case reports and ten case series. Further the reviewers conducted meta analysis focused on indicated pooled prevalence of family reintegration of HPMI exclusively in India by pooling the retrospective studies. The finding indicated that pooled prevalence of successful family reintegration of HPMI in India was 0.51. [51% (95% CI: 36%–66%)]. This implies that nearly one in every two HPMI institutionalised recently can be successfully reunited with their families when appropriate reintegration strategies adapted.

However, high level of heterogeneity ($I^2 = 87.7\%$) was observed in the meta-analysis. The successful family reintegration proportion (FRP) varied from institution to institution. For instance, in Tripathi et al (2013) the FRP was 0.70, in Gowda et al (2017) study, the FRP was 0.51 and in singla et al (2019), it was 0.22. hence there is a considerable high variation in terms of institution's policy and current practices, resources that are available, family tracing strategies adapted, patient characteristics, interdepartmental coordination across different regions of India. Hence, there is a geographical disparities in the family reintegration services.

When comes to evolution of family tracing strategies, there is a remarkable advancement happened over the last decade. Earlier studies (tripati et al, 2013) depended on the conventional strategies where as more recent studies have incorporated various digital technologies such as Aadhaar biometric authentication, Google Maps, mobile communication (Gowda et al., 2019; Kumar et al., 2019; Garg et al., 2025). Bharadwaj et al (2024) in their case series in a tertiary care psychiatric hospital in North Karnataka demonstrated how online electoral list published by election commission of India provided an avenue to trace the family members of HPMI. These technological innovations have reduce a great amount of the time required for family tracing and successful reintegration (Gowda et al., 2019; Bharadwaj et al, 2024; singh et al, 2023; Garg et al., 2025). Still, ethical concerns regarding privacy, confidentiality, informed consent, and potential misuse of digital information may be a concern. [see table 8]

In our review in was found out that in almost all the studies that are included, it was through multi-disciplinary collaborative work successful reintegration was achieved rather than isolated clinical interventions. Psychiatric social workers played a central role by coordinating family tracing, conducting psychosocial assessments, communicating with relatives, organising legal documentation, and facilitating community reintegration. Collaboration with psychiatrists, psychologists, police departments, district administration, Gram Panchayats, Child Welfare Committees, non-governmental organisations, community volunteers, and family members was repeatedly identified as essential for successful rehabilitation.

From a policy perspective, our findings support implementation of structured national guidelines for rehabilitation of homeless persons with mental illness under the Mental Healthcare Act, 2017. Although several institutions have independently developed innovative rehabilitation models, there remains no standardised protocol for family tracing, inter-agency collaboration, documentation, use of digital technology, or follow-up after reintegration exist at the national level. It is important to establish a uniform national level homeless person mentally illness policy to address this issue.

Strengths and Limitations

The strength of the present systematic review is to the reviewers' knowledge this is first of its kind in India exclusively focusing on family reintegration among HPMI. The study incorporated PRISMA 2020 guidelines. For the case series and case records the study adapted narrative synthesis and for retrospective chart review, meta-analysis of proportion was conducted. separate risks of bias assessments were done to case series, case study and retrospective study.

On the other hand, several limitations must be acknowledged. First, the quantitative synthesis was limited to six retrospective studies. Second, while substantial between-study heterogeneity constrains generalisability. Third, most of the evidences were from tertiary psychiatric institutions. Critically, long-term follow-up data following reintegration were largely absent, leaving the sustainability of reunification and associated relapse rates poorly characterised.

Conclusion

The present systematic review shows that reintegration with the family is an important and feasible component of psychiatric rehabilitation of homeless persons with mental illness in India. The 22 included studies provided evidence that multidisciplinary rehabilitation, active family tracing, psychosocial interventions and collaboration with police, community agencies, local administration and families can facilitate successful reintegration. A meta-analysis of six retrospective studies ($n = 423$) estimated a pooled family reintegration prevalence of 51% (95% CI: 36%–66%) suggesting that about half of homeless persons with mental illness may be successfully reunited with their families when appropriate rehabilitation and tracing mechanisms are implemented. However, there was substantial heterogeneity ($I^2 = 87.7\%$) indicating significant differences between institutions and regions, which may be due to differences in patient characteristics, available resources, institutional practices and family tracing approaches. The review also points to a move away from traditional family tracking methods to technology-aided methods like Aadhaar based identification, Google Maps, mobile communication, online electoral database and police information systems. While these approaches seem to improve the efficiency and feasibility of family tracing, their use must be carefully weighed against privacy, confidentiality, consent, data protection and other legal and ethical safeguards. Psychiatric social workers became key coordinators in the family tracing and reintegration process, in particular through multidisciplinary collaboration and community linkage. In conclusion, the findings point to the need for a structured, standardised homeless persons with mental illness policy for family tracing and reintegration of HPMI in India.

Declarations

Data availability statement

Upon request to the corresponding author

Author contributions statement

Conceptualisation: YB (Lead)

Data Curation: SM;IM; RP

Formal Analysis: YB; SM

Investigation: YB;SM;IM;RP

Methodology: YB;SM;IM;RP

Project Administration: YB

Resources: YB

Software: YB

Supervision: YB

Validation: YB;SM;IM;RP

Visualization: YB;SM;IM;RP

Writing – Original Draft Preparation: YB; SM;

Writing – Review & Editing: YB;SM;IM;RP;

YB= Yatheesh Bharadwaj; SM= Sivaranjini M; IM= Iddi Chedieli Mkojera; RP= Rakshita Poojari

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Conflict of interest

None declared.

Generative AI statement

The authors declare that generative AI was not used in creation of this manuscript.

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Figures

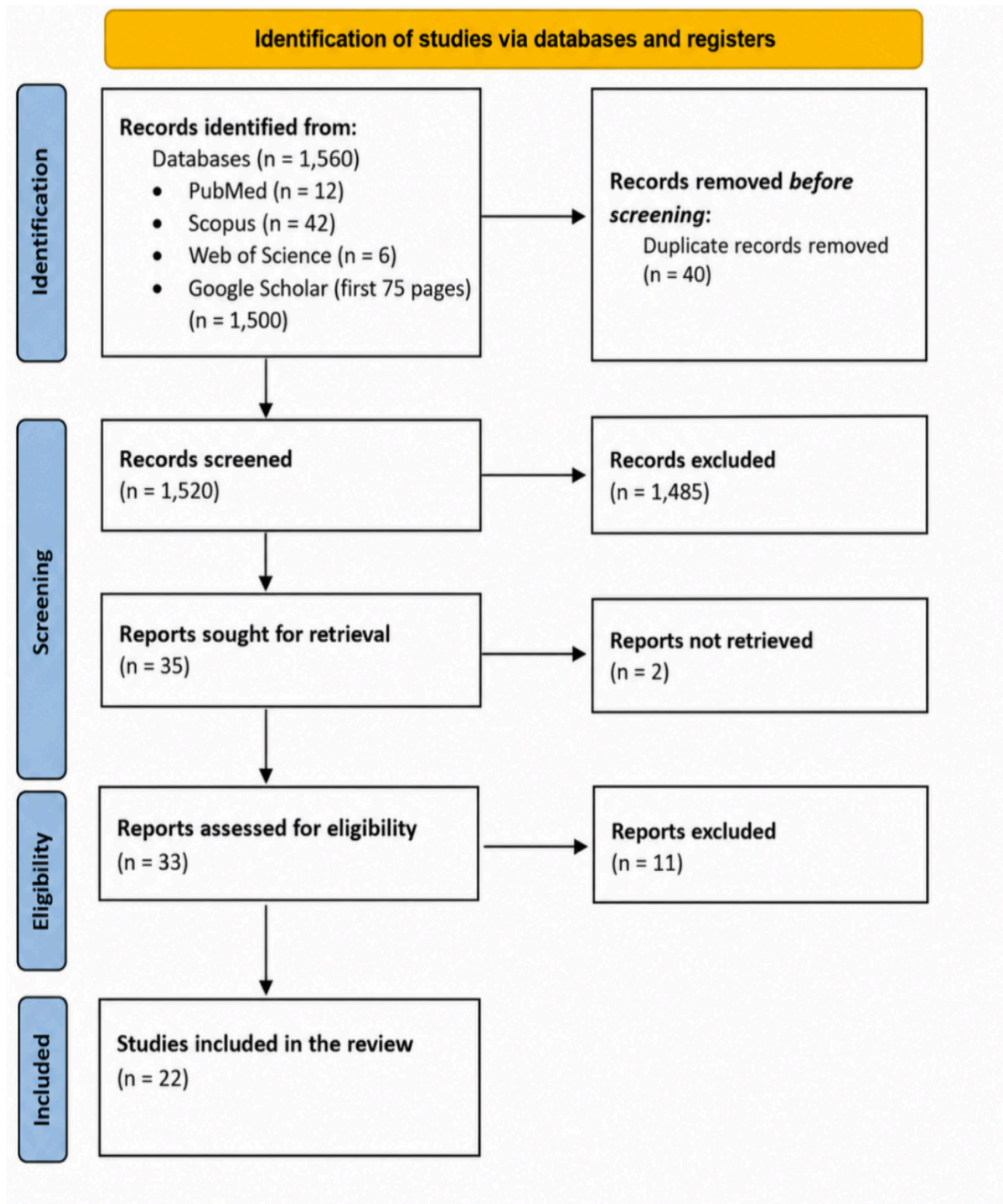


Figure 1

PRISMA flow diagram of studies included family reintegration of HPMI in India.

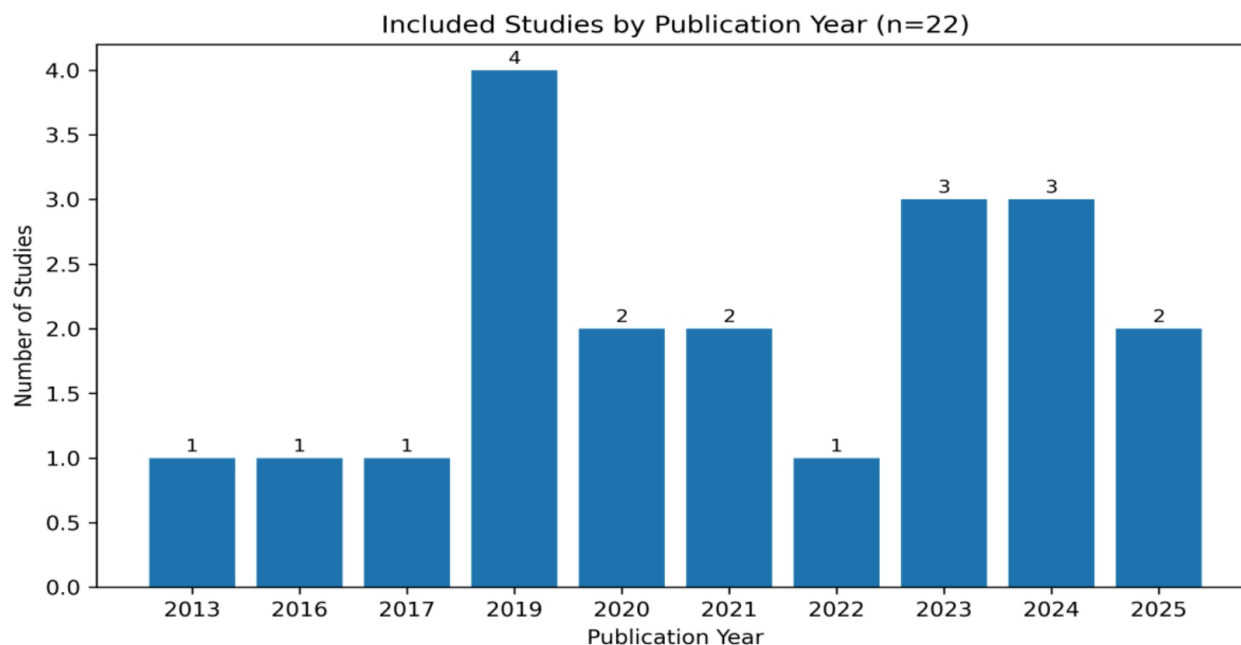


Figure 2

Represents included studies by publication year

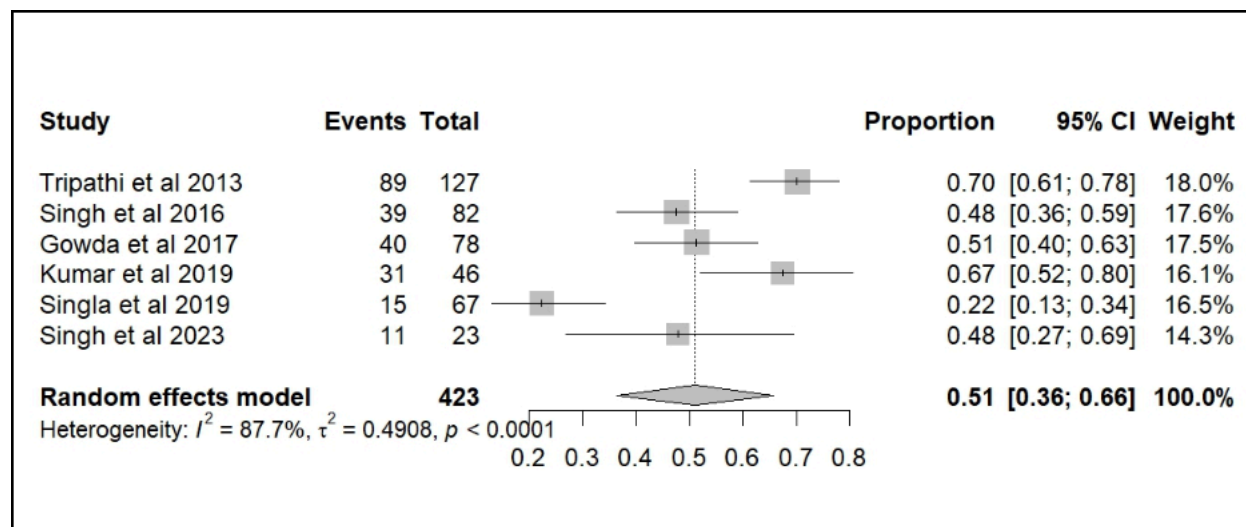


Figure 3

Pooled prevalence of family reintegration of HPMI