Summary

Mental disorders account for one out of every ten healthy years lost due to disease and left untreated lead to substantial disability, economic losses and social suffering. Despite strides in evidence-based interventions, 50-90% of people with psychosocial disability in low-medium income contexts are out of care that can help regain health. Several systemic barriers in low- and medium- income countries (LMICS) persist and prevent access to care. These include underfunding, human resource deficits, challenged and overburdened public health systems, leadership and governance dynamics, multidimensional poverty and pervasive stigma.

A similar scenario is echoed in India where 150 million people are living with mental disorders but less than 10% of people with common mental disorders and only 40-50% of people with schizophrenia are estimated to be accessing any form of care. Mental health is chronically underfunded in the country and these limited resources are further disproportionately applied to large institutional tertiary care facilities, which bear the burden of a hegemonic colonial inheritance and have sizeable long stay populations. The District Mental Health Programme (DMHP), India’s community mental health delivery platform, is challenged by existent deficiencies in public health systems and offers limited access to proximal services and negligent social care. Fragmentation between health and social sectors in the framework of delivery and human resource deficits, both in numbers and quality, further complicate the scenario. These limitations arising out of systemic barriers to resource infusions into community care contribute to inconsistent outcomes with limited meaning among people with mental illness.

Within this context, homelessness in the background of mental illness is a particularly complex issue. Homelessness and mental health interact recursively to produce marginalisation characterised by pervasive abuse and victimisation, disenfranchisement and distancing from variegated socio-economic resources. However, much of the evidence base for interconnections between homelessness and mental health and for interventions
that can break this cycle and end social exclusion is from the West representing a significant knowledge gap to inform the design of large-scale public health responses in the context of low- and middle- income countries.

The thesis considered the evolution and influences of the work of The Banyan, a non-profit organisation based in India, which has been working with homeless people with mental illness since 1993, in an attempt to answer the following main question:

How can mental health systems be developed to redress the marginalisation of homeless people with mental illness and what are the possible influences of community re-entry interventions on their recovery and social inclusion?

The objective was three-fold:
1. To contribute to better understanding of relationships between homelessness, poverty and mental illness, particularly in the low-medium income context of India
2. To understand the evolution of a select mental health system in the local context of homelessness and mental illness in India
3. To investigate the effect of select interventions in facilitating recovery and social inclusion of homeless people with mental illness in the Indian context

This thesis is divided into three parts reflecting each of the objectives stated above. Part 1 of the thesis considered the nexus between homelessness and mental illness and reviewed challenges that are present in the Indian scenario. The nature of the nexus was investigated by comparing women with mental illness with and without history of homelessness and drawing out risk factors for homelessness. Part 2 examined the evolution of an organisation working at this nexus and analysed the journey for attributes and values that may inform the development of responsive health systems for homeless people with mental illness. Part 3 considered outcomes from two interventions – hospital-based care and housing with supportive services - that aim to promote social inclusion of people with mental illness to understand the potential gains for homeless people with mental illness.
The main question was approached through a series of six sub-questions associated with Chapters embedded in each of the three parts:

1. What are the challenges at the intersection of homelessness, mental illness and poverty nexus in the Indian scenario?
2. What are the predictors of homelessness among women with mental illness?
3. In what way can mental health systems be constructed to be responsive and aligned with self-identified needs of a population facing the double jeopardy of homelessness and mental illness in a resource scarce, oppressive context?
4. What are the lessons and prospects emerging from The Banyan’s experience of implementing a crisis intervention to reintegration intervention for homeless women with mental illness?
5. What are the effects of a housing with supportive services intervention on recovery and social inclusion outcomes of homeless women with mental illness experiencing long-term care needs?
6. How can the lessons from these approaches for recovery and social inclusion be translated into a larger agenda for mental health policy and practice so that we can move towards newer socio-economic realities for homeless people with mental illness?

This thesis used an interactive approach combining quantitative and qualitative studies to answer the main question, and associated sub-queries. The capabilities approach towards poverty beyond the utilitarian conception of absence of financial resources informs the conceptualisation of recovery and social integration for this thesis. Recovery, on the one hand, is concerned with individual preferences and pursuits of well-being, but also entails the larger agenda of removal of the vicious onslaught of recurrent social and economic barriers for people with mental illness to pursue lives of their choosing. Social inclusion, with increased participation and citizenship of people with psychosocial disability, is considered as a significant indicator of quality of life in contrast to utilitarian formulations that emphasise income and satisfaction. Transdisciplinary research process is applied as it presents a critical alternative to conventional methods of problem-solving for complex, persistent issues. System innovation and transition management theories are
used to analyse mechanisms for knowledge co-production, integration and radical system change.

In Part 1, Chapter 4 a narrative review of literature on homelessness, poverty and mental health is discussed in the context of challenges in the provision, accessibility and corresponding treatment gaps in mental health services in India. Ramifications of the nexus between homelessness, mental health and poverty affects access to health care, productive living and full participation, and social attitudes and responsiveness of health systems. The failure to engage with these issues results in greater vulnerability, distress and social defeat among the affected populations. Chapter 5 reports results from multivariate logistic regression analysis of data, from a cross sectional survey of 346 women in active service contact across four clinics of The Banyan, to examine predictor variables for homelessness among women with mental illness. Factors rooted in gender-based disadvantage, low educational attainment and disruptions in relationships, predominantly explained homelessness among women with mental illness in the study cohort.

For the elimination of these social structures and embedded machinations that produce, persist and maintain gender discrimination, policies may need to focus on sustained affirmative action. Interconnected service supports, derived from integrated, personalised formulations of presenting distress, that range from clinical to social may be efficacious for positive gains among those who face multiple jeopardies and need to be investigated as potential preventive strategies. Community mental health policies may need gender responsive restructuring into a programme to build psychosocial competence among children, youth and households to alter patterns of socialisation towards egalitarian norms.

In Part 2, Chapter 6 an action learning framework is applied analyse the timeline narrative of The Banyan, a twenty-five year old mental health organisation from India to help unpack key elements underlying mental health system responses that may address the homelessness, mental illhealth and poverty nexus. 'User-centred' and 'service integration' emerge as the main dimensions of responsive health systems. Dimensions of the attribute user centred include self-determination of personal, constituency and service
system priorities and co-creating responses through process of dialogue. Service integration dimensions include quantitative increase in diversity of service offerings and qualitative improvement in the level of integration among these varied services. Four core values drive these attributes in the system: commitment to well-being, drive to understand needs of clients, acceptance of complexity of client realities and willingness to adapt organisational identity. Responsiveness includes the ability of health systems to change and evolve with shifting health needs and priorities for well-being among service users. A typology matrix, based on the low to high combinations of the two parameters - ‘User-centred’ and ‘Service integration’, may be used to examine degree of responsiveness of health systems to marginalised populations.

In Part 3, Chapter 7 examines quantitative and qualitative data between 2014-2017 of a hospital based service, the Emergency Care and Recovery Centre (ECRC) for homeless women with mental illness of The Banyan in Chennai, India. ECRC as a crisis intervention to reintegration and aftercare approach delivered through a cadre of lay health workers supervised by a multidisciplinary team is effective in facilitating community re-entry for three-quarters of homeless women with mental illness who used these services between 2014-17. An approximate 60% continue to remain within the care ambit with supports offered post discharge. Heterogeneity in clinical recovery and pathways out of acute care service are implicated by the findings - a proportion continue to stay in the inpatient settings with needs for long term care. Inpatient services play a critical role in the continuum of care for mental health, as they do for several other health conditions. The history of state mental hospitals must serve as a reminder of the futility of efforts in haste that neglect to embed long-term ideological and value underpinnings that ensure intent is scaled in concordance with the vision. The substantial legacy of repeated reform failure of these totalitarian regimes that have controversially served as means of social and ideological control must inform future initiatives that seek to reorganise the social architecture of these spaces.

Chapter 8 presents results of a non-randomised controlled study to examine the effects of housing with supportive services – Home Again – for women with mental illness and long-term care needs. Repeated measures of 126
Participants (homeless women with mental illness with long term needs), 53 in the intervention arm (Home Again) and 53 in the Care as Usual (Institutional services) were analysed. Home Again was found to have a significant effect on their community integration and disability. Community Integration among service users of Home Again improved significantly when compared to a matched cohort of users from Care as Usual. Disability decreased significantly over time among those who were in Home Again compared to a matched cohort of women who remained in Care as Usual. Without deriving any causal inferences, improved reintegration rate and reduced average number of inpatient days in the institutional facility in Tamil Nadu coincided with the transition of long stay service users into Home Again. In Home Again, women were able to access resources, bonds of kinship and pursue alternative lifestyles in atypical families of single women living together against a significant history of gender-based disadvantages that are associated with homelessness in our cohort. Lessons from Home Again may be used to springboard action to alter the paradigm of institutional mental health care, with a particular focus on the forty-three state mental health facilities in India. In addition to facilitating transitions, the opportunity to work with the state mental hospitals may be expanded in due course to engage in initiatives that can transform the social architecture of these facilities to reflect a recovery-based ethos in acute care settings and take a leap ahead in human rights and quality assurance in mental health.

Chapter 9 discusses the lessons from these various enquiries and implications for policy, practice and translation of these results at scale. There is an urgent need for recalibration of landscape worldviews and regime systems in mental health and homelessness to be derived from and responsive to local feedback. Methods for collaborative enquiry, incorporating actors from civil society, user-carer groups, academia and policy, will need to be embedded through precise mechanisms for dialogue and synthesis of knowledge. Service user representations in advocacy and change initiatives for the sector need to include those with first-hand experiences of poverty and structural violence. Health systems will need to acknowledge social determinants, work with a positive bias in favour of disadvantaged populations and deliver care packages that incorporate clinical and social recovery pathways to eliminate inequity and lift people out of extreme poverty. Critical physical, social and
philosophical barriers to recovery and social inclusion continue to persist in institutional facilities in mental health which are encapsulated in vestiges of a colonial era. Transforming these, not by renaming or similar token methods, but through radical restructuring to embrace a contemporary mode of care, that is driven by service user needs and preferences for recovery, will have far-ranging consequences for human resources and leadership quality in the mental health sector. Leadership with transformative competencies vested with the imperative to develop an expansive, accountable, process-oriented system, may be critical in the creation of a meaningful path to scale.

In conclusion, removing structural barriers at the individual and the broader societal level are critical imperatives to pursue mental health recovery. Mental health systems may need to adopt a user-centred service innovation and service integration focus to engender radical shifts driven by priorities, preferences and narratives of services users. Both the institutional intervention and the housing with supportive service intervention that the thesis examined offer promising prospects to promote recovery and social inclusion in the context of mental health and homelessness. However, it becomes necessary to recognise that such innovations may not be transferred through didactic distillations into components but may rather be characterised by underlying values and tacit knowledge that determine how transfer in practice with the real world occurs. Unveiling the underlying values and processes through which these values and tacit knowledge are diffused will offer new directions and ways in which health system responses and interventions may be devised for marginalised populations.