Chapter 1. Introduction

One of Taslima’s earliest memories is being given away at the age of seven by her mother, homeless with a mental illness, to a woman on the railway platform who promised to place her in the care of a ‘good family’. This separation was followed by serial childhood sexual abuse by a brother figure in this ‘adoptive’ family, who called her a liar for speaking about the abuse and threw her out of the house. Her brief marriage at the age of 14 was marred by domestic violence and ended when her husband died in an accident. This disruption in yet another relationship was the final straw for Taslima, who disintegrated into a world within. Despite treatment at the psychiatric outpatient clinic at a public hospital, she often wandered away leaving behind four sons. After several years, she sought admission at an institutional facility for homeless women with mental illness, recovered and reunited with her 'adult' sons. Taslima's life is better today in some measure. She is symptom-free and self-reliant in day-to-day functions. However, unresolved painful memories of the past interfere with her well-being. The relationship with her sons, who have grown up with an absent mother, is tenuous and marked by persistent verbal abuse, degradation and othering as ‘mental’. She often ponders over the meaninglessness of her life and reminisces about what it might have been with intact bonds, a family that felt like one. In Taslima's perspective is she doing well? No direct answers encapsulate her complex reality.

Taslima's story illustrates the complexities we must traverse while developing health system responses and interventions that can mitigate multifactorial distress and meet priorities for recovery that are beyond and perhaps distinct from living a symptom-free life. More than ever, we now have evidence-based interventions for clinical management of mental illness. However, only an estimated 10% of people with mental illness in India receive the care they
need (Patel et al., 2016), and even when they do, concomitant homelessness and socio-economic hurdles result in systematic marginalisation and jeopardise the possibility of personally meaningful recovery. In this thesis, I attempt to explore how mental health systems may be developed in the context of this complex, oppressive combination of homelessness and mental ill health and investigate possible interventions that may promote recovery and social inclusion.

Contemporary discourse acknowledges mental disorders as a critical global health priority and a leading contributor to the Global Burden of Disease, about 13% in one estimate (Vigo, Thornicroft, & Atun, 2016). 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, globally people with mental disorders continue to remain out of treatment. 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. The treatment gap is particularly stark in low-medium income contexts where 50-90% are out of care that can help regain health (Demyttenaere et al., 2004). Despite advances in clinical management and commitment at the policy level, these are not translating into outcomes on the ground.

Neglect of mental health exacts a heavy toll on society. In the absence of substantive public sector resources, there are visible costs associated with out of pocket expenses on medication, physician visits and so on, invariably in the private sector. More critically there are invisible costs on account of untreated mental illness that are associated with early mortality, disability, loss of productivity and unemployment. 80% of people with mental illness die before reaching average life expectancy, reducing years lived by anywhere between 10-25 years (Parks, Svendsen, Singer, & Foti, 2006). Mental ill health when not addressed leads to low workforce participation, reduced personal income, loss of power and agency in family and community transactions and inequitable access to socioeconomic resources. Costs are exacerbated by both undertreatment and delayed treatment of mental ill health which perpetuate
chronicity necessitating greater longitudinal investments for maintenance. Persistent disability affects carer participation in work increasing costs associated with care. This scenario of less than optimal outcomes foments pervasive negative notions of mental ill health and affects help-seeking and social inclusion prospects. 2011 global estimates of economic costs USD 2.5 trillion, indirect costs alone were USD 1.7 trillion (Bloom et al., 2011).

The goal of health care is not to merely prolong disease-free life and avert economic losses associated with compromised productivity. People seek meaning, ways to author their lived experiences and feel valued, lead a worthwhile life in small measures. There are multiplier effects at an individual level associated with low workforce participation - these include the loss of valued social roles, identity, relationships and dignity (Beecham & Knapp, 2001). Social exclusion of people with mental illness, characterised by neglect, abuse, segregation and organised distancing from opportunities to participate in the social, cultural, economic and political fabric, continues unabated (Drew et al., 2011). People with mental illness remain outside development initiatives as well (Funk, Drew, & Knapp, 2012), a resonant reality in India where most remain outside even basic disability benefits. In this scenario, it becomes important to consider ways in which health systems can close gaps in mental health care from the perspective of addressing this reprehensible reality of exclusion of people with mental illness.

**Mental Health Care in India**

150 million Indians are living with mental disorders (Gururaj, Varghese, Benegal, Rao, et al., 2016), 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 (Patel et al., 2016). Mental health is chronically underfunded in the country. 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. Resources infusions into community supports for mental health are negligent with no focus on social inclusion. The District Mental Health Programme (DMHP), India’s community mental health delivery platform, is challenged by existent deficiencies in public health systems. Confined within a retrograde paradigm of curative care, DMHP offers limited
access to proximal services and negligent targeted disorder-specific early intervention packages. Fragmentation between health and social sectors in the framework of delivery disregards concomitant social distress such as gender-based violence, chronic, pervasive poverty, homelessness that deeply impact mental health. Human resource deficits, both in numbers and quality, further complicate the scenario. There are not enough psychiatrists, social workers, psychologists, nurses, and even among those who work in the sector, there are familiar trappings of system reinforced medicalised orientation. 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.

**Homelessness and Mental Health**
Within this scenario, homelessness in the background of mental illness is a particularly complex issue. Homelessness and mental health represent a precarious state of double jeopardy that is further accentuated by consequent marginalisation. Structural violence is a significant determinant of who gets pushed to the fringes of society. People with mental illness living on the streets in India ensnared into a disenfranchised, invisible, fringe existence that is more often than not predicated on a background of extreme poverty and critical life incidents. Trapped in an unrelenting, cruel coupling of mental ill-health and homelessness, this injustice is further exacerbated when met with services that mirror a dogmatic curative archetype, detached from the underlying sociocultural and economic associations. In an already resource and services scarce environment, the dominant recourse oscillates between ignoring homeless people with mental illness or incarcerating their existence away from the public eye within beggar’s homes, state mental hospitals or jails. Social drift theory explains how poverty renders people with mental illness homeless, while conversely, social causation explains how poverty is involved in the maintenance of ill-health (Read, 2010). However, much of the evidence base for inter-connections between homelessness and mental health 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.
A small number of niche experiments, predominantly led by civil society actors, have emerged in the Indian context to tackle challenges at the intersection of mental illness and homelessness. These include personal recovery-oriented hospital and transit care services, work participation and employment facilitation, shelter-based services and community outreach, supported and independent living options in the community, and localised community care models focused on early intervention, continuity of care and prevention of homelessness. Unique, grounded in diverse spatial and temporal contexts and yet thematically strung by their accent on social interventions, emerging evidence of outcomes from these approaches paint a story of increased community participation, reclaimed identities and agency. Understanding ways in which these systems have developed and evaluations of interventions in the Indian context can assist in furthering knowledge necessary to translate into policy.

Based on this context of homelessness and mental health in India and the current knowledge gaps, the main question that the thesis explores is:

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 thesis considers 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 main question.
Chapter 2. Theoretical Concepts

In the previous section, I have outlined the background to this thesis and the central question. In this chapter, I present the scientific framework of core concepts that form the basis of enquiry in the thesis. In focus are:

- The relationship between homelessness, mental illness and poverty
- Marginalisation, social exclusion and inclusion in the context of mental health
- The transdisciplinary perspective on health systems development

**Mental Health, Homelessness and Poverty: Inter-relations**

The notion of mental ill health, is conceptualised in diametrically opposite forms – on the one hand there are perspectives that acknowledge these as legitimate health conditions that cause changes in thoughts, behaviours or emotions that are intra and interpersonally disruptive; while on the other some scholars have argued for the construct of mental illness as a false façade to perpetrate hegemonic forms of social and ideological control against those who diverge from the majoritarian norm. To pathologise all forms of perceived deviance from socially sanctioned thoughts, behaviours or emotions, such as homosexuality, expression of diverse gender identity beyond binaries, is unacceptable oppression that society must be rid of. Yet to deny that mental illnesses exist at all is to deny the experiences of distressing symptoms that several first-person narratives recount. To quote Elyn Saks from *Refusing Care*,

> Most people with serious mental illnesses seriously suffer. They are in pain. Not only are they distressed and disabled but they lack the ability to change by their own efforts. (Saks, 2010, p. 42)

There is diversity in the experience of mental health and ill health – some people embrace symptoms that may begin to define aspects of their identity, some have mixed experiences while yet others experience deep distress. Different healing and treatment pathways and patterns are sought – some chose clinical treatment and successfully step down from therapy in some
months or years, some remain in long-term relationships with treatment, while some prefer to pursue only alternative forms of healing. This diversity in the experience of mental ill-health and preferences and pathways to recovery informs the studies undertaken for this thesis.

In contemporary discourse, the well-being perspective on mental health has been steadily gaining momentum. Trends in positive psychology are recommending for a newer understanding moving beyond earlier notions of well-being from an absolute description of defining characteristics such as demographics, economic factors, intelligence (Wilson, 1967) to the broader understanding of well-being as being subjective, and encompassing various domains such as pleasant affect, unpleasant affect, life satisfaction (Diener, 1984); pursuing aspirations (Csikszentmihalyi, 1990); and positive emotions, engagement, relationships, meaning and achievement (Seligman, 2011). Parallelly in the field of economics, the concept of well-being has been at the centre of debates urging for a movement to consider measures of well-being as markers of growth and development, including positive elements beyond economic prosperity (Diener et al., 1999). Angus Deaton concludes his 2008 examination of income, health and well-being data from the Gallup World poll thus,

The survey measures of life and health satisfaction are direct measures of an important aspect of human experience, and economists and other social scientists need to understand what they mean, how they relate to familiar objective measures such as income and life expectancy, whether they are superior, inferior, or just different measures of well-being, and whether they are really as irrelevant as might be supposed from a reading of all but the most recent economic literature. (Deaton, 2008, p.71)

Similar developments are also mirrored in voices emerging from the user recovery movements which aim to reclaim recovery as growing beyond the reduction of symptoms and developing new meaning and purpose in life (Anthony, 1993) and influence contemporary understandings of well-being. Differentiating between clinical and personal recovery, Mike Slade (2009) points to the need to develop a more nuanced understanding of well-being,
given that priorities for recovery for persons living with mental illnesses are unique and varied. In this vein, the capabilities approach towards poverty beyond the utilitarian conception of absence of financial resources is apt to consider. Poverty is defined as fundamental gaps that prevent people from accessing and exercising their capabilities to pursue the lives they have ‘reason to value’ (Sen, 1999). This conceptualisation of poverty allows for evaluation of social, economic and political arrangements that ensure or disrupt justice. For this thesis, while perspectives of recovery, on the one hand, are concerned with individual preferences and pursuits of well-being, 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 is considered.

The associations between mental ill health, poverty and homelessness are widely acknowledged in literature, though the precise relationship parameters regarding cause-effect pathways among these multidimensional concepts remain indeterminate. Studies have established a higher prevalence of mental disorders among low-income groups, uncovered increased risks for mental illness in relation to poverty and forms of structural violence that persist in disadvantaged groups and found higher risks for downward trajectories into poverty and homelessness among those with mental illness. Read (2010) in his paper, ‘Can poverty drive you mad?’ synthesises the evidence by positing that while social causation explains ‘how poverty is a major cause of psychosis’, social drift hypothesis explains ‘how poverty is involved in its maintenance’. In this context, a study in Manhattan that examined a large service user population between 1994–2000 found a strong inverse curvilinear correlation between socioeconomic conditions and mental disorders, including schizophrenia which was not explained by downward trajectories in economic or geographical terms (Hudson, 2005). Evidence from a study examining four-year longitudinal data has emerged recently to support the simultaneous persistence of both social drift and social causation in the context of depression in South Africa (Lund & Cois, 2018).

What facets of poverty are associated with mental ill health? An analysis of nationally representative household surveys in low resource settings including India revealed greater likelihood of reporting worse mental health outcomes
among women, elderly, those who are widowed, and those in poor health. (Das, Do, Friedman, McKenzie, & Scott, 2007). The same study found no association between consumption poverty and mental health outcomes. However, in 2010, a systematic review of 115 studies examining the association between poverty and common mental disorders found an equivocal association of common mental disorders with income, employment and consumption, and consistent associations with education, food insecurity, housing, social class, socio-economic status and financial stress. Similarly, results reported from an Indonesian survey found those living on less than $2 a day were to have a 5% higher score on depression than those well off (Tampubolon & Hanandita, 2014). More recently, the National Mental Health Survey of 2015-16 conducted in India revealed greater prevalence of mental disorders, both current and lifetime, in the lowest income quintile (Gururaj et al., 2016).

Evidence has also examined the associations between serious mental disorders and poverty, particularly from the perspective of socioeconomic deprivations being a precursor to the onset of psychosis. In an early study in America, poverty was found to increase risks for mental disorders with almost eight times higher risks for schizophrenia among low socio-economic groups (Holzer, Shea, Swanson, Leaf, & al, 1986). A prospective cohort evaluation comparing adults with exposure to poverty and those without found that healthy adults exposed to poverty had a two-fold increase risk of developing a psychiatric disorder (Bruce, Takeuchi, & Leaf, 1991). A more recent study examined individual and neighbourhood socioeconomic deprivations at birth and found odds of receiving a diagnosis of schizophrenia increased with being born in poorer social class or deprived area; and these odds increased, even more, when both class and neighbourhood deprivations combined (Harrison, Gunnell, Glazebrook, Page, & Kwiecinski, 2001). These findings that household- and neighbourhood- level social disadvantage during formative years predispose people to later life diagnosis of schizophrenia is reflected in other studies as well (Castle, Scott, Wessely, & Murray, 1993; Werner, Malaspina, & Rabinowitz, 2006). Some contrary evidence also exists disproving this inverse relationship between socioeconomic deprivations (parental social class) and subsequent risk of developing serious mental ill health (Mulvany et al., 2001), though delayed access at a later age was seen
among the low socioeconomic strata possibly mediating the relationship between low SES and poor outcomes. In the Indian context, a case-control study conducted in the National Capital Region found mental illness to increase odds of multidimensional poverty (Trani et al., 2015), with a 69% difference in multi-dimensional poverty between persons with serious mental illness and those without. More interestingly, the same study found a significant interaction effect of stigma, mental illness, caste and gender, with women from disadvantaged castes with a mental illness more likely to experience poverty as a consequence of stigma than male controls.

In what ways does homelessness feature at this intersection between poverty and mental illness? On the one hand, while studies have investigated the prevalence of mental illness among homeless people, the phenomenon has been discussed mainly as an outcome of structural inequities and mental disorders co-occurring or combining in some form. Compared to rates in the age-matched general population, a systematic review of 29 surveys conducted in the West found a higher prevalence of harmful substance use, psychosis and personality disorders among homeless people (Fazel, Khosla, Doll, & Geddes, 2008). Research on pathways into homelessness has presented variegated risk factors, most of which converge on social determinants and poor mental health. Low income, poor mental and physical health, diagnosis of schizophrenia, bipolar disorder or substance use disorder, socially disadvantaged ethnicity, housing crisis/instability, family breakdown, male gender, younger age and childhood adversities are some of the more frequently reported determinants associated with lifetime experience homelessness among people with mental illness (Folsom et al., 2005; Sullivan, Burnam, & Koegel, 2000; Tsai, Link, Rosenheck, & Pietrzak, 2016). A qualitative enquiry into narratives of pathways into homelessness among participants of a large housing intervention in Canada, At Home/Chez Soi, revealed that while individual factors such as substance use, relationship and mental health issues contributed to homelessness, community level structural factors accentuated these individual risk factors and further obstructed their exit from homelessness (Piat et al., 2015). Data from a large Australian administrative database point to long-term homelessness being more prevalent among those who experienced either substance use or youth to adult pathway into homelessness, where individuals became absorbed into
the subculture and practised homelessness as a lifestyle (Chamberlain & Johnson, 2013). In the same study, people with mental health pathways also experienced long-term homelessness but did not endorse it as a way of life. Instead, in this sample, people with mental health pathways continued living rough because of lack of exit options. Draine and colleagues (2002) caution against a simplistic interpretation of mental disorders by themselves producing social problems such as homelessness, unemployment and crime, and instead argue that context of acute social disadvantage moderates the relationship between mental ill health and social problems (Draine, Salzer, Culhane, & Hadley, 2002).

In summary, mental health, homelessness and poverty share a bidirectional relationship explained by both social causation and social drift. Mental illness carries higher risks for poverty and homelessness, and conversely, higher rates of mental illness are observed in those who live in poverty and homelessness. A multidimensional construct of poverty explains underlying risks factors for homelessness concurrent with mental illness. Structural violence, at the individual, family and geographical levels, predicts the downward trajectories into mental ill health, poverty and homelessness and prevents successful exits from conditions of deprivation.

**Marginalisation, Social Exclusion and Inclusion in the context of Mental Health**

Extending the capabilities approach, Ware and colleagues (2008) argue for the conceptualisation of social integration as a significant quality of life indicator in contrast to utilitarian formulations that emphasise income and satisfaction. They define social integration “as a process through which individuals with psychiatric disabilities develop and increasingly exercise capacities for interpersonal connectedness and citizenship.”

The recurrent, recursive relationship between mental ill health poverty and homelessness marginalises those caught at the cusp of these challenging realities, engendering their exclusion from all spheres of the societal system, and the associated rights and privileges. The widespread social exclusion of homeless people with mental illness manifests in several ways. Urban geographies turn inhabitable and hostile with receding spaces for homeless
people with mental illness. Homeless people with mental illness remain out of employment, suffer from poor health, and have increased risks of crime, abuse and suicide and a higher rate of death than a comparable general population (Babidge, Buhrich, & Butler, 2001; Cheung & Hwang, 2004). Pervasive enduring human rights abuses continue to be perpetrated against people with mental illness across civil, cultural, economic, political, and social rights (Drew et al., 2011). Homelessness is often criminalised, and high rates of jail incarceration among those with mental illness are observed in several countries (Greenberg & Rosenheck, 2008; McNiel, Binder, & Robinson, 2005). In India, the legacy of anti-poverty legislation and its ramifications have resulted in a substantial penalty for those who are poor and homeless, who are left to navigate an unforgiving circuitous path between custodial institutions and the streets (Raghavan & Tarique, 2018).

Asylums were first established based on the ‘moral treatment’ paradigm that advocated for humane psychosocial environments, sometimes departing from medical treatments, freeing people with mental illness from chains, opening up grounds for mobility and recruiting them as staff. There were features of control such as rewards and punishments associated with the model of ‘good patient’ through engagement in work within family-like communities. By the 19th century, a majority of these asylums had adopted a pernicious nature, segregating the ‘insane’ from the ‘sane’ in far-removed geographies. Michael Foucault (1965) characteristics asylums born out of ‘moral treatment’ as ‘moral imprisonment’ - structures that subjugate and establish conformity to the majoritarian social order. Goffman’s provocative examination of the social situation of people with mental illness detailed in his book Asylums (1961), that emerged from a participant ethnographic research at St Elizabeth’s hospital, describes these places removed spatially from society as ‘total institutions’ producing the very same disordered conducts, for which people had been ostensibly admitted, through oppressive regimes.

In the 1960s-1970s, a combination of the arrival of new therapeutics, alignment with feminist and disability movements of social justice and sustained advocacy by user-survivors such as Judi Chamberlain started the process of deinstitutionalisation that returned people from hospitals to
communities, reduced hospital sizes or in some cases moved hospital beds to community centres. Deinstitutionalisation movement produced different results in different countries. Some scholars have noted that when the process was not accompanied by necessary supports, this return to deprived socio-economic environments in communities, resulted in homelessness, unemployment, repeated admissions or ‘revolving door’, or worse incarceration in prisons (Bachrach, 1976; Warner, R, 1989; Goering et al 1984; Munk-Jørgenson, 1999; Raphael & Stoll, 2013). However, there is evidence from high-income countries that initiatives to enable the transition of people staying long in institutional spaces into community care can accomplish favourable outcomes if carried out with adequate creation of supports and a diverse allocation of services across a continuum of care from hospital to community based (Tansella, M., 1985; Leff et al 2000; Rothbard et al 2000). However, social integration outcomes, such as developing relationships, work and community participation continue to remain inconsistent and low (Gerber et al., 2003; Tsai, Mares, & Rosenheck, 2012). Communities may continue to propagate structural violence and discrimination as they are located in the same landscape as hospitals, and people with serious mental illness may be harmed through relocations into deprived communities that are ‘unreceptive, uncaring and resistant’ and do not have necessary supports (Pattison & Armitage, 1986). In Pat Capponi’s memoir *Upstairs in the Crazy House* she recounts narratives of despair, depression and societal indifference she experienced and witnessed as a service user who was shifted to a group boarding home, painting a complex picture of true benefits of community living and housing options that have gained traction as buzzwords recently in addressing homelessness and mental illness.

Closer home in India, asylums arrived with the East India Company and mirrored a similar pathway of developing into totalitarian regimes vested with racial prejudice – while in the initial years indigenous socio-medical explanations of presenting symptoms appeared in formulations, in the later years distinctions between the superior Western mind and the native mind emerged (Radhika, Murthy, Sarin, & Jain, 2015). Mapother as early as 1937-1938 noted the deplorable conditions marked by desolation, overcrowding and indifference and made several recommendations not very different from those being reiterated today to improve these facilities (Murthy & Isaac,
This was followed by the Moore Taylor report in 1946, which after ten years noted the very same continuing conditions of custody and detention and recommended modernisation of these hospitals with adequate training of staff, community engagement, outpatient clinics, and work therapy (Murthy & Isaac, 2016). In the late 1980s, a series of litigations culminated in the appointment of The National Human Rights Commission (NHRC) to monitor and improve conditions of the state mental hospitals across India. In the two decades since the while there have been several initiatives, workshops and meetings, including the declaration of these facilities as Centres of Excellence with a grant for improvement, the situation remains unaltered (Murthy, Kumar, Desai, & Teja, 2016).

In summary, historically, institutions and community re-entry interventions such as reintegration to family and community living have emerged in response to the unabated social exclusion and rights abuse of people with mental illness. Mixed experiences are indicated in applications of these approaches. Repeated attempts of reform of large institutions in India have failed, indicating the necessity to use a different framework towards health system change.

**The Transdisciplinary perspective on Health Systems change**

The World Health Organisation (WHO) defines health systems as encompassing “activities whose primary purpose is to promote, restore, improve or maintain health, protect people against the impoverishing effects of illness, and ensure that those who need care are treated with dignity and respect.” (WHO, 2000). Further to this definition, WHO offers a framework (Figure 2.1) for analysis of health systems by describing six components that must collaboratively work towards four key goals – improved health (including equity), financial risk protection, responsiveness and efficiency. A well-functioning health system in this framework is one that offers safe, effective, quality health services efficiently through a responsive health workforce. These include necessary evidence-based, cost-effective technologies. In this endeavour, the health system is supported by systematic information on determinants and performance by a health information system and with adequate investments through a health financing system that ensures people are not impoverished by out of pocket
payments. Finally, the framework emphasises **Leadership and governance** that engages in strategic system design, coalition-building, and provision of appropriate regulations and incentives, and ensures accountability.

**Figure 2.1: WHO Health System Framework**

The WHO definition and framework illustrate that mental health systems perform a vital function in redressing marginalisation of people with mental illness, particularly those facing concurrent homelessness and poverty, by eliminating inequities that persist with ill-health. Mental health systems globally have witnessed reform shifts in two areas: the first is the deinstitutionalisation that ascended in response to the enduring atrocities in mental health services highlighted by the user-survivor movement in the West, and the second is the shift of care from tertiary acute care centres to primary health care. These changes initiated in the 1960s-1970s have offered mixed results as discussed in the previous section, as well not transcended into meaningful benefits in low to medium income countries which continue to face enormous treatment gaps with a substantial number of people remaining out of the care.

In the last decade, ‘global mental health’ has developed as a movement of collaborations between academicians and practitioners across many countries.
engaged in systematically evaluating interventions, more often than not using randomised controlled trials, with the aim to scale up initiatives and close treatment gaps. The agenda and knowledge base of this movement, more so the WHO policy, have been criticised to be western influenced, culturally irrelevant fixes that are not applicable to LMICs and therefore bound to fail (Jakubec, 2004; Summerfield, 2013). Marginalised populations, such as those living in homelessness and poverty, face conflated difficulties of mental ill health along with prevailing socio-economic, cultural and political conditions. Within seemingly homogenous contexts, there is heterogeneity in illness manifestation, their meaning in the lives of people and user needs. Cultural formulations in mental health focus on the emic perspective eliciting user perspectives on illness including aetiology, the course of illness, treatment expectations and their role (Littlewood, 1990). Moreover, the influence of culture on human psychology and behaviour is so significant, that universal theories of human nature often derived from western experiential subjects are not applicable to other cultural contexts (Henrich, 2009). The pervasive failure of mental health care reform historically in several countries including India combined with the unique socio-political position of homeless people with mental illness necessitates an examination regarding the consonance between nature of mental health problems and health systems responses.

The intersection of mental health, homelessness and poverty and the challenge of marginalisation that occurs in the context of this nexus represent complex and persistent problems. Analysing from the framework offered by (Rotmans, 2005) this nexus is rooted in social structures, characterised by a multitude of actors who pursue their own agendas and do not engage in any dialogue, and is unstructured in that the precise mechanisms of how it is produced, sustained and propagated remain undefined and unknown. This intractable nature of the nexus combined with discontents concerning its nature, facts that define it and value orientations that may guide redressal mechanisms contribute to a disinclination to engage among policy makers (Hisschemöller & Hoppe, 1995) and result in repeated applications of predetermined, fragmented template approaches. Several authors have argued that the complexity of healthcare makes normative or typical approaches towards change in the health system ineffective (Atun, 2012; Broerse & Bunders, 2010; Plsek & Greenhalgh, 2001). Commenting on the
futility of attempting to solve a large complex problem by breaking it down into smaller parts, (Plsek & Greenhalgh, 2001, p.625-8) write:

…. the machine metaphor lets us down badly when no part of the equation is constant, independent, or predictable.

In mental health, poverty and homelessness, we see that despite decades of intent and pursuit of reform both globally and within India, there has been widespread system failure with large treatment gaps in low-medium resource settings. Such system failures can be countered only with radical restructuring of societal systems, a transition “that is the result of coevolution of economic, cultural, technological, ecological, and institutional developments at different scale levels” (Rotmans & Loorbach, 2009). The constellation perspective of health systems proposes three parameters – structures (economic, financial, legal, power structures that enable and constrain actors), practices (operations actors carry out for the system to function) and culture (dominant values) (Van Raak, 2010). For a fundamental transition in a health system to occur, all three must change. How can such radical restructuring be pursued?

Transdisciplinary research process emerges as an alternative to conventional methods of problem-solving. In contrast to monodisciplinary and interdisciplinary research, transdisciplinarity entails both crossing contours of diverse disciplines and adopting equitable participatory mechanisms for normatively segmented scientific and non-scientific actors to collaboratively deliberate, dialogue, and synthesize such collectively produced knowledge to influence research agendas and policy (Bunders et al., 2010; Gibbons & Nowotny, 2001; Regeer & Bunders, 2003; Thompson Klein, 2003). This calls for a new mode of potentially transformative praxis, iterative experimentation guided by collaborative, democratic learning and reflexivity, embedded and contextualised within realities of grassroots constituencies. Critically analysing the potential of transdisciplinarity in reconceptualising the social work paradigm of community organisation (CO) (Andharia, 2013) draws attention to features that define CO – actors organised on the basis of the common thread in their experiences, negotiating sociopolitical institutions and structures and the dialogue-praxis cycle. For those with significant experiences of systemic oppression, that has disempowered and dispossessed them from spaces of deterministic knowledge-making regarding their
realities; transdisciplinary processes may offer the opportunity to reclaim their agency in change processes with personal and political implications. How can the transdisciplinary paradigm be applied to health systems transformation for marginalised populations?

The scientific field of system innovation and transition management offers the theory that can inform mechanisms to bring together diverse stakeholders to engage in experiments and integrate learnings which may be diffused for system-wide effects. Broerse and colleagues (2010) describe the three central notions in system innovation and transition management theory: the multi-level perspective, the multi-phase concept and transition management. The multi-level perspective illustrated in Figure 2.2 (Geels, 2002) involves three levels of social organisation in the transition process:

1. The landscape level (macro): Containing the macro social, cultural, economic, political climate in which transitions occur. This includes the economy, natural environment, worldviews, value orientations and social norms. The landscape influences both the regime and niche levels, though it typically develops independently.

2. The regime level (meso): Consists of a variety of actors who transact with each other through a dominant culture, structure and practice. The regime offers stability by determining decision making and actions of actors within a system. Due to this inherent function, regime is resistant to change. However, significant pressure from trends at the landscape level and networks of successful niche experiments can catalyse necessary transition.

3. The niche level (micro): Consists of individual actors developing and testing radical innovations - novel cultures, structures, and practices - transformative ways of approaching and solving problems that cannot be realised within the dominant, unchanging regime.
The multi-phase concept presented in Figure 2.3 conceptualises transitions to occur across four sequential phases over time:

1. Predevelopment phase: There are experiments at the niche level, which do not possess necessary critical mass to influence the regime level which resorts to optimising existing structures and practices. Status quo is thus maintained.
2. Take-off phase: With emerging positive feedback on niche experiments, aspects begin to diffuse at the regime level. Change is initiated but is not widespread as yet, and the direction of change remains unknown.
3. Acceleration phase: Networks of niche actors emerge and achieve critical mass through their influences on social, cultural, economic and institutional structures. Knowledge is collectively integrated, diffused and embedded in the regime. Change becomes more evident as more parts of the system adopt radical new approaches and there are structural transitions.
4. Stabilisation phase: A new equilibrium emerges as new ways of thinking and acting replace the old regime.

![Figure 2.3: The multiphase model](image)

Transition management offers heuristics for influencing these complex change processes wherein actors can coalesce and collaborate in a social learning process through shared visions and coordinated niche experiments. Hans de Haan and colleagues (2011) offer three broad patterns of transition pathways: reconstellation, empowerment and adaptation. **Reconstellation** is top-down change imposed on the system, where landscape-level change induces a new regime. Change may fail if regime actors are resistant and unable to adhere to the new norms. **Empowerment** is bottom-up change which occurs when a new regime is established, and niche experiments are mainstreamed at the regime level. In such instances, backlash may emerge when structures, practices and cultures of the incumbent regime are unable to cope with the change. **Adaptation** is change that is internally induced by the regime. Regimes with no pressures from landscape or niche levels may develop lock-in and stabilise. van den Bosch et al (2008) describe a conceptual framework to analyse steering of transitions consisting of three notions: **deepening** or novel learning and experimentation within a context, **broadening** or replication of experiments in diverse contexts to broaden learning and increase applicability and generalisability and finally **scaling-up** which requires embedding of the innovation at the regime level. Besides these conceptual frameworks, which assist in understanding, diagnosing and planning for health system change,
the allied theory of action research offers methods for organising group learning to induce fundamental change. System innovation theory generates insights on system change, while action research makes evident learning from personal trajectories of innovation development and thereby complement each other (Hoes, Regeer, & Bunders, 2008).

These concepts are embedded in a variety of ways in this thesis to understand development of mental health systems and interventions that promote recovery and social inclusion in the context of the marginalising homelessness and mental health nexus. They have guided choice of research methods and process; and served as analytical frameworks for contextualising the learnings from this thesis for broader change in the Indian mental health sector. In the next chapter, the research design of the thesis is described, and in chapter 4, the setting of this thesis is discussed by analysing the Indian discourse in mental health and homelessness to unpack challenges that persist and result in intractability of the problem.
Chapter 3. Research Design

The preceding chapters briefly outlined the present gaps in knowledge base for understanding and tackling the intersections of homelessness, poverty and mental illness in low to medium income contexts. This thesis employs a theoretical framework that conceptualises the homelessness-mental ill health-poverty nexus as an unstructured, social challenge of grave marginalisation and recognises the significance of indigenously developed solutions in contributing to robust knowledge that can help address such complex problems. The aim of this thesis is, therefore, to contribute towards closing knowledge gaps by exploring the challenge of homelessness and mental illness in India, the possible gains of a contextually developed mental health system and interventions nested within for homeless people with mental illness. The main research question is:

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 is 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 explores the interrelations between homelessness, poverty and mental illness and sets the background for the rest of the enquiry. Part 2 of the thesis considers the experience of a not-for-profit organisation
in developing responses for homeless people with mental illness over a twenty-year period and assists in identifying features and processes underlying the development of a mental health system that is responsive to issues of marginalisation. Part 3 of the thesis evaluates, using mixed methods, two interventions, first, an emergency care and recovery centre and second, a housing with supportive services approach, for homeless people with mental illness and considers their effects in relation to recovery and social inclusion and derives policy and practice implications on the basis of this analysis.

**Research Approach**

This thesis uses an interactive approach combining quantitative and qualitative studies to answer the main question, and associated sub enquires. Quantitative methods of investigating phenomena assist in constructing broad-based discourses where data may be synthesised, and effects of statistical significance established. Qualitative methods of understanding phenomena are well suited to explorations of context bound processes, structures and narratives that are characteristic of sociologically embedded enquires. A combination of data from both paradigms may be suited to generalised interpretations with rich, granular descriptions of uncovered facts and better understanding of clinical and societal relevance of effects discovered in a sample. Literature points to the several advantages that the complementarity of quantitative and qualitative methods is able to offer - such as qualitative hypothesis generation followed by quantitative testing to understand multifactorial, under-researched phenomena, opportunity to triangulate and discuss discordant and concordant findings emerging from each paradigm, obtaining a more complete picture of the domain under study and their suitability for studies involving vulnerable groups wherein participant perspectives must gain primacy (Creswell, Klassen, Plano Clark, & Smith, 2011; Johnson & Onwuegbuzie, 2004; Lund, 2012; Routledge & Kelle, 2006). In this thesis, I attempt to approach the main question using a mixed methods lens integrating data emerging from both strands of enquiry to construct possible answers to my questions. Five studies form this thesis where both paradigms of approaching research questions have been applied independently or in combination based on pragmatic choices of suitability and feasibility. The five studies, the corresponding methods and the reason for these choices are elucidated below.
Part 1: Understanding the Homelessness, Mental Health and Poverty Nexus

The first part of the thesis concerns with interrogating the nature of recursive interrelations between homelessness, mental health and poverty. Homeless people with mental illness are amongst the most disadvantaged and oppressed sections of society. Pervasive abuse and victimisation (Latalova, Kamaradova, & Prasko, 2014; Wenzel, Koegel, & Gelberg, 2000), disenfranchisement (Chaudhry, Joseph, & Singh, 2014) and distancing from variegated socio-economic resources (Desai et al., 2008) are some of the deleterious effects of concurrent homelessness and mental illness. In this part of the thesis, I attempt to unpack the interwoven strands of these phenomena that present a particularly difficult challenge for health systems and set the context for subsequent sections of this thesis that considers potential mental health system responses and interventions. The first enquiry (Chapter 4) consists of a narrative review of literature to answer the following sub-question:

1. What are the challenges at the intersection of homelessness, mental illness and poverty nexus in the Indian scenario?

The sub-question focuses on developing a conceptual understanding that necessitates theoretical and critical exploration and analysis. Therefore, Chapter 4, adopts a critical review methodology (Grant & Booth, 2009). It is based on a narrative review of literature on poverty, homelessness and mental illness, both independently and in relation to each other, in a global and local context. The review includes a summary of contemporary discourse in mental health in India. By juxtaposing the nature of concurrent homelessness, mental illness and poverty with the Indian reality of mental health, the review analyses ramifications for practice, research and policy.

The second enquiry (Chapter 5) focuses on the intersections of gender with homelessness and mental illness and attempts to answer the following sub-question:

2. What are the predictors of homelessness among women with mental illness?
Chapter 5 is based on part of a larger mixed methods study that uses a cross-sectional survey of women with mental illness (n=346) accessing rural and urban outpatient clinics in Tamil Nadu. Data elicited included socio-demographic characteristics, history of homelessness, trajectories of mental illness and critical life events. Data were summarised to compare those with homelessness and those without using descriptive statistics (mean and standard deviation or median with interquartile range for continuous variables; frequency and percentage for categorical variables). T-tests, Mann Whitney U and Chi-square tests of association were performed to examine differences between the groups. A multivariate logistic regression model was used to uncover predictors associated with increased odds of becoming homeless among women with mental illness. Data were analysed using SPSS 22.0 and R.

**Part 2: Responsive Mental Health Systems: Features emerging from praxis in the Indian context**

The second part of the thesis focuses on understanding ways in which mental health systems may be developed in the context of deep rooted marginalisation arising out of concurrent homelessness, mental illness and poverty. In Chapter 6, I focus on the sub-question:

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?

Chapter 6 analyses the timeline narrative of The Banyan, a two-decades old organisation in Tamil Nadu (India) working in the homelessness-mental health space, using an action-reflection learning framework. The choice of The Banyan as a case to examine the construction and evolution of a mental health system was driven in large part by my association and that of my co-authors with the work of the organisation. Michael Oliver points out:
As researchers, then, we labour to produce ourselves and our worlds. We do not investigate something out there, we do not merely deconstruct and reconstruct discourses about our world. Research as a production requires us to engage with the world, not distance ourselves from it, for ultimately we are responsible for the product of our labours and as such we must struggle to produce a world in which we can all truly live as human beings. (Oliver & Barnes, 2012, p. 30)

The schema of knowledge creation and enhancement within a constructivist paradigm also relies on experiential learning: the creation or addition to knowledge by doing and engaging with reality. In transdisciplinary research, unstructured, complex and persistent social issues are recognised to require engaged and embedded processes of evolving innovative solutions (Bunders et al., 2010). In contrast to colonised forms of expert knowledge, these practical action-based niche experiments are acknowledged as empirically valid experiential knowledge, co-produced and integrated by actors in context (Regeer & Bunders, 2003). Chapter 6 derives from these methodological paradigms wherein the collective enquiry of various actors in The Banyan – the constituency, staff, leadership – is examined retrospectively.

**Part 3: Interventions to promote recovery and social inclusion**

The third part of this thesis attempts to understand the influences of two select interventions that intend to promote social inclusion of homeless people with mental illness. The first intervention selected is a 120-bed tertiary emergency care and recovery centre run by The Banyan in the city of Chennai in India. The facility offers crisis intervention services for homeless women with mental illness, multidisciplinary care followed by personalised plans for community re-entry that range from reunion with families, independent living with employment or referrals to other long-term care options. The sub-question of the study is:

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?
Quantitative data of service use maintained by the Monitoring and Evaluation Department of The Banyan for the period 2014-2017 were examined to understand background characteristics of service users and evaluate reintegration and continued care rates. Descriptive statistics were used to summarise the data. Data were combined with interim analysis of qualitative in-depth interviews with select participants of same population that were undertaken as part of a book by one of my co-authors. The outputs were critically evaluated against the background of the intervention’s placement on a continuum of care and the contemporary mental health law and policy climate in India to draw implications for the mental health sector in the country. Chapter 7 describes the findings from this study.

Chapter 8 is based on the analysis of repeated measures that were gathered as part of a quasi-experimental, mixed method, two group trial, investigating the effects of Home Again (HA), a housing with supportive services intervention, for homeless women with mental illness experiencing long-term needs. I was a co-Principal Investigator for this trial, and the pilot phase was undertaken predominantly in Thiruporur Taluk, Tamil Nadu between 2014-2016. Home Again offers the opportunity to live in a home in ordinary rural or urban neighbourhoods, shared with peers from similar circumstances, with the option of an onsite personal assistants who are support staff available to assist in diverse domains of living from caring for self, use of transport to pursuit of leisure in ways that service users desire. Chapter 8 addresses the following sub-question:

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?

Service users with one or more years of stay across The Banyan’s institutional facilities, with low prospects of other forms of reintegration, irrespective of levels of disability, were interviewed for their preferences. 53 participants allocated to HA based on preferences were compared prospectively over an 18-month period with a matched cohort of 53 participants who remained in Care as Usual (CAU) or one of the institutional facilities. Data were gathered through face to face interviews with the participants every 6 months on
outcome measures of community functioning, psychological health and quality of life. Descriptive statistics were used to compare baseline characteristics of the two groups. Generalised Estimating Equations (GEEs) were used to examine statistically significant effects over time after controlling for baseline characteristics. Data were analysed using SPSS.

Chapter 4 to 8 jointly address the following question in light of their respective findings, that are summarised in Chapter 9:

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?

As discussed previously in the Introduction to this thesis, mental health care in India is characterised by chronic underfunding, tertiary care dependence, low community care provision and poor cross-sectoral integration. However, recent changes in the law where both the acts pertaining to mental health care and disability were replaced with progressive, rights compliant version and an intent to close these gaps articulated in a national policy, present the opportunity for transformative action. Therefore, the existent reality of mental health service provision, policy, law and discourse are critically examined to derive prospects for system reform based on results from the five studies in this thesis.

**Research teams**

There were four research teams engaged in the studies that form this thesis. The teams included mental health professionals, lay health workers and research associates. I was co-principal investigator in the studies pertaining to Chapters 5 and 8, and principal investigator in enquires that form the basis for Chapter 6 and 7. In my role as co-PI for the study pertaining to Chapter 5, I jointly conceptualised and designed the research with my colleague, planned, supervised and conducted the final analysis and wrote the article integrating inputs from co-authors. For Chapter 6, I participated in the formulation of the enquiry, gathered the data, analysed it jointly with my colleagues through the process of deliberation and wrote the article along
with co-researcher and supervisor, integrating intellectual inputs from the other authors. For Chapter 7, I designed the enquiry based on secondary data available from the Monitoring and Evaluation Department, conducted the analysis and wrote the article integrating inputs from the co-authors. As co-PI in the pilot of the Home Again intervention that forms the basis for Chapter 8, I led the quantitative repeated measures evaluation by designing the evaluation and instruments, validating the measures, gathering data and supervising overall data collection, conducting the analysis and writing up the final article. Also, I was part of the implementation team of the intervention evaluated in Chapter 8, allowing for reflexivity and participatory dialogue in the process of research.

Validity
Both quantitative and qualitative data can have a number of limitations that can reduce validity. In this thesis, I attempted to conserve validity through the following strategies:

- Gathering data on the context in which studies occur and basing analysis in the frame of this understanding
- Piloting of all instruments and making changes based on feedback from constituency and responses from multiple members of the research teams
- Repeating interviews, independently auditing data to ensure consistency in interpretations of various items, suitability for population and concordance/discordance between data elicited through different researchers in the same team
- Using methodological triangulation through application of diverse methods
- Triangulating with multiple researchers embedded in the various research teams
- Soliciting feedback on article drafts from experts outside the research teams
- Searching for discrepancies or contradictions in broader evidence in the process of formulating conclusions based on findings of this thesis
Exercising reflexivity to gauge how personal presence and practice affects the research process

Ethical Considerations
All studies described in this thesis were independently evaluated by the Institutional Research Review Board of The Banyan and The Banyan Academy of Leadership in Mental Health (BALM) prior to the start of the studies. Chapter 4 was a narrative review of existing literature, and ethical approval was not sought. Science is useful only when benefits accrue to people – in the case of the thesis the constituency of homeless people with mental illness. This was considered of prime importance ethically and all studies reported are shaped by feedback acquired during the course of practice interactions with the constituency and with considerations of sustainability of intervention beyond study period in the case of Chapter 8 that sets up and evaluates an intervention prospectively. Participants of all studies remained anonymous, and no names were used during analysis or reporting of study results. To facilitate decisions on consent to participate or not for studies used in Chapter 5 and 8, participants were informed about the purpose of studies in addition to their rights as participants. These included the right to choose intervention in case of the Home Again evaluation, the right to refuse to answer all or any part of the instruments, the right to leave interviews/focus group discussions/other workshops at any point and the right to decide to withdraw their information at a later point. They were also given the contact details of a researcher in case they have further questions about the study or their data. Legal implications of a housing intervention, protection of rights such as choice within care including exit from intervention, adverse events such as death or interpersonal violence necessitate ongoing ethical oversight mechanisms for work with marginalised populations. For this purpose, three service users served as independent observers for Home Again.
# Outline of thesis

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Study</th>
<th>Participants/Data Sources</th>
<th>Chapter /Part</th>
</tr>
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<td>Persistent, complex and unresolved issues in the Indian discourse on mental ill health and homelessness</td>
<td>Critical Review</td>
<td>-</td>
<td>4, Part 1</td>
</tr>
<tr>
<td>Predictors of homelessness among women with serious mental disorders accessing outpatient clinics in The Banyan, Tamil Nadu</td>
<td>Cross-sectional Survey</td>
<td>346 women with mental illness from four mental health clinics (urban and rural) of The Banyan in Chennai and Kancheepuram districts</td>
<td>5, Part 1</td>
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<tr>
<td>Responsive mental health systems: A conceptual framework emerging from The Banyan’s experience in Tamil Nadu, India</td>
<td>Timeline Narrative, Action Learning Framework</td>
<td>20 annual reports, 3 evaluation studies and 4 key informants (service users and staff) from The Banyan</td>
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<tr>
<td>Homelessness and Mental Health Care: Lessons from The Banyan experience in Chennai, India</td>
<td>Retrospective longitudinal service evaluation</td>
<td>Service indicators maintained for 203 participants who used The Banyan’s Emergency Care and Recovery Centre</td>
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<tr>
<td>Home Again: Effects of a Housing with Supportive Services intervention for Homeless women with mental illness in India</td>
<td>Non-randomised controlled two-group trial</td>
<td>126 participants, 53 in Home Again intervention arm and 53 in Care as Usual comparison arm</td>
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