Chapter 9. Discussion and Conclusions

This thesis aimed to understand pathways towards social inclusion of women affected by double jeopardy of homelessness and mental illness. Chapters 4 to 8 present the results of enquiries that I engaged in as part of research teams. In this chapter, I synthesise these findings and present the conclusions of this thesis guided by the 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?

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. In this chapter, I revisit these sub-questions and discuss findings in the context of literature. This is followed by a reflection on implications for practice and future research. Finally, I comment on the validity and transferability of the findings from this thesis by considering methodological issues.
Sub-question 1: What are the challenges at the intersection of homelessness, mental illness and poverty in the Indian context?

Chapter 4 critically considers literature and current realities to review challenges situated in the nexus between homelessness, mental illness and poverty in the Indian scenario. Understanding entrenched strands that define complex, persistent problems may assist in developing and examining innovative formulations that address these issues with fresh perspectives and new strategies. Several challenges in the Indian context emerge from this paper, which may be divided into those at the landscape level (social, economic and political setting or context) and those at the regime level (health and social care systems, organised state and non-state actors) using a multi-level perspective (Geels, 2002).

At the landscape level, entrenched caste, class and gender-based prejudices intersect with mental health to produce enduring and intractable social liabilities that dispossess particular groups of people and cause serious injustice, increasing risks for a downward trajectory of extreme poverty and homelessness. The sociological imagination of people with mental illness is defined by images of violence, deviance and incapacity, aided in part by the conditions of large asylums established in the colonial era that serve as modern-day state mental health facilities. Similarly, homelessness is widely criminalised and perceived as a function of one’s own poor choices. Rather than recognising these conditions as products of social oppression and unjust economic order, such perceptions posit people with mental illness living in homelessness outside of the acceptable social order normatively dictated by the majority. Despite the rising tide of discourse on mental health as a public priority, the recognition of mental illness as a leading contributor to healthy years lost to disease is not matched by widespread public outrage and demand for better services.

There is evidence of nearly four decades of expressed intent to improve access to mental health care, in the form of the National Mental Health Programme (NMHP). However, these constructs of intent are driven by predetermined templates offered by international players, with limited acculturation to local needs and sensibilities, and dominated by World Health
Organisation’s (WHO) recommendations of transferring care to the community by introducing mental health at the primary care level. In an inequitable context, the vision of improved mental health access fails to translate at the regime level. Although one could argue that the District Mental Health Programme (DMHP)’s design was also informed by pilots undertaken in select districts in Karnataka, the process of knowledge production, particularly in the scale-up, was not wholly adaptive with changes and transitions informed by shifting dialogue among a diverse set of actors. A small degree of inter-disciplinarily does permeate the recorded intent of DMHP with sections devoted to life skills and livelihood. However, the overwhelming emphasis in practice on dispensing of medication whether through Psychiatric Camps or at Primary Health Centres (PHCs), diminish the other components. Transdisciplinarity engages both diverse disciplines that explain phenomena and multiple stakeholders who dialogue about the phenomena to reflexively develop solutions to persistent, complex problems. This aspect of knowledge co-production may be essential for sustainable approaches in dealing with problems that are characterised by multifactorial causes and manifestations and multiplicity of actors. However, the macro climate of policy direction and intent driven by outside influences in India remains inflexible to adaptations given preparedness of regime structures and politics among various regime networks. Further, it is disjoint from niche level narratives and experiences. Accessibility apart, deficits in the services to address micro-level, diverse realities render them inefficacious in making meaningful contributions to people’s lives. Worldviews generated independent of dialogues with micro, and meso-level actors bias a top-down approach towards addressing social problems, diminishing their feasibility, acceptability and appropriateness in local contexts.

At the regime level, public health systems in India suffer from chronic underfunding, infrastructure and human resource deficits, regarding quantity and quality with gaps in knowledge, skills and value orientation to serve a recovery focus beyond remission of symptoms. Even with the expanded health sector outlay in the most recent Central government budget of 2018, the investments are primarily towards public health insurance purported to improve access by putting private players within reach of those who cannot afford such services. A tertiary bias permeates mental health funding where
the forty-three institutional facilities in India garner the majority of the limited outlay. The delivery of interventions and services are fragmented within healthcare itself where comorbid conditions are often underdiagnosed and left untreated. With no synchronised delivery with social care systems, underlying determinants of multi-dimensional poverty that both produce and persist diseases, are left unchecked. Social care schemes propagated by the Centre and State governments in shared forms under a federal system are beset by an array of endemic problems. Besides funding that is disproportionately low to the size of social problems in India, bureaucratic hurdles in financial transfers and expending of resources, dynamics in beneficiary identification and disbursement and ill-defined mechanisms of delivery lead to the exclusion of most populations who need such supports. The National Mental Health Programme (NMHP) initiated in 1982, and the corresponding District Mental Health Programme (DMHP) is expected to ride on these very same systems in the effort to enhance access to care. Unsurprisingly, translations in the past four decades have been sporadic and marked by a failure to achieve scale.

The regime level is further complicated by divergent perspectives regarding the nature of mental health and homelessness, consequent priorities and desired service formats among various actors in India. Lobbies in the Indian mental health sector, while highly diverse, may be considered from two perspectives for analysis – one that emphasises the right to autonomy and agency and second that derives from the right to health. The right to autonomy and agency perspective argues for the urgent need to empower users to make their own choices, including the choice to reject treatment, while the right to health emphasises on the primacy of care and early intervention for mental illness. There is lack of consistent dialogue among various actors and low representation of voices of people who have experienced both mental illness and homelessness to help intercede these differences beyond binaries to address deprivations that can assist people in their path to securing rights.
Sub-question 2: What are the predictors of homelessness among women with mental illness?

Chapter 5 reports the results of a cross-sectional survey of 346 women accessing mental health clinics in Chennai and Kancheepuram districts of Tamil Nadu (India) that was used to examine history of homelessness. Comparison of women with homelessness and without homelessness, followed by multivariate logistic regression was employed to unpack predictors that increased odds of becoming homeless among women with mental illness. The analysis revealed disruption in relationships and low educational attainment, both of which are factors that indicate gender-based disadvantage, to predict higher risks for homelessness among women who received diagnoses of serious mental disorders. In the current scenario of limited literature on homelessness, gender and mental health in India, these findings offer a small beginning. This is consistent with current literature that points to the interplay of relationship issues and gender biases with mental ill-health in pathways to homelessness among women with mental illness (Buckner, Bassuk, & Zima, 1993; Hamilton, Poza, & Washington, 2011; Padgett, Hawkins, Abrams, & Davis, 2006).

There were significant differences in caste between those who experienced homelessness and those who did not — greater proportion of women with history of homelessness were from the disadvantaged castes. However, this did not show up significantly in logistic regression models possibly because low sample size in reference category of forward caste prevented meaningful comparisons. Income did not show up in this analysis. However, this may again be attributable to the fact that the sample was drawn from clinics that attracted low-income households. An interesting collobary that emerges from this observation is that within a homogenous group of low-income families, there are indications of differences in female educational attainment which was associated with increased risks for homelessness and that perhaps the role of neighbourhood deprivation in perpetrating inequities and risks for homelessness needs to be examined.

History of mental health treatment and diagnosis did not predict homelessness in this sample contrary to the popular hypothesis echoed across
several practitioners that if early treatment is ensured, homelessness among people with mental illness can be curbed. One perspective to take is to acknowledge that seeking treatment may not equate with appropriate and effective treatment. A variety of reasons could have interfered with treatment efficacy – services may have been constrained and deficient in many ways to offer the evidence-based interventions and family dynamics and gender disadvantage may have resulted in failure to engage over a longer period for uncertain future outcomes central to medical management of chronic diseases, although differences in reported adherence were not present in this sample. Conversely, one may argue that lack of redressal of underlying problem, social intersections of presenting symptoms, may have caused disengagement. In fact, in this sample, a clear majority of people had sought treatment, and yet some of them ended up homeless, with the difference in risks being explained by the experience of gender-based disadvantage. Structural violence rather than mental illness is implicated in risks for homelessness, as some scholars have suggested earlier. Evidence demonstrates that early treatment in psychosis is associated with superior outcomes (Craig et al., 2004; Petersen et al., 2005; R. Rosenheck et al., 2016). However, forms of early treatment accessed by marginalised communities may not have sufficiently mirrored the best possible evidence, and treatment alone appears insufficient in the face of concurrent social adversities.

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. Data of 44,769 youth from a sub-nationally representative survey from India revealed that patterns of gender socialisation are associated with mental health (Ram, Strohschein, & Gaur, 2014). Gender discriminatory practices favouring male over female in households were associated with an increase in mental health problems among females, whereas the same were associated with lesser mental health problems among males. In the same study, the performance of roles that transgress normative expected gender norms (e.g. men participating in greater household work) was associated with higher mental health problems among males and females. As this study indicates, families operating within the landscape of gender discriminatory norms, propagate
and sustain prejudicial treatment of genders potentially adversely altering life chances of women and those who contravene these norms. Community mental health policies have included a life skills work with youth and children component, which mostly remain unimplemented; and may need gender responsive restructuring into a programme involving children, youth and households to alter patterns of socialisation towards egalitarian norms.

Gender-based disadvantage, however, cannot be addressed only within the frame of service delivery with individuals and families. Service delivery and constituencies may be surrounded by affirming social cues that perpetrate a patriarchal mindset, potentially negating intent, quality and effects of the service-participant transaction. Faced with adversity, there are no social or economic resources for several women to draw from as they are systematically removed from meaningful forms of ownership. In his essay highlighting women’s invisible, unpaid, devalued pastoral work in India, (Sainath, 2018) writes that though they perform a majority of tasks:

Yet, few women own and control cattle themselves. Men dominate most of India’s 70,000 village-level dairy cooperative societies (DCs). Only 18 per cent of all society members are women. They also make up less than three per cent of all DC board members

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.

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 investigates the evolution of The Banyan’s mental health system, with a particular focus on transitions, using a timeline narrative to examine attributes and underlying values that sustain the function of these attributes. The mental health system derived its responsiveness to the constituency of people with mental illness living in homelessness and poverty and the consequent development from two central attributes - ‘User-centred’ and ‘Service integration’. 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.

The World Health Report of 2000 defines responsiveness as, “not a measure of how the system responds to health needs, which shows up in health outcomes, but of how the system performs relative to non-health aspects, meeting or not meeting a population’s expectations of how it should be treated by providers of prevention, care or non-personal services.” (Musgrove et al., 2000). Experiences of service users with providers along seven domains are considered in this model: dignity, autonomy, confidentiality, prompt attention, quality of amenities, access to social support networks, with an eighth domain of autonomy (involvement in treatment decisions concerning self) added in the measurement instrument (Darby et al., 2000). The predominant focus appears to be on the acceptability of interactions that take place with provider personnel and infrastructure. However, better health outcomes do not occur in silos of the present - the ability of health systems to discern and adapt to emerging shifts in present needs and anticipated future needs determines the quality of health outcomes. This may be significant in practice with disempowered communities so that their experiences are not appropriated into deterministic frames, and formulations occur in context. Besides, measurements of outcomes can be misleading, if they are not adaptive to nuances and changes in what outcomes are experienced as meaningful gains. It may not be feasible for cultural resonance to occur in selected blocks of health systems but rather it must be embedded throughout.

For this discussion, it is useful to visit a systematic review that defines user centred access to healthcare on five domains: 1) Approachability; 2) Acceptability; 3) Availability and accommodation; 4) Affordability; 5) Appropriateness; with the interaction of demand and supply side factors predicting the process of obtaining care and receiving benefits of such services. Postulating a user-centric view of access, the five corresponding
abilities of people interact with the dimensions of accessibility to generate access to health care (Levesque, Harris, & Russell, 2013). Health systems that view mental health access as a problem in the first four domains are likely to focus on health interventions as goods and services that require to proximate. On the other hand, if mental health access is perceived from a lens of 'inequity' and focus on the fifth domain of ‘appropriateness’, interventions that address such marginalisation are likely to be privileged. While the former may also focus on increasing bottom level capacities, the nature of the health system may continue to be top-down or vertical. The latter may focus more on adapting to changing user perceptions of their needs and be more spontaneous, diffuse, experimental and transition sensitive. This thesis argues that responsiveness includes the ability of health systems to change and evolve with shifting health needs and priorities for well-being among service users and presents a typology matrix that may be used to examine degree of responsiveness of health systems based on the low to high combinations of the two parameters - ‘User-centred’ and ‘Service integration’.

Sub-question 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?

Chapter 7 examines service indicators of rate of reintegration, retention in aftercare, proportion of long-stay and average length of stay over 2014-2017 for The Banyan’s Emergency Care and Recovery Centre (ECRC) for homeless women with mental illness. The findings are discussed in the broader context of The Banyan’s practice with this constituency.

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. Although reintegration is pursued and realised for three-quarters of women who access these services, a growing population of long-term users exerts pressure on the system, possibly reducing quality and effectiveness but certainly compromising intended tertiary role in the continuum of care. Rates of reintegration were low in 2014 when the proportion of long-stay service users was high and improved as bed spaces opened up with the exit of people from this cohort into inclusive living options in the community. Present data are insufficient to quantitatively or qualitatively derive determinants of and pathways into long-stay, but it is an important investigation for future research to consider.

3500 people with mental illness, half of whom reportedly with history of homelessness, are living long-term across state mental hospitals in India, according to data that were gathered from self-reported, partially completed affidavits filed with the National Human Rights Commission (NHRC). Barring a few exceptions, the majority of these hospitals are beset by quality of care issues and serious human rights violations. Retaining people within such settings beyond the acute phase of illness poses a detriment to their opportunities and rights while compromising on the ability of tertiary centres to absorb new service users who may need acute care. Unless these institutions that are vested with leadership roles in state-level community mental health provisioning and serve as training grounds for mental health professionals are able to redress this enduring incarceration and rights abuse, broader reform translations in mental health care in India may not be realised. The paradigm of care must be cross-sectionally and vertically aligned with dogged pursuit of reclaiming spaces in the social fabric for people with mental illness, in the absence of which the notion of community-based mental health services may continue to be trapped in paternalistic views of control and management of people with mental illness to move towards defined parameters of a ‘good patient’, rather than persevering to promote outcomes that are of personal relevance. Realigning delivery towards therapeutic alliance, providing a minimum quality assurance in essential facilities such as housing, food, water, safety, privacy, sanitation, health, creating universal discharge options irrespective of nature of admission, eliminating human rights violations even in mere spirit – these will serve as steps towards destigmatising mental illness and inspiring people to take up occupations in the
mental health sector. Systematic, continuous and long-term effort is required in comprehensively developing and applying a framework of transformation for mental health hospitals across India.

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.

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?

Home Again offers housing with supportive services for people with mental illness experiencing long-term needs with significant impact 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.

Globally, housing has emerged as an empirically supported intervention for homeless people, including those with mental health needs (Tsemberis, 2000; Tsemberis, 2004; O’Hara, 2007; Chez Soi, At Home, Early Findings Report, 2011). However, these interventions have rarely been applied and studied to address issues of long stay and needs of people with enduring psychosocial disabilities. The process and outcomes for such a cohort may be different due to their long stay within a hospital environment that is unlike the streets or shelters. This pilot offers preliminary and promising evidence for feasibility
and positive outcomes of a housing with supportive services intervention for women living with significant psychosocial disabilities. They are able to 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. Within these formed families, women access resources and bonds of kinship that challenge the heteronormative notions of family units in the Indian context.

The study also offers possible new directions in the space of developing community supports for one of the most marginalised populations within society - people with mental illness and history of homelessness who have been relegated to being incarcerated lifelong in institutional settings because of existing inadequacies in treatment and rehabilitation options. While low levels of social integration are indicated in studies of several similar initiatives, in the context of Home Again, a main effect was observed. The precise moderators and mediators of these effects are important to gauge in this was a complex intervention involving scatter-site housing in several neighbourhoods and family-like living in small affinity groups combined with personalised supports. Was it the nature of built environments – housing in a community versus a hospital? Alternatively, did neighbourhood features promote these outcomes? In what way were outcomes influenced by staff training and supervision to ensure an ethos of care where their conduct and actions are supports rather than substitutes for users preferences? How did the processes to ensure service users are capacitated to offer opinions on all decisions involving the approach contribute to these effects? These enquires present essential directions for future analysis and research to consider.

Home Again was not found viable during the study’s period for a section of users (n=14) primarily on account of upstream referrals for clinical needs. This indicates that alternate paradigms for such service users within an acute care setting or in a new form of environment may need to be developed.

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. A series of multi-stakeholder collaborative demonstration projects in diverse contexts across India is a necessary next step in broadening and building on these initial results. Replications assist in not only recognising the contours of generalisability of results, but they help unpack dynamics engaged in the transfer of complex innovations and develop stakeholder discourse towards a shared vision of change.

In this context, it is important to consider the substantial history of mental health reform and repeated failure in both institutional and non-institutional formats. Novel innovation typologies may be characterised by underlying value drivers and tacit knowledge rather than explicitly expressed concrete components. Retaining fidelity to intervention and therefore translation in practice as intended rather than in morphed forms may necessarily involve transactional processes that allow for joint re-experiencing and value-based diffusion, setting conditions for the innovation to exist and flourish, across geographies, languages, cultures and disability levels. Leadership with transformative competencies vested with the imperative to develop an expansive, accountable, process-oriented system, may be critical in this collaborative defining and redefining of the idea, and therefore in the creation of a meaningful path to scale.

**Sub-question 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?**

India is currently in the midst of an increasingly polarised climate and ‘jobless’ economic growth. Ironically, in this dismal scenario, the mental health sector is witnessing a promising policy climate with the promulgation of the new Mental Healthcare Act of 2017 and the Rights of Persons with Disabilities Act of 2016 and the Mental Health Policy formulated in 2011. The Delhi High Court recently set aside the criminalising sections of the anti-poor Beggary Act. On the basis of a public interest litigation highlighting the lack of exit options for people with mental illness from state mental health
facilities, the Supreme Court of India directed the central government to formulate a policy for ‘rehabilitation’ of these long-stay service users.

However, transitions are demanded in how practice, research and policy are conducted if the actual intents of these laws and policy and court orders are to be catalysed into gains for people living with mental illness. In the absence of such transformative shifts in ways of thinking and doing, recourse to reductionist approaches or repurposed failed strategies (e.g. trans-institutionalisation in rehabilitation homes) may dominate. Based on this thesis, I recognise four conditions that will need to be pursued and realised before we can even begin to grasp the vision of new socio-economic realities for homeless people with mental illness.

First, 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. Particularly pathways need to be created for integrating knowledge emerging from niche actors, their personal experiences and experiments in addressing homelessness and mental illness. In this endeavour, health and social care systems in India may benefit from undertaking a critical analysis of participatory social action in the context of marginalisation, the processes and methodologies used to realise multi-stakeholder participation and the forms of embodied knowledge that reside in these spaces.

Second, service user representations in advocacy and change initiatives for the sector need to urgently include those with first-hand experiences of poverty and structural violence. Support for user-led niche experiments, adoption of peer support workers and advocates as mandatory in services, incremental federation as social cooperatives and advocacy groups are possible pathways for service users to ultimately take leadership on their issues and drive necessary change in the mental health system.
Third, efforts must be made to bridge not just the clinical treatment gap but the social care gap. 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. Integrated teams as well as interagency collaborations, both are found to be effective ways to promote convergence between health and social welfare mechanisms which is essential to deliver comprehensive care that can mitigate both clinical symptoms and concomitant socio-economic issues (Rosenheck et al., 1998; Rosenheck et al., 2002). Intersectoral linkages through formalised agreements to enable delivery of social care interventions with a particular focus on affirmative disability supports, employment and housing may be a necessary beginning in this process.

Fourth, concerns the nature of transitions necessary in hospital-based care which must move towards an alternate praxis. 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. Unless the dominant structure begins to dismantle into identifiable and commutable forms of care for those at the margins, entrapments of prevailing dogma will curb social justice.

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In this thesis, I have attempted to understand approaches to mental health systems and interventions that can help remove marginalisation and promote social inclusion of homeless people with mental illness. It considers twenty-five years of The Banyan’s experiences and the novel approaches that emerged through participatory learning and evolution, lending new dimensions through which the issues of homelessness and mental health may be considered in a low resource setting. In the context of the enquiries of this thesis and the participants I engaged with, social factors responsible for inequity were involved in predicting descent into homelessness against a
background of mental illness. Kleinman and colleagues (1997) point to how power vested in social, political and economic institutions produces social suffering and determines the ways in which the very same social problems are approached. This is reflected in the history of repeated failure of mental health reform, particularly the unchanged scenario of people rendered homeless or incarcerated in tertiary care regimes with persistent challenges in quality and human rights. Removing structural barriers at the individual and the broader societal level may, therefore, be critical imperatives to pursue mental health recovery.

In this scenario, niche experiments offer us novel ways of thinking and doing, that can unpack and address complex problems such as those at the intersection of homelessness and mental illness. 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.

**Validity**

*Internal Validity*

For studies in Chapter 5 and 8, all instruments were translated and back-translated and piloted before data collection. Researchers with Masters level degree gathered the data and were supervised throughout the process. Particular attention was paid to fidelity to item interpretation among data collectors. In every phase of data collection, a proportion of interviews were reconducted by the Co-principal investigators to check for consistency and reliability of data. Variables that elicited subjective perspectives were based
only on service-user reports (e.g. quality of life ratings). Other variables were triangulated for consistency during data collection with reports from staff and peers and prior to analysis with the indicators maintained by the Monitoring and Evaluation Department (e.g. work status) of The Banyan. Similarly, for qualitative data used in Chapter 6, multiple data sources were used rather than relying on a single informant.

Exclusion and inclusion criteria to aid recruitment of participants were clear at the proposal stage of the studies. For the study in Chapter 5, the research team attempted recruitment of the entire sampling frame of 485 possible participants and secured a response rate of 71%. Those who declined to participate and those who could not be traced are potential sources of participation bias. Non-respondents primarily consisted of people who were newly enrolled and did not continue to engage with the service. For the Home Again study in Chapter 8, participant preferred allocation was employed for ethical reasons. To minimise bias, controls were randomly matched. Additionally, post hoc examination of differences in baseline characteristics (besides the preference) was conducted. 80% of participants were retained for the duration of the study.

The Home Again study was seated in a larger investigation that included extensive longitudinal ethnographic observations which assisted in triangulating results from the quantitative analysis. Data used in Chapter 7 were verified with medical records of the sample. Prior to analysis of data used in Chapter 5, 7 and 8, validation checks were conducted to gauge the consistency of responses to complementary items (e.g. prevalence of homelessness and frequency of experiencing homelessness). Inconsistencies were verified and resolved by revisiting the physical records of data and the participant. For the qualitative data used in Chapter 6 and Chapter 7, multiple investigators were engaged in examining and interpreting the data. Preliminary results were discussed with colleagues and experts not directly engaged in these studies and reflected upon. Additionally, results were presented and discussed with a broader national and international audience of academics and practitioners.
**External Validity**

This thesis is placed in the context of The Banyan’s work in South India and specifically considers the constituency of homeless women with mental illness. It serves to be exploratory rather than confirmatory as not much evidence on mental health and homelessness in the Indian context is available. Replications of niche experiments are necessary to move towards a better, more generalisable understanding. The conclusions are discussed in light of existing evidence to elucidate the boundaries within which interpretations may be applied. Although predominantly from Tamil Nadu, a relatively progressive state in the Indian context, the constituency of The Banyan includes women from diverse geographies and socio-cultural contexts in India. There are common threads between the context described in the thesis, of complex histories of structural violence among people with mental illness, repeated reform failure and deficient health system responses, and contexts of other states in India and low- and medium-income countries. Descriptions of the context, The Banyan’s mental health system and the interventions are included in the articles for findings to be recontextualised to other settings and geographies.

**Future research**

Research on niche experiments and populations in diverse social and cultural contexts is an important step to building the knowledge base in mental health. Future research agendas may consider replication of the investigations embedded in this thesis, in other contexts and with diverse populations to a still nascent body of knowledge in the Indian context. Social disadvantage is implicated as a predictor of homelessness. Insight into variegated experiences of structural violence, the individual, familial and geographical associations in relation to mental health and homelessness will be essential to formulate necessary interventions. Studies of effects of these interventions, their moderators and mediators and narratives of processes engaged will assist in understanding policy imperatives to address modifiable risk factors for mental health and homelessness. In framing such enquiries, future research agendas may be informed by a life course approach (see for e.g. Ben-Shlomo & Kuh, 2002) to understand cause-effect pathways better as well as develop and test preventive strategies.
How transitions towards user-centred health systems are construed and rendered remains an area that needs to be explored in depth. In the particular context of serious mental disorders, values and processes that engender service-user participation, especially those from marginalised circumstances will need to be probed. If clinical and social recovery pathways are to merge, it becomes important to investigate in what ways these strands can be interwoven at a system level and what the effects are at multiple levels from the micro to the macro.

Translations of complex interventions, in particular during broadening and scale up, are dependent on the transfer of underlying values and tacit knowledge. Paradigmatic orientations can determine the direction of how intents are recast in reality as the history of scale-up of ideas including mental health hospitals, community living and so on show us. Unpacking processes involved in the successful diffusion of complex interventions such as Home Again, including how stakeholder engagements and shared visions were realised during the broadening phase will be important in designing a path to scale up. Equally important will be to consider regimes that have a record of transforming such as tertiary mental health centres that have progressed to include some measure of alternate praxis, in the Indian context. This will help gauge conditions that may need to be pursued before environments can absorb and deliver comprehensive solutions emphasising meaningful, inclusive and satisfying lives for people with mental illness.

Heterogenous outcomes are witnessed in the population of homeless people with mental illness, including The Banyan’s constituency where some have paved successful recovery pathways while others have not. In this regard, moderators and mediators of the effects are essential to gauge in a complex intervention such as Home Again. Further investigations to probe narratives and pathways associated with different recovery realities will assist in planning, provisioning and testing innovations that mitigate risks for downward trajectories and enable positive recovery trajectories.