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## Understanding the Mental ill Health - Poverty - Homelessness Nexus in India:

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# Summary

In the last two decades, the increased prevalence of mental health issues and their detrimental impact on well-being has been firmly established, drawing keen interest and engagement of practitioners, researchers, policy makers and philosophers alike. No longer is the genesis of mental ill health located exclusively in the brain or in biology. The role of social, economic and sociological triggers and ecology and environment have been observably integrated into the larger mental health discourse, in lieu of findings that co- relate these factors with an enhanced vulnerability to mental illness.

In this relation, it must be noted that the highest incidence of the global burden of neuropsychiatric disorders is prevalent in low and middle-income countries (LMICs). The enormity of the problem is thus of special significance to the Indian context, where almost 70% of the population live on less than USD 2.00 per day. Approximately 55- 70 million people are estimated as being affected with a mental illness in India, with the reported treatment gap being distinctly high at 90%. In extreme situations, the lack of social protection, limited or non-existent pathways to mental health care, combined with abject poverty, could render a person homeless. At a conservative estimate, India is home to 1.5 million homelessness people, many of whom live with a mental illness. The nexus between mental ill health, homelessness and poverty in this context, assumes significance, considering the devastating impact it could have on human life, particularly in resource scarce settings, where the problem acquires significant momentum and magnitude. The consequences of this nexus are grave and hazardous, with far ranging repercussions that impact individuals, families and communities, in particular, and society at large.

This thesis focuses on understanding this nexus in greater detail, exploring in depth, its intricacies and contexts. It examines the broader lacunae in the mental health system, and draws associations between personal narratives, organizational storylines and larger health and human rights frameworks. Considering that the problem in question is complex and persistent, and some of the strategies used to address the distress experienced at the intersection of homelessness, poverty and mental ill health, adaptive and dynamic; this thesis also devotes particular attention to findings that emerge from niche experiments. This approach helps us analyse and document contextually and culturally relevant experiences, even as

broader and more general understanding of loss, deprivation and suffering are perhaps similar.

While a few studies have been conducted on this tragically symbiotic relationship in India, a robust understanding still seems lacking. This thesis attempts to contribute to this body of knowledge by answering the following research question:

**What are the complex problems experienced by homeless persons in India living in poverty with mental health concerns and what are the strategies that help address that distress?**

This thesis draws from a number of theoretical concepts, beginning with an understanding of persistent problems – a central line of inquiry, in all the studies and narratives. It then unravels the nature of persistence using frameworks of poverty, mental ill health and homelessness. The interactional models and multi-factorial pathways examined within each of these frameworks capture the relationship between vulnerabilities, mental disorders and adverse development, linking many triggers that build distress and negatively impact social capital. The studies also draw from the Capabilities Approach and the framework of personal recovery, especially in the context of understanding human rights and recovery from mental disorders in diverse contexts. Martha Nussbaum's central capabilities (2000) within the Capabilities approach, amongst others, most relevant to this context, include bodily integrity, affiliation, control over one's environment and senses, imagination and thought. The Capabilities framework has been widely recognised as a key theoretical concept on well-being, development and justice. Meanwhile, central to the framework of personal recovery is the transformation from an illness-dominated identity to an identity of agency, as illustrated by Mancini, 2007. This thesis uses all these frameworks as lenses to analyse and evaluate findings from niche experiments and studies.

The Dialogue Model, System Innovation Theory and Action Research serve as important approaches and methods in this thesis. The former allows for an emergent design in practice, encouraging participation of multiple stakeholders, particularly users of a service, whose expressed needs and insights drive programmatic formulation and development. Both user-centricity, integral to this method and the two-way engagement between individual and organisational narratives, that the dialogue model promotes, foster an environment in which a responsive health system thrives. System Innovation theory on the other hand

emphasises the need to incubate a wide diversity of experiments in the context of persistent problems, so as to arrive at the most appropriate response. The role of multiple actors, systems and processes are etched out in this approach, indicating the role and importance of micro-level, niche experiments that interact with meso-level regimes and draw from and influence macro-level changes of the landscape. Meanwhile, action research as a method is used to capture cyclic processes of action, execution and reflection that are analysed in some of the niche experiments illustrated in this thesis, particularly, in relevance to the developments of The Banyan.

In order to answer the main research question, eight sub questions were addressed through the research presented in different chapters in this thesis. They are the following:

1. What are the complex, yet somewhat ignored strands of the mental ill health-poverty and mental ill health-homelessness discourse that need renewed focus and attention?
2. What are the specific problems emerging as a result of the mental ill health-poverty-homelessness nexus?
3. What are the attributes and response systems of organisations that address the multi-dimensional needs of homeless and poor persons with mental health concerns?
4. What precipitates the descent into homelessness? What are critical methods and values that promote recovery and appropriate human resource development?
5. How are rights understood from the perspective of Indian women who have experienced mental ill health, poverty and homelessness?
6. Are the needs of vulnerable groups reflected in the amendments to the Indian Mental Health Act, 1987?
7. How can academics and practitioners collaborate to develop skills and shape perspectives in the mental health sector?
8. How can the mechanism of corporate social responsibility (CSR) lend itself as a strategy to address complex societal problems?

In order to address these sub questions, this thesis largely employed qualitative methods using participatory action research and phenomenology as approaches. The studies include narrative reviews, timeline narratives, analytical and descriptive reviews, discourse analysis and qualitative narratives and use observation, shadowing, case study analysis, organizational memory, focus group

discussions, in depth interviews, besides literature reviews, as tools. The advantage of using qualitative methods in the case of this inquiry, is that it better represents the needs of the underserved, is more flexible and incorporates values as a critical theme, besides providing depth in responses and discussions. Rigour in usage of these methods was observed by ensuring triangulation, member check and prolonged engagement. These methods also fit in well into the scope of action research and dialogue model.

The principal units of analysis include that of the problem (in this case, the poverty-homelessness-mental ill health nexus), and that of strategies that alleviate distress, through evaluations of niche experiments. Part 1 of the thesis examines the former, analysing critical features that enhance the gravity of the problem, using literature, case studies, shadowing, observation and interviews as tools; while part 2 and 3 examine evaluations of niche experiments using action research, focus group discussions, interviews, observation and descriptive studies and the dialogue model as tools.

Based on the knowledge elicited, critical themes of inquiry were arrived at and interview schedules and probes for focus group discussions structured and designed. Typically, the data was shared with external researchers and practitioners, participants recruited for the studies and co- members of the research and implementation team for validity check and verification. Based on feedback received from these key stakeholders, the data gathered was analysed, clustered thematically where required, interpreted and conclusions drawn.

## **Findings**

**Part 1** of this thesis presents an overview of the mental ill health-poverty-homelessness nexus in India and identifies the extent and source of distress and vulnerability experienced as a result of this co-occurring phenomenon. **Chapters 4 and 5** probe into social causation factors such as social structure inequities, challenges in the ecosystem, health systems level gaps and various other vicious poverty traps. The ill health – poverty- mental ill health- poor health care access and untreated mental ill health- poverty -poor mental health care access-pathways leading to homelessness are analysed in depth. A matrix that links this co-occurring phenomenon is developed to present the intractability of the problem. Critical barriers to developing a robust mental health programme seem situated in weak health systems, poor quality human resources, poor leadership development, poor motivation amongst practitioners, minimal understanding or

use of values resulting in poor organisational culture, divisiveness in the mental health and disability sectors and a fragmented understanding of rights. Other critical issues such as co-morbidity, increased suicide risks and challenges of long-term care also emerged as significant conditions unique to this nexus. In this regard, the association between ontological security and improved mental health is discussed, as are consequences of inaction, lethargic responses and lack of urgency in distress alleviation. The urgency to tap human potential to the fullest and thus approach mental health from a well-being rather than a disease perspective is presented. Implications for research and practice include promotion of stronger stakeholder participation and initiation of a typology of experiments with increasing complexity that match the needs of this vulnerable and characteristically diverse group, with unique problems and ill health trajectories. This is in line with an emerging scientific field – that of system innovation and transition theory.

An implication for Policy includes an urgent acknowledgment of the negative cycle of poor mental health and homelessness, which perpetuates poverty and vice versa, thus placing at risk a significant Indian population, owing to inadequacies at multiple levels, predominantly at the State and Societal levels. Social disadvantage exhibited in inadequate housing, poor education, inequitable health access and other such factors results in stressful living conditions, increasing one's vulnerability to mental ill health. While poverty is a predictor of ill health at individual and community levels, India continues to spend less than 1.2% of its GDP towards health, and even lesser on mental health; leaving a significant part of its population underserved and at risk of spiralling further downward into abject poverty, worsened health and homelessness. Findings from the studies in this section recommend substantive focus on both health and social welfare policies to promote both equitable health and living circumstances.

**Part 2** of the thesis examines niche experiments that have attempted to address the distress emerging from this nexus. In this regard, The Banyan, a Non-Governmental Organisation's service packages and development are studied using a timeline narrative. The non-linear evolution of complex problems and the emergence of need-based, reflexive and adaptive response structures that are value-driven are discussed as a key finding. Within The Banyan's context, themes of civil commitment and institutional and alternate living spaces that respond to long-term needs, both emerging problems referred to in **Part 1**, are examined in greater detail here. Similar experiments in different contexts using multi-level,

multi-modal approaches are further analysed in **Chapter 8**, all pointing at the importance of initiating and scaling up niche experiences, fostering partnerships and incubating social innovations, in order build responsive models. Besides deprivation and poverty, breakdown in the family emerges as a key factor in rendering a person homeless. The importance of social relationships and kinship is probed in this regard and the importance of mimicking some of these attributes as a strategy in caring effectively for vulnerable groups like homeless persons with mental illness, especially in institutions, is discussed in **Chapter 9**. The importance of formulating a value framework within which human resources are trained and protocols for services, developed, is also discussed in this chapter.

**Part 3** of the thesis discusses the construct of human rights, another complex problem in the mental ill health – poverty- homelessness nexus and examines diversity and uniqueness in its conceptualization, based on interviews and focus group discussions with homeless women with mental illness who have achieved personal recovery and are able to live independently in The Banyan’s clustered group homes or in rural communities at Kovalam, Tamil Nadu, India. The dialogue model as a theoretical framework and method was used extensively in the development of this human rights construction. Key insights were elicited from the study’s participants, experiential experts who within the framework of the dialogue model are critical contributors to knowledge. Findings emerging from consultations emphasized the essentiality of attainment of fundamentals like adequate food, housing and work as a primary goal, in pursuing more complex personal states of agency, affiliation and control over life. Most participants advocated for the need to look beyond binaries and focus on the move from ‘distress to a happy place’. In this context, complex issues such as the balance between autonomy and the right to health are discussed in detail. Using the lens of the capabilities approach, the findings elicited from the participants were in accordance with most of the ten central capabilities enlisted in **Chapter 2** of this thesis. While this analysis may be in deviance from the conventional International human rights instruments and mandates, they perhaps represent the voices of the Global South, a somewhat underrepresented segment in the larger human rights discourse.

**Part 4** of the thesis examines the importance of aligning strategies with diverse sectors, actors and stakeholders, as discussed within the framework of system innovation theory in **Chapter 2**, and examines the role of public policy, responsible business and education in building equitable and effective plans, programmes and

services. A key finding that emerges is that despite challenges encountered in any collaboration, partnerships between civil society and academic organisations, Corporates and the State or Non-Governmental Organisations, and policy makers and service providers and service users can help build robust, grounded, culturally relevant responses in health systems and human resource development, prompt positive social change and inspire social good. In the context of policy formulation, the necessity for a strategic situational analysis, presenting a clear representation of grassroots needs and an account of available resources, is evidenced as essential. In the context of community and institutional care, preparedness is advised through the process of transition, so as to avoid crises other Nations have encountered. Similarly, using a confluence of theory and practice embedded in real world problems and scenarios, using teaching and training as methods, seems like a good pedagogical approach to developing effective human resources in the mental health sector.

## **Conclusions**

This thesis, through its many studies, attempts to meet its objectives of ‘opening up the discussion of the unique nature of the mental ill health- poverty-homelessness nexus and understanding the grave challenges this nexus presents’, and ‘learning from innovative experiments and approaches to respond to this complexity’. In doing so, it analyses both the persistent problem and explores strategies that promote distress alleviation and social inclusion through niche experiments. The need for a cyclic relationship between individual narratives, organizational narratives and public policy, embedded in a framework of the dialogue model that considers stakeholder participation, experiential expertise and dialoguing as essential to a responsive health system, is alluded to in most chapters, and more prominently so in **Chapters 4 -12**. While the nature of distress perceived and experienced at the intersections of mental ill health, poverty and homeless is severe, findings from this thesis argue that niche experiments can contribute in significant and strategic ways to address the multi-dimensionality and diversity of needs, in the Indian context.