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World Journal of Psychiatry and Mental Health Research

Review Article
Published: 24 Mar, 2021

Developing Care Approaches to Address the Homelessness, Poverty and Severe Mental Illnesses Crisis

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Abstract

Mental ill-health is increasingly recognized as a complex human rights issue with far ranging consequences outside of the health ambit, influencing poverty, exclusion and homelessness. We use the framework of Intersectionalities to better understand the bi-directional relationship between psychosocial disability, concomitant social disadvantage and conventional identity markers such as class, caste, ethnicity and gender. Despite the impact of social determinants on mental ill health being evidenced in minority mental health studies, integrated, responsive and user-centered care paradigms for persons with mental health concerns from marginalized backgrounds are relatively scarce, particularly in low- and middle-income countries.

Within this background, we examine a range of services along a mental health care continuum, developed by The Banyan, a not for profit organization based in Tamil Nadu, India. The Banyan has serviced a million low-income households including persons from indigenous communities through its ambulatory mental health care services. Its flagship program has serviced 3,000 homeless persons experiencing severe mental disorders through its hospital based emergency care and community inclusion focused recovery services. For individuals with enduring and persistent mental health concerns, experiencing moderate to severe disability, community based inclusive and independent living options were developed. The impact of these programs on the quality of life of ultra-vulnerable individuals and communities is discussed.

Keywords: Mental health; Poverty; Integrated care; Social disadvantage; Social needs care

OPEN ACCESS

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Received Date: *17 Feb 2021*
Accepted Date: *22 Mar 2021*
Published Date: *24 Mar 2021*

Citation:
Radhakrishnan RK, Vallath S, de Wit EE, Bunders JGF, Gopikumar V. Developing Care Approaches to Address the Homelessness, Poverty and Severe Mental Illnesses Crisis. World J Psychiatry Ment Health Res. 2021; 5(1): 1027.

Introduction

It has been evidenced that the homeless, poor, and marginalized share the largest mental health burden [1-3]. This often results in a double jeopardy situation, amplifying vulnerabilities [4,5]. Within the Indian context, over 100,000 persons are estimated to be homeless and experiencing severe mental illnesses [6]. It is further posited that systemic and structural barriers and loss of social relationships and support networks influence a downward descent into homelessness among persons living with psychosocial disabilities. Long distances to tertiary care facilities, inadequately resourced primary health centers, interruptions in care giving, socioeconomic contingencies, and treatment focused primarily on the biomedical, results in unaddressed, psychological, and social needs. While with some individuals homelessness precedes mental illnesses, with many, homelessness is a consequence of mental illnesses and lack of adequate and integrated care pathways [7,8].

The Government of India has made efforts to manage these barriers during the past years. However, resourced sparsely, with less than 1% of the government's budget allocated for mental health care, India today experiences a human resources crunch with only two mental health workers and 0.3 psychiatrists per 100,000 population, significantly lower than the global average and conceivable increasing treatment gap [9,10].

As a response to increased prevalence of mental disorders, high treatment gaps and in an effort to bridge inequities globally, the Sustainable Development Goals (SDGs) have put forth ambitious

targets, that focus on Non-Communicable Diseases (NCDs) including mental health "Target 3.4 for e.g. states by 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being". The WHO's Comprehensive Mental Health Action Plan (2013-2020) has framed the marginalization of people with 'mental disorders' as a significant impediment to the achievement of national and international development goals (WHO, 2013). Despite these strides, significant progress in many countries, including India, has, to date, been limited. Mills raises concerns about the reconfiguration of structural poverty at an individualized level (e.g. framing people as mentally ill when they are just coping with chronic deprivation). It emphasizes the need to ascertain why people are in distress and to understand what people require to uplift their lives and avoid responses where suffering is largely pathologized, within bio-psychological paradigms, with the social relegated to the margins [11,12].

The Mental Health Policy Group constituted by the Government of India recommended comprehensive solutions in the context of vulnerable groups with an emphasis on convergence between health and social sectors. In addition, access to mental health care was adopted as a basic right based on the Mental Health Care Act (MHCA) 2017. However, owing to lack of strong leadership, limited intersectoral collaboration, restricted investment of resources and the inability to translate policy and legislation into tangible goals, constraints around equitable mental health care still persist.

The Banyan Case Study

Founded in 1993, The Banyan adopted an integrated approach to mental health care early on, taking into cognizance the bidirectional impact of social disadvantage on mental ill-health and vice-versa and the predisposing, precipitating and perpetuating impact that social determinants had on homeless persons with mental illness. Hence, a targeted focus to address intersectionalities around the needs of minority or vulnerable groups led to the conceptualization of bespoke mental health care and social needs care packages along a continuum ranging from emergency to long term care. At the core of The Banyan's services is its focus on individual strengths, support networks, enhancement of social capital and participation in social and cultural life. The sections below elucidate each model of care, highlighting their impact and outcomes.

The emergency care and recovery center (ECRC)

The ECRCs are accessed by homeless Persons with SMI (hPSMI) for care and rehabilitation services (stay period ranges between 6 to 12 months on average). These centers operate across three districts, in two states, Tamil Nadu and Kerala, and provide ambulatory mental health care services for homeless and ultra-poor persons through crisis support services and critical time interventions. If admissions are necessitated, transparency in communication on processes of care, peer support that helps foster trust and a care coordination team that liaises on behalf of the client with multiple specialist services are mandatory. Stages of care at the ECRC include an in-depth understanding of the clinical and social histories and development of individual care plans implemented by multi-disciplinary teams. Social role valorization, creative use of living spaces, culture-sensitive psychosocial services, and collaborative work on domains of functionality are stressed. Service delivery is characterized by the use of evidence-based approaches adapted to suit the socio-cultural context; such adoption of trauma informed interventions in an eclectic mix of traditional and non-traditional therapeutic offerings such as sociotherapy, cognitive-behavioral therapeutic strategies, open dialogue, befriending, forming fictive kinship bonds, the use of rituals, therapist and client discussions on life events and vulnerabilities etc. From a rights perspective, a legal aid cell is available for individuals to address grievances and seek legal recourse. In addition, an internal Human Rights cell with diverse membership from external organizations and advocacy groups and a service user audit mechanism are integral to The Banyan's value based operations. The service audit is a collaborative process led by peer researchers and auditors in an attempt to gather service delivery related feedback that is then incorporated into the supply chain. Co-production of knowledge has helped The Banyan develop some of its most fearless innovations that include open dialogues and discussions on suffering, existentialism, social relationships, commonalities in life events between the therapist and client, personal growth and purpose etc. Isolation rooms and locked wards for person with high needs were replaced with open wards and a small special needs room that offers comfort and support; cultural congruence in care provision was stressed in diet, grooming rituals, spirituality and recreation. Self-discharge was deliberated upon, balancing the pros and cons around quality of life and healing, transparency was initiated by ushering in movement between the 'outer social world' and those otherwise 'behind the walls of the hospital' using social and cultural spaces such as cafes and other social hubs that enthused passersby to engage with this mental health system; visits to the movies, places of worship and recreation was encouraged in small and self-formed affinity groups. Numbers were capped so as to be able to keep the unit small, that allowed for personal attention and swift recovery, MHCTs and client ratios were better managed, peer engagement strengthened and continued training and experiential learning mechanisms were further integrated into the organization's collective vision. Peer leaders also trained interns and scholars, besides the mental health care teams, such that lived experience contributed to the organization's development and culture, while influencing social dynamics and obscuring social hierarchies.

The notion of personal recovery was appreciated and neurodiversity recognized and integrated into the pre-discharge process. These pre discharge hubs focus on intensive life skills retraining, self-awareness, compassion, confidence and grit building as well as deconstructing suffering, personal meaning, progress, relationships, happiness, passion etc. Mental health self-management further focuses on identifying early signs of recurrence of symptoms including knowledge of one's stressors and triggers, training on the escalation of concerns with the mental health care team, and one's support network. Managing work and family, self-care, self-therapy, and the role of science and society is also emphasized to ensure continued well-being. The pre-discharge assessment uses a matrix to evaluate the individual's extent of functionality, social capital, rights, and preferences that influence community living such that continued care plans can be made accordingly.

Within the first decade of the banyan, it was clear that a significant proportion of persons who accessed services could return to their families of origin. The reintegration process supports the client across five domains - psychological and social health, quality of life, addressing caregiver strain, and all, with an emphasis on community inclusion. This process is aided by a highly-skilled non-technical workforce of community and health care coordinators, who comprise 60% of The Banyan's workforce. They hail from local

Table 1: Impact of three Banyan models on mental health, reintegration and quality of life.

	Number of people/low income households impacted	Social and Mental Health Gains	Impact on community inclusion
ECRC	Since its initiation in 1993, 2585 homeless men and women have accessed ECRC centers, across Tamil Nadu and Kerala. At any point of time, about 200 persons with SMI reside in the centers. Additionally, given the intersectionality and Interlinkages between caregiver burden, and family involvement in mental health recovery gains, The Banyan ECRCs also cater to 10,340 families of the aforementioned 2585 individuals.	1478 (nearly three-quarters) of residents have successfully returned to their families after attaining recovery at ECRC, combating homelessness. Additionally, About 40% of those in residential care participate in work, full-time or part time employment or social enterprises. Of those individuals discharged, 20% are in paid employment and 61% are engaged in household occupational roles [7].	Seven out of 10 (73.3 %) of women in ECRC exited life of homelessness after care, and were able to sustain themselves within the family or otherwise. Support networks were enhanced resulting in arresting homelessness.
CSNL	1 million persons across the country have accessed services, since its initiation in 2007. Additionally, 8510 individuals experiencing severe mental illnesses from socially disadvantaged backgrounds, are direct beneficiaries of medical, social and psychological services through outreach programs and outpatient clinics.	As part of the outreach programs, several enterprises such as a cafe, a mess, an all-purpose store, a salon, a laundry unit etc. were set up and run by persons with SMI, 1655 have accessed social entitlements such as . Caregivers, taking care of family members or extended relatives with SMI were supported by the Banyan through holistic services to cope with the various symptoms of their loved ones by a variety of need based interventions [10].	It maybe hypothesized that families and individuals have experienced a reduction in levels of poverty and an increase in work force participation alongside expansion of social support networks and community participation. Further inquiry into impact is underway.
CMHID	Since its initiation in 2015, about 329 persons with severe mental illnesses, experiencing long term care needs have accessed inclusive living options	Outcomes on quality of life indicates a significant improvement in residents after five months, in relation to physical health and social relations in addition to significant reduction in psychiatric symptoms [7,10].	CMHID has been influential in hPSMIs existing institutionalization. Through enhanced social mixing and participation mental illnesses and allied disability is normalized, decreasing stigma and discrimination [7], as measured through community integration.

communities and are trained to identify mental health issues early on within the communities, facilitate referral pathways, and engage with clients and families as they negotiate their illness. Psycho-education, community sensitization and accessing local support networks including Panchayats, public health systems including the District Mental Health Program, form a large part of the multi modal 'recovery' planning process.

Consistent with global evidence which suggests that homeless persons have higher abuse, morbidity, and mortality rates, when compared to the general population (Folsom 2005; Yim 2015), an evaluation of the banyan's service users indicates that 47% have suffered abuse and adverse experiences, with a majority experiencing physical violence (49%; Krishnadas and Guptan) while 54% have at least two comorbidities such as anemia, hypothyroidism, etc. this indicates intersectionality between social disadvantage, mental illness, and homelessness, stigma and discrimination and gender roles. Focusing on minority mental health, The Banyan services target this intersectionality by promoting access to opportunities, equitable care, support networks and strengthening of self-reliance. Further, by enhancing workforce participation, and the pursuit of capabilities, multiple poverty traps and exclusionary practices maybe broken.

ECRC's services thus operate within a biopsychosocial framework through integrated care options with an emphasis on identity affiliations, meaning-making, and hope. Strengths-based approaches rooted in the Capabilities Framework guide The Banyan's values in mental health practice.

A characteristic sample of the population accessing the ECRC facility over the past 3 years can be found in Table 1 and 2. A statically significant difference was obtained in sociodemographic characteristics of male and female homeless persons experiencing severe mental illnesses. The mean age for males is 41.07 and females is 43.12 (t= -1.52; df=290; p=0.00). A majority of homeless women are married (53.10%) while men are single (57.60%) indicating a significant difference in social support patterns between genders (X2=44.21, df=3, p=0.00). Similarly, diagnostic categories also indicated significant differences between genders with a majority, diagnosed with psychosis not-otherwise-specified (NOS; X2=19.09, df=7, p=0.00). While the mean age did not vary widely between the two groups, more married women and single men appear to experience homelessness. Women, especially from rural Indian societies often are married at an early age, and move homes. The pressures to integrate and conform to a new social role cannot be understated. More often than not, the sole responsibility of care-giving for the husband lies with her as also is the task of caring for one's children in a patriarchal and parochial ecosystem, while living in poverty and social disadvantage. Men, on the other hand, face the burden of being considered as the sole breadwinner, and often remain unmarried in the absence of a job, migrating to cities in search of employment. The uncertainty of employment in the informal sector intersecting with substance misuse, displacement from one's roots, and pressure to acculturate results in distress. In both situations, distress could predicate pathways into homelessness. Lack of access to localized mental health care however remains the most significant pathway into homelessness. Interruptions in care and care giving and low education status, indicative of reduced social capital were observed as factors that influenced this descent [7]. Similarly, results obtained in other studies exploring the content of hallucinations and delusions indicated that negative life events such as violence, loss of dreams and aspirations and intense religious affiliations, etc. influence the content of psychotic experience further emphasizing the socio-cultural impact on causation, symptomatology, and prognosis.

Center for social action and livelihoods (CSAL)

While goals of personal recovery are pursued through services offered in ECRC, structural barriers continue to impact the quality of life, distress, and well-being. Research suggests that a reciprocal relationship exists between social status and mental health, while also noting the social drift hypothesis suggesting that mental ill-health can further deplete one's resources and attainment of well-being needs [4]. The two theoretical frameworks indicate a need to address the social determinants of mental health and ill-health. Additionally, discharge planning, crucial to the sustenance of community living,

Table 2: Sociodemographic characteristics of homeless persons with severe mental illnesses during the period 2017-2019 (n=296).

	Mean (SD)				
	Male	**Female**	**T**	**df**	**P**
Age	41.07 (12.78)	43.12 (10.13)	-1.522	290	0
	N (%)	**N (%)**	**X2**	**df**	**P**
Marital Status					
Single	53 (57.60)	29 (17.90)	44.21	3	0
Married/Living with partner	25 (27.20)	86 (53.10)			
Widowed	5 (5.40)	21 (17.30)			
Divorced/Separated	9 (9.80)	19 (11.70)			
Religion					
Hindu	78 (78.80)	120 (76.90)	0.26	2	0.87
Christian	11 (11.10)	17 (10.90)			
Muslim	10 (10.10)	19 (12.20)			
Language					
Hindi	26 (21.10)	25 (14.50)	13.5	5	0.01
Tamil	84 (68.30)	111 (61.30)			
Other North Indian Languages	8 (6.50)	16 (9.20)			
Other South Indian Languages	3 (2.40)	24 (13.90)			
Unknown	1 (0.80)	1 (0.60)			
Diagnosis					
Affective Disorder	10 (8.10)	29 (16.80)	19.09	7	0
Developmental Disorder	21 (17.10)	9 (5.20)			
Psychosis with ID	6 (4.90)	10 (5.80)			
No Mental Illness Diagnosed	4 (3.30)	2 (1.20)			
Psychosis NOS	42 (34.10)	66 (38.2)			
Schizophrenia	22 (17.90)	40 (23.10)			
Others	6 (4.90)	8 (4.60)			

must be aligned with the goal of addressing the impact of structural barriers that impede access to livelihoods and perpetuate cycles of distress and disability.

The Center for Social Action and Livelihoods (CSAL), The Banyan, therefore aims to address this through three verticals. First, continued care services ensure uninterrupted access to case managers/care coordinators, psychological support and psychiatric reviews post-discharge, and facilitation of social needs care to address distress around deprivation. Facilitated through help lines and on-site support *via* the clinical and social care hubs, these contact sessions encourage proactive interface between families and the mental health systems, and focus on de-escalation of distress, problem-solving support, facilitating access to respite care or short stays if required and promoting options for livelihoods and social entitlements ranging from food security (Public Distribution System), citizenship rights (Voter ID, Aadhar), disability allowance (Rights for Persons with Disabilities Act) and access to other poverty reduction schemes, and financial inclusion (Jan Dhan accounts, Kisan Kalyan Yojana) as well as Health Insurance (there are 17 different government sponsored socially oriented insurance schemes) (Government of India, 2020) and pension schemes (the latest to be announced was the Pradhan Manthri Shram Yogi Mandhan). State Governments have widow pension and old-age pensions, (which vary with each State) and affordable housing (Pradhan Mantri Awaaz Yojana). This is enabled, using local support systems including local governance structures (Panchayats), public hospitals and health systems (District Mental Health Programs), peer support networks, disability networks and the community-based rehabilitation workforce, civil society organizations, self-help groups, etc.

Allied to this, enrollment into the Mahatma Gandhi National Rural Employment Guarantee Schemes (MNREGS), federating into social cooperatives, incubating social enterprises through skilling and training in business management, career fairs that result in job placement, etc. are stressed. Access to livelihood options that aids in transcending structural barriers and limitations, works with rural and urban structures. Place and Train and *vice-versa*, both work in somewhat equal measure, as evidence based approaches, with the former finding more traction amongst mental health service users. A skills development hub with focus on aptitude based training offers many options; some along the lines of the recovery college with focus on building a cadre of peer researchers, mental health care and social coaches and peer advocates, others around honing skills in arts and crafts involving tailoring and block printing units and yet another focused on hospitality services that train mental health service users in money management, administration, social enterprise and/or social cooperative formation etc. 35% of The Banyan's clients are therefore employed; this encourages a shift in social roles and identity with movement from 'a sick role' to an 'empowered' role. However,

Table 3: Sociodemographic characteristics of homeless persons with severe mental illnesses during the period 2015-2019 (n=308).

	Mean (SD)				
	Male	**Female**	**H**	**df**	**P**
Age	44.6 (20.15)	37.81 (14.50)	13.099	1	0
	N (%)	N (%)	X2	df	P
Marital Status					
Married	101 (39%)	6 (12.50%)	29.51	3	0
Single	74 (28.60%)	33 (68.80%)			
Divorced/Separated	41 (15.80%)	5 (10.40%)			
Diagnosis					
Affective Disorder	49 (20.10%)	16 (34%)	12.19	5	0.03
Developmental Disorder	26 (10.70%)	3 (6.40%)			
Intellectual Disability	39 (16%)	2 (4.30%)			
Psychosis NOS	30 (12.30%)	7 (14.90%)			
Schizophrenia	96 (39.30%)	16 (34%)			
Others	4 (1.60%)	3 (6.40%)			

strengths and vulnerabilities are both valued equally at The Banyan, such that no one form of recovery underwhelms subjective notions of distress and resilience or personal meaning.

Center for mental health and inclusive development

Despite emergency and outpatient services, 11% of hPSMI remained within in-patient facilities. The Banyan's Center for Mental Health and Inclusive Development (CMHID), therefore, caters to the needs of hPSMI experiencing long term care needs through two primary programs - Supported housing and Supported living options. 'Home Again' a supported living option for persons with severe mental illnesses experiencing long term care needs is an innovative approach that offers non clustered housing and personal recovery support as key interventions. 4 to 5 women in each home form affinity groups and live together in formed families with opportunities to engage with the community and normalize mental illness. The community living experiences creates organic changes in self-care and learning through observation and social comparison, impacts individual and group behavior. 50% of individuals who have moved into such facilities have transitioned to support housing with no or minimal staff contact for support.

The program has been successful in the rehabilitation and integration of hPSMI with community services at costs 50% below the average expenditure in any institutional facility. Further, social mixing enthuses communities to challenge prejudice and through social connection better understand individuals with SMI. More importantly, disrupting the specialist driven care trajectories, peer leaders have anchored home again in rural contexts, adhering to standardized protocols, but integrating their unique wisdom to develop a vibrant version of the prototype. Outcomes of CMHID have been further elucidated in Table 1.

Similar to ECRC significant gender differences are observed in age (H=13.099, df=1, p<0.00), marital status (X2=29.51, df=3, p<0.00), and diagnosis (X2=12.19, df=5, p<0.03) among persons accessing the home again program. This strengthens the understanding of intersectionality in homelessness and mental illness. Results indicate social networks (as indicated through marital status) are crucial to exiting mental hospitals especially when observed co-occurring with diagnostic subgroups such as intellectual disability and schizophrenia which require increased support owing to disability and debilitating effects on functionality (Table 3).

Suggestions for Up Scaling

In order to achieve mental health improvement for the people of India, successful interventions or those that have been found effective in reducing symptoms and improving quality of life for persons with SMI, should be 'scaled up' and implemented more widely. Scaling up refers to making 'deliberate efforts to increase the impact of successfully tested health interventions so as to benefit more people and to foster policy and program development on a lasting basis (WHO, 2010).

Health system reforms have to be done in collaboration with various partners, across various sectors. It is important, particularly, for end-users to feel a need for the intervention [12]. Top-down measures often fail due to lack of sensitivity to the field practice and the community needs. As features of mental health are products of the social, political and cultural environment, similarly interventions, even when replicated, need to be contextualized to sensibly respond to the specific needs. Over the past decade, some of the models have been replicated and scaled up in various other states, showing great promise and potential for growth as a result of expressed need by local communities, participation of local stakeholders and a large influx of peer leaders driving these movements at multiple levels across the program, bringing in their collective wisdom and lived experience into problem solving and negotiating ethical dilemmas.

Scaling up also requires adequate training and transfer of knowledge. The key however, is an alignment in the value deck of parenting organizations. Value based care is the fulcrum of The Banyan, considering the legacy of mental ill health and human rights violations.

Based on literature, factors that help to scale-up interventions are e.g. to keep the design of interventions simple and allow for the involvement of community and national 'champions' [1]. This has also been the experience of The Banyan, that involving people with a relevant network, a level of power and a passion for change, works well. Champions, in that sense, can be actors at all levels, ranging from people who are actively engaging with others in their

schools, community, and among colleagues, but also figures active at policy and development level. Advocating for champions may also be important to gain more momentum. Open communication systems to enable responsible, responsive and immediate problem solving support for the partner organization helps in strengthening collaborations.

Other strategies involve being aware and sensitive to any policy or institutional changes in the country that may facilitate scale-up, such as the introduction of a financial scheme or change in a previously obstructing legality. Personal connections with government decision-makers might be important here, but also finding ways to connect interventions to ongoing and potentially related subjects currently addressed by the government [3]. Political will can be crucial in facilitating change, which means that to scale-up successful interventions; efforts must be made to bring forward evidence and arguments for government bodies to invest in a particular direction. Similarly, Spicer et al. [12] describe that interventions that align with governments' health priorities and political frameworks are scaled up more effectively and sustainably.

Thought-Points

1. Data on homelessness mentally ill are underestimated globally. Diversity of models that service them are also limited in their creativity. The extent of social and health losses incurred as a result of this wicked problem therefore remains largely hidden. Persons currently continue to live symptomatic, unwell, impoverished and disenfranchised in jails and prisons, beggar's homes, National Urban Livelihoods Mission (NULM) shelters, on the streets, in mental hospitals, and in care homes. Clear and standardized pathways into care and protocols to enable these inroads are absent.

2. This could be operationalized within a policy framework which is nonexistent for HPLMI, an important aspect of Minority Mental Health that attempts to address intersectionalities.

3. Implementation challenge is a significant barrier in translating policies into actionable outcomes. Training and increased status and compensation for mental health professionals (MHPs)/Human Service Professionals (HSPs)/Development sector workers and the skilled non tech workforce is mandatory. Psychiatry has to open up to embrace related domains and remain less territorial. Staff client ratio in most places remains grossly inadequate as do measures to promote effective use of public spaces and public health infrastructure. Non-negotiable should include sanitation, nutrition, personal attention, and therapeutic needs being met; both for service users and care providers.

4. Care centers, be it ECRC type setups or hospitals or NULM shelters, are overcrowded, with limited scope for in depth work on trauma, rehabilitation, enhancement of social capital and the like. Such centers should ideally follow a set of protocols that treat the clients' using bio medical, psychological and social approaches and at the same time focus on prevention of recurrence of homelessness and unbearable suffering by establishment of support networks. Therefore after care that is integrated within public health and social care systems are key and facilitation of the same as part of care protocols essential. A bio-bio or bio-psycho approach is what we currently observe.

5. Decentralization through establishment of ECRCs for HPLMI at the district level, like in Tamil Nadu, implemented by the NHM is one of the ways forward. As a result, localized access may be offered, coverage is greater, continued care easier, turnaround time significantly lesser as the person in distress is serviced faster (Social losses as a result of long travels, exposure to harm and abuse and exacerbation of symptoms owing to delay in accessing mental health care, may be prevented), therefore total number of persons benefited increases substantially. Stigma is also addressed effectively as a consequence of the centers' location within a PH service. In addition cost per unit is significantly lower; both are notable secondary level gains.

6. Social care components that address the bi-directionality are critical along the continuum - therefore a policy unique to Minority Mental Health (MMH; ref: point 2) may emphasize access to constitution mandated entitlements and access to livelihoods based on reservations as per the Rights for Persons with Disabilities Act (RPDA). Workforce participation is essential to addressing the poverty traps and structural barriers associated exclusion.

7. In the case of hPLMI with severe disabilities, inclusive living options not just promote social mixing and by association, impact attitudes, key to battling stigma, but also challenge neurotypical world views. Quality of life gains and cost effectiveness related to the model have also been established.

8. Partnerships between state and state actors, state and civil society and within civil society is a sensitive issue concerning human relations. While the vision is universal, personal approaches, ideologies, aspirations and organizational structures sometimes come in the way of healthy collaborations. This needs to be recognized and addressed in pragmatic ways.

9. Finally appropriateness of care alongside accessibility and affordability cannot be emphasized enough. Attitudes in care provision, a sound value deck that serves as a fulcrum advising services, focusing on dignity, cultural congruence and subjective realities of the mental health service user. The future of academic psychiatry is social [11], this cannot be closer to the truth in a country with the sort of diversity that India presents.

Conclusion

An integrated model of equitable mental health care has to address social disadvantage, and exclusion. However, landscape level policy and implementation changes have to be initiated to improve basic standards of living of a majority of persons. Health is a public good and increased investments may widen scope and include nutrition, awareness of health rights, focus on social health, women's health, child health etc and segway into broader social justice and equity based care paradigms that challenge discriminatory practices. These will therefore require intersectoral coordination, a certain path towards bridging care gaps, addressing intersectionalities and promoting convergence. Mental health is an appropriate lens that can lend itself to addressing individual, familial, community and societal well- being in keeping with the Sustainable Development Goals.

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