

# Chapter 4. Persistent, complex and unresolved issues in the Indian discourse on mental ill health and homelessness

## **Abstract**

Challenges in the provision, accessibility and corresponding treatment gaps in mental health services in India and other low- and middle-income countries have been the subject of considerable discussion in recent times. Moving away from frequently acknowledged macro concerns, a few recurring, persistent problems remain insufficiently analysed. The chapter aims to capture the complexity and distress caused by the co-occurrence and interrelatedness of poverty, mental ill health and homelessness. It examines the ramifications of this nexus in domains including health systems and access to health care, productive living and full participation, social attitudes and responsiveness, and the development of human resources and leadership in the social sector. It also discusses the failure to engage with these issues which results in greater vulnerability, distress and social defeat among the affected populations.

## **Introduction**

‘The global burden of disease study 2010’ indicates that the health of a given population can only improve if the prevention and treatment of mental ill health and the prevention of substance abuse are public health priorities (Institute of Health Metrics and Evaluation, Human Development Network, & The World Bank, 2013). Epidemiological studies indicate a lifetime prevalence of mental disorders among adults ranging from 12.2% to 48.6% (Kohn, Saxena, Levav, & Saraceno, 2004). There is, however, great variation among individuals and populations who are able to obtain access to mental health services. Rates of access to mental health services are lower in low and middle-income countries (LMICs), including India, despite greater need. Multiple factors influence health outcomes, many of which have been well

researched and discussed in scientific and grey literature. These have led to the emergence of substantive policy recommendations, including increased public expenditure on health, the development of effective human resources, and the deployment of well integrated, cost-effective and accessible treatment options. These recommendations have become increasingly rhetorical because changes in the Indian context remain painfully slow.

In the next section, some of the persistent problems that have hampered change in the Indian mental health system are considered. Many of these problems are to be found at the nexus between mental ill health and poverty. In this discussion, the following definition of persistent problems is employed:

Firstly, they are complex: multiple causes and consequences exist- covering societal domains – and they are rooted in social structures and institutions. Furthermore, they are uncertain; no easy solution exists, reduction of uncertainty by mere knowledge is not always possible, and every possible solution changes the perception of the problem. Thirdly, they are difficult to manage; a lot of different actors – representing different interests – are involved, and they all try to influence each other while remaining relatively autonomous. And lastly, they are difficult to grasp; structure and boundaries are unclear in relation to a strong system dynamic.

(Scuitmaker, 2010 in Broerse & Bunders, 2010, p. 31)

Against this background, the nexus between mental ill health, poverty and homelessness is discussed. The contemporary understanding of mental health accepts the association between ontological security (a stable mental state), an acceptable quality of life and improved mental health. The discussion is no longer restricted to the realms of neuroscience and psychiatry and to dopamine and serotonin balances; it is also about the social system and its impact on the way people think, act and live in harmony with themselves and their surroundings. While poverty, mental ill health and homelessness are complex problems in isolation, they are particularly persistent when combined. Each of these phenomena is influenced by multiple factors

(Loorbach, D., & Rotmans, 2006). The consequences are also detrimental and multi-dimensional, resulting in acute distress that affects many domains, especially health, quality of life and emotional strength. Poverty is at the core of this distress. Poverty can often be the tipping point, pushing a person who is experiencing mental ill health into homelessness, and vice versa. In the next section, the nature and extent of poverty and its impact on other strands of the mental ill health- poverty-homelessness nexus are considered.

### **The Poverty Factor**

Seventy per cent of India's population continues to live on less than USD2.00 a day, while 37% live on less than USD1.25 a day. This measure of poverty is defined in terms of the ability to purchase basic goods. However, many other impediments also affect the lives of the poor. For example, people living in rural and remote areas in India either succumb to chronic ailments like cancer and kidney problems, or are unable to seek treatment because of the lack of adequate facilities in low- resource settings. Despite the large spread of Primary Health Centres (PHCs) across India, many remain closed (Banerjee & Duflo, 2012). When they are open, they are inadequately equipped to respond to needs in terms of attitudes, human resources and infrastructure. These inadequacies push people further into debt as a result of having to pay for private health care. The Business Standard Health Report 2010 states that nearly 25% of the poorest quintile in rural areas forgo treatment when they fall sick (Mahal, Karan, & Engelgau, 2010). The National Sample Survey Organisation indicates a rise in out-of-pocket spending from 32% of total income in 1995–96 to nearly 45% in 2004, pushing many people below the poverty line (Mahal et al., 2010).

While there continue to be major deficits in health care, education is also failing to promote upward mobility. Public education is grossly inadequate and does not prepare children for a healthy, productive future. This has been demonstrated by a survey conducted by Pratham, a large Indian non-governmental organisation (NGO) as part of the Annual State of Education Report (Banerji, Bhattacharjea, & Wadhwa, 2013). Pratham tested 700,000 children in randomly chosen villages. Almost 35% of those aged 7-14 years were unable to read a simple paragraph (first-grade level) and almost 60% could not read a simple story (second-grade level). Only 30% could perform

second-grade mathematics (Banerjee & Duflo, 2012).

Despite India's industrial progress which has created an affluent few, 200 million of the 600 million population are without electricity and have never been connected to power (Dreze & Sen, 2013) symbolic of the darkness they experience on many counts. While India's economy has grown rapidly in the past two decades, basic requirements such as good nutrition – 'children and adult women are more undernourished in India (and South Asia) than almost anywhere else in the world' (Dreze & Sen, 2013) – are being neglected. Although India's gross domestic product (GDP) per capita has increased dramatically compared to the South Asian region as a whole, its social indicators and commitment to equity have been gravely neglected. Lack of commitment to equity is also evident in the government approach to health:

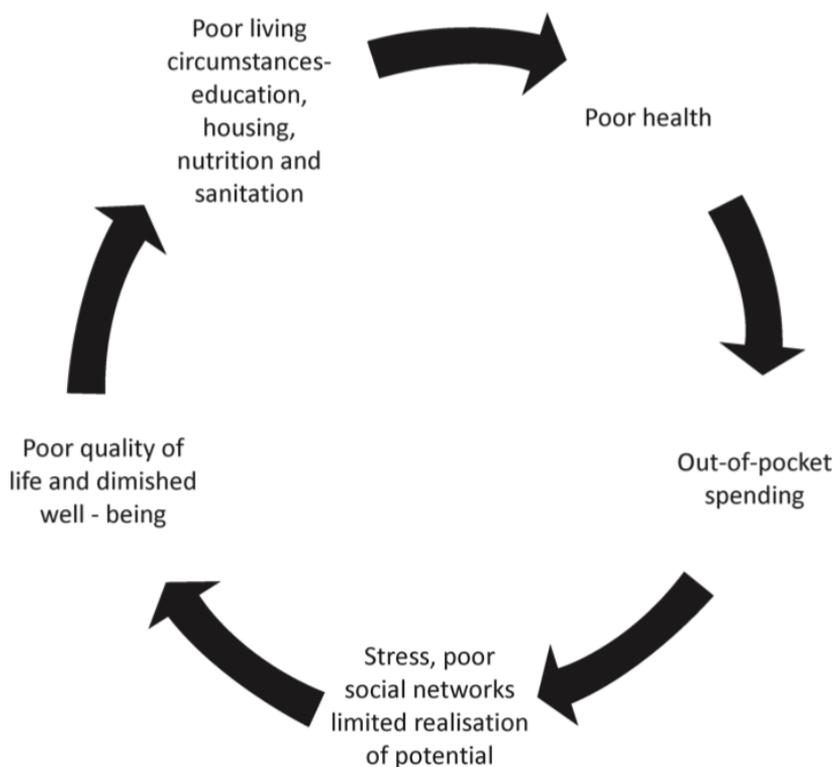
A related symptom of India's lack of governmental commitment to health care is that public expenditure on health accounts for less than one-third of total health expenditure. Only a few countries (such as Afghanistan, Haiti, and Sierra Leone) have a lower ratio of public health expenditure to total health expenditure.

(Dreze and Sen, 2013, p. 139)

In addition, sanitation is also poor in India with almost 50 million people defecating in the open, resulting in rising rates of diarrhoeal infections (UNICEF, 2009). India has lower literacy rates, poorer nutritional status, and higher infant and maternal mortality rates than most other countries in South Asia. Its long-standing neglect of children (the proportion of underweight children in is twice that in Sub-Saharan Africa), women and other vulnerable groups has led to skewed, non-inclusive and disparate growth (Dreze and Sen, 2013).

Figure 4.1 indicates the absence of exits from this vicious cycle of poverty, ill health and compromised well-being. The fragmentation in India's public health system has reinforced linear understandings of health and well-being; interconnections between health and well-being are often ignored. There is poor coordination between horizontal and vertical systems, resulting in few or no linkages in implementation, health-related communication and training.

This situation interplays with gender and other cultural dimensions to further fragment the system. Neglect of the social system generates inequity, increasing the extent of multi-dimensional poverty.



**Figure 4.1: The Ill Health and Poverty Nexus**

The associations between health, inequality and income or social disadvantage have been explored by epidemiologists, social scientists, health researchers and economists. According to the economist Angus Deaton (2008), the richer and better educated are likely to live longer, healthier lives than the poorer and less educated, and also experience lower rates of mortality and morbidity. The psychiatrist Daniel Kahneman and economist Angus Deaton suggest that low income exacerbates emotional pain as a result of poor health. It results in a greater incidence of divorce, lack of care and loneliness, and has a negative impact on emotional well-being (Kahneman & Deaton, 2010). The Gallup data analysed by Angus Deaton in 2006 demonstrated the positive effect of wealth on life satisfaction (Deaton, 2008).

Epidemiologists regard socio-economic status as the fundamental cause of health outcomes and classify income inequality as a health hazard. Research conducted on sugarcane farmers demonstrated the negative impact of scarcity on cognition (Mani, Mullainathan, Shafir, & Zhao, 2013). In addition, scarcity affects mindsets, influencing people to think and behave in ways that could negatively affect long-term gains (Mani et al., 2013). The focus is always on meeting the most immediate need; investments in health and education are forgone or neglected.

### **The ill health and mental ill health and poverty nexus**

Studying the epidemiology of common mental disorders in South Asia, Patel and colleagues (1999) cited old age, poverty, female gender and low levels of education as risk factors for vulnerability to stress and to experiencing depression and anxiety. Further, close interactions have also been observed between socioeconomic deprivation and mental disorders, with debt, poor housing, overcrowding and economically disparate societies emerging as risk factors that lead to greater susceptibility to schizophrenia (Patel & Kleinman, 2003). In 2010, the World Health Organization (WHO) found that people living with disabilities were among the poorest worldwide, with nearly 75% of mental disorders among people in LMICs (WHO, 2010). Besides the obvious manifestation of disorders, income inequality was found to be negatively correlated with social cohesion and social capital, and could precipitate a state of chronic stress.

The diverse, transformational and evolving nature of mental illness and society – and thus the set of anomalies, ambiguities and inconsistencies that go with it – can make it stressful to work in this sector. Whatever the intervention, there can never be complete confidence that it will have a clear outcome, unlike the case of most physical ailments. The system of detection and treatment, while based on science and empiricism, is not always accurate since the spirit-level dynamics of the psyche cannot always be captured in absolute ways. The relationship between the body and the spirit exists in mental health more than in any other branch of medical care.



**Figure 4.2: Pursuing well-being**

Figure 4.2 shows representations of the many facets that contribute to overall well-being over the course of a person's life. The variables and influences include demography, birth, parenting, kinship, socio-economic background, social, sociological and ecological health, working life and major life events. In addition to biochemical changes and life disruptions, personality traits and stress endurance, coping mechanisms and resilience patterns also need to be taken into account.

As a consequence, a basket of interventions that combine the conventional evidence-based responses with the eclectic or psychodynamic – through a trial-and-error method – would constitute a care plan that would typically vary from one individual to another, with some basic protocols that could be regarded as an optimum intervention plan. All these dimensions work together to contribute to a person's mental health which makes the related

discourse very complex. This lack of simplistic clarity in the science of mental health is disconcerting and hampers effective interventions.

### **Homelessness and mental illness**

Conceptually, homelessness refers to the absence of a safe, clean and permanent habitation or home. Those living in emergency shelters, on the streets (sleeping rough) or in insecure or inadequate arrangements can be classified as homeless (Tsemberis & Eisenberg, 2000). Research indicates that the safety threshold is crossed when a person experiences extreme vulnerability, resulting in a downward spiral into homelessness. Those who are living on the streets are just as likely to experience psychotic episodes as a person who has a mental disorder; and those who experience psychosis are just as likely to become homeless as a result of the illness. Tanya Luhrmann (2010) considers the risk:

In 1998 the American Journal of Psychiatry published research that tracked patients after first hospitalization at ten out of twelve Long Island, New York hospitals. In this study, one in six patients with psychotic disorder either had been homeless or would become homeless in the following two years. In 2005 the journal published another study that analysed the records of all patients treated in the public mental health system in San Diego over the course of one year. One in five patients diagnosed with schizophrenia was homeless at time of contact. Both studies – by the nature of their measurement and method – undoubtedly underestimate the risk of periodic homelessness for those with schizophrenia or some other psychotic disorder.

(Luhrmann, 2010, p. 146-47)

Very few conditions have as debilitating or devastating an effect as the co-occurrence of homelessness and mental illness. Periods of homelessness compromise mental health while untreated or chronic mental illness can render a person homeless. The latter process tends to be more frequent in low-resource settings, especially among people who are living in poverty with poor access to health care. Homeless persons with a mental illness suffer a

life of uncertainty, often scavenging for food from garbage bins. Largely feared or ignored by society, they often are victims of crime and deprivation, and are vulnerable to other types of ill health. Women, in particular, are prone to exploitation and often live in fear. People's mental ill health often robs them of basic survival and self-preservation skills; many are found wandering emaciated and with wounds that are sometimes infested with maggots. Homeless persons who have a mental illness are also far more likely to suffer from other problems including substance abuse, cognitive deficits and suicidal thoughts (Muñoz, Vázquez, Koegel, Sanz, & Burnam, 1998)

While mental illness and substance abuse are pathways to homelessness, other causal factors include urbanisation; industrialisation and the related loss of traditional jobs such as farming or weaving; migration; acute poverty; unemployment; social exclusion; the changing structure and culture of the family; and chronic health issues and related out-of-pocket spending (Johnson & Chamberlain, 2008). According to the 2011 Census of India, there are 1.8 million homeless persons in India (*Census of India 2011*). While developing nations seem to be struggling with this issue, similar trends are observed in high-income countries. It is estimated that 20-25% of a nation's homeless population suffers from some form of severe and persistent mental illness (National Resource and Training Centre on Homelessness and Mental Illness 2003).

In conclusion, the absence of an appropriate, accessible public mental health system and strong poverty-alleviation mechanisms distances the poor from pathways to care (WHO, 2010). When this journey culminates in homelessness, the problem assumes the grave dimensions of a public health emergency and a social catastrophe. Given the increase in mental ill health and inequity, this downward spiral is not to be ignored, placing those at the bottom of the socioeconomic pyramid at high risk. Having established the complexity and persistence of the mental ill health-homelessness nexus, this framework is now employed to discuss the significant challenges that require urgent attention at multiple levels.

### **Disability and health promotion – a development agenda**

Disability and health are somewhat marginalised in the development agenda, despite the fact that persons with living with disabilities have been found to

among the poorest in the world (WHO, 2011). While niche movements to promote rights of people with disabilities provide an impetus in the right direction, the United Nations Convention on the Rights of Persons with Disabilities rightly focuses on the need for greater cooperation to ensure that disability issues are integrated into the wider development discourse (UN General Assembly, 2006). Similarly, according to Amartya Sen, 'health constitutes an important capability, in that it enables individuals to pursue things they may value' (cited in Mahal et al., 2010, p. 9). In India, where the health budget represents as little as 1.2% of GDP – compared to the military budget which is among the top ten worldwide and represents 2.5% of GDP – the intent to allow health and productivity to take centre stage seems questionable. Mental ill health is affected as a result of lethargic action on both counts, sitting at the cusp of health and disability discourses (Garg & Nagpal, 2014).

### **Poverty alleviation: how serious is serious?**

The endemic nature of Indian poverty has long been the reality; most Indians are conditioned to this injustice. Multiple deprivations, inequities and disparities are growing, as is the divide between the affluent and the less privileged. While markets and the economy are essential to growth and progress, these cannot be achieved at the cost of inclusion and justice. Many policy-makers and reformers, including the polity, claim to have given this all-pervasive issue considerable thought and resources, but how serious are these stated intentions? If growth targets have been surpassed and a few luxuriate in high-quality health care, housing and other amenities, why is the vast majority relegated to a life of penury and hopelessness?

Srinivasan & Mohanty (2004) observed that households belonging to the Scheduled Tribes (ST) and Scheduled Castes (SC) were living in 'abject deprivation' (49%) and 'moderate deprivation' (41%) respectively, and have limited access even to basic amenities. Reporting of ailments and the uptake of health services is lowest among these groups. Diversity is the norm in India: districts can show enormous variation on many indicators; single villages can demonstrate caste, class and gender bias; and there are considerable rural and urban divides and disparity in political investment and resources.

Among the many aspects that render a person vulnerable, gender is critical in determining health-seeking behaviour. India ranks 137 in the 2012 Human Development Index and 129 on the Gender Inequality Index (GII) (UNDP, 2012). The GII is based on three dimensions: women's reproductive health, empowerment and participation in the labour force. Thus, the susceptibility to ill health, stress and marginalisation is pronounced at different stages of the life of girls and women.

### **Weak and inaccessible health systems**

Health in India is politically and administratively divided between the central and State governments, with federal independence playing an important role in budget allocation, interpretation of policy and implementation. So what the central government mandates is not necessarily relevant or regarded as obligatory in any given State.

The National Mental Health Programme (NMHP) is integrated into the primary health care system in India, through its PHCs, the only accessible and affordable provision of health care across its uneven, diversely and differently resourced regions. The 1978 Alma Ata Declaration identified primary health care as a critical pathway to achieve universalization of healthcare. WHO describes, primary health care as involving the health sector, agriculture, animal husbandry, food, industry, education, housing, public works, communications and other related sectors and demands the coordinated efforts of all these sectors (WHO, 2005). As early as 1946, the Bhole Committee stipulated that 'no individual should fail to secure adequate medical, curative or preventive care, because of the inability to pay for it'. It called for special focus on vulnerable groups, including those with a mental illness.

Against this background, the PHCs are not always accessible and 11% (14.4 million) of rural households do not receive treatment (Implementation, 2002). Poor connectivity and inadequate road and transport services impede the use of PHC services. In addition, potential users do not have faith in the services and fear discrimination on account of their poverty and lowly status, further distancing people living in poverty from those who provide the services. In a crowded, understaffed PHC, patients are hardly given the opportunity to express concerns or grief and enjoy private time. Das and

Hammer refer to the prevalence of the 3- 3-3 rule: ‘the median interaction lasts three minutes; the provider asks three questions and occasionally performs some examinations. The patient is then provided with three medicines’ (Das et al. 2008 cited in Banerjee and Duflo 2012). While this is the observation in the private sector, public health providers are said to spend negligible time with patients, with minimal communication and physical contact.

In these circumstances, health is not the equitable commodity envisaged in the Indian Constitution. It is on a shaky, unequal and under-resourced public health system that the NMHP piggybacks. The NMHP was initiated in 1982, with the aim of integrating mental health care and primary health care and reaching the previously unreached through the early identification, treatment and referral systems for common and severe mental disorders. The District Mental Health Programme (DMHP), however, covers only 123 of the country’s 640 Districts, 30 years after the NMHP was introduced. Even in these districts, the programme is not fully operational, facing problems akin to those faced by the PHCs – lack of human resources, training and medication etc., forcing those in need of health care to seek private services or simply to ignore the problem or live with it. Community participation and linkages that are considered mandatory in any public health programme are virtually absent in the NMHP which is almost always driven by a specialist, usually a psychiatrist, despite the integration and convergence of approaches promoted by WHO.

Health management includes effective vision, leadership, governance and implementation. In order to plan for a robust and systematic approach to health, the stage has to be set. In the current scenario, frequently exposed to inadequacies, crisis-fighting becomes the norm, allowing only limited time and space for the adoption of finer values such as responsiveness, sustainability, impact measurement and enhancement. Poor sanitation, nutrition and housing, under-equipped clinics and demotivated, overburdened staff are the norm. Exploration of financial and medical products, promoting community health and positively influencing help-seeking methods to build healthier and happier communities remains a distant goal, despite being reiterated frequently in policy documents and international

treaties and mandates. Systemic changes and innovations, while urgently needed, may not thrive in a disempowered, poorly regulated, fragmented system, where coordination among departments responsible for health, social welfare, health education, and rural and urban development is far from healthy or cohesive. Usually only the symptom is treated, if at all, allowing for the barrage of reasons behind the external manifestation to fester, building a climate and attitude of poor accountability, apathy and inertia.

According to a study by Patel and colleagues (2012), suicide rates in India are among the highest in the world. A significant number of those who take their own lives are aged between 15 and 29 years, primarily women. While distress related to socio-economic factors could well be the underlying cause of this trend, the high incidence is also a mental health concern and a public health priority.

### **Human resources: better quality and motivated or more in number?**

Professionals and others working in the mental health sector include nurses, psychiatrists, social workers, psychologists, occupational therapists, primary care physicians, community workers, barefoot counsellors and health workers. While some of these are part of mainstream health system, few have been trained to work with people who have mental health issues. A 2002–2003 World Bank study on absenteeism in Bangladesh, Ecuador, India, Indonesia, Peru and Uganda found that the average absentee rate of doctors and nurses across these countries was 35%, against India's 43% (Chaudhury & Hammer, 2004).

However, the challenge is not only the number of staff but also the quality of training, interventions and services. The current response to many psychological problems is predominantly medical; this approach needs a re-think within the public health system, keeping in mind the cultural and social contexts. If medication is the first line of treatment and primary care physicians are mainly responsible for identifying and treating mental illness, many of them feel under-equipped to do so given the brief training in psychiatry in the medical curriculum (Jacob & Kuruvilla, 2016). Jacob questions the capacity of general practitioners to identify depression, anxiety or other common mental disorders if their only interface with psychiatry is

an acute care centre or tertiary-level hospital for patients with severe mental disorders. Besides pharmacotherapy, there are few resources at this level to alleviate distress related to the patient's psycho-social concerns.

From another perspective, motivation seems to be a significant challenge in this sector. To work in the public sector, health professionals need to sacrifice more lucrative career paths in favour of working in a low-resource setting. In such an environment, the professional would be facing the same complex problems as those of communities, ranging from poor infrastructure, sanitation, education systems to inadequate roads, connectivity and health services. The stress of living in a politically layered society and facing such barriers would intimidate the most committed and passionate of health professionals. How can one expect services to be highly efficient when morale is low? While convergence is largely a broad policy goal, to date many of the District Mental Health Programmes do not recruit social workers or psychologists. This sets barriers to transdisciplinary participation. Working with complex mental health issues can present its own set of difficulties for the mental health professional. Occupational hazards, interdisciplinary rivalry and being undervalued are further challenges faced by non-medical specialists.

*Leadership:* Even in the training of mental health practitioners, strategic management and leadership development take a back seat. Implementation involves not simply the accumulation of knowledge to inform practice but also the development of an *aptitude for creative problem-solving and critical, analytical and sometimes lateral thinking* as well as an ability to *innovate*, keeping a clear view of the long-term vision and goals. In the social sciences, in particular, there is a need to examine and review current teaching methods in order to promote the development of real-life and real-time perspectives, strategy and character.

*Values:* Among the many values that are universally critical to any individual, those that stand out as most relevant in the context of mental health include appreciation of diversity; affinity with a culture and ethos of responsiveness; ability to understand, live, confront and work with complex problems; and, most importantly, to respect the inherent dignity and rights of the individual person.

Values are lost or deficient on many counts: in the mental hospitals, in the community, in civil society organisations (CSOs) and in society at large. Mental hospitals are, in a sense, the opposite of everything that represents healing and recovery from mental disorders. Owing to poor living conditions and a discriminatory approach, mental hospitals are feared rather than sought. This raises stigma levels rather than offering relief and encouraging caring partnerships between the patient and those providing health care. Even today, there have been only limited reforms in mental hospitals.

There is widespread apathy and inertia; Indian society has become focused on advancement, accepting that personhood and rights only apply to a few. People in mental hospitals or living in communities under distressing conditions become invisible. Homeless people are barely a part of our society: they exist and yet are expendable. Democracy based on simple majority rule seems to have led to the assertion of the primacy and rights of the dominant and powerful groups, undermining empathy, acceptance of diversity, kinship and culture.

*Fragmentation of rights:* Standards of rights and models of care are critical in this discourse. However, factoring in niches that are unique to geo-socio-political contexts is essential to the appropriateness of care. Macro planning has to be informed by micro-contexts and particularities. In India, rights seem to be dictated by international habitats and sensibilities that are sometimes irrelevant on the ground. Basic rights are critical for all and have to be set out clearly and also be made mandatory. In the context of disability and mental ill health, however, measures to promote human rights have to be understood in the language and culture of the persons affected which is often at variance with global standards. These balances are delicate; the sophistication of expression alone cannot be deemed a significant protector of rights. Deep engagement with socio-political contexts and distress arising from the denial of rights and voice is the only way to build trust and to empower groups and individuals experiencing issues related to their mental health. Any sense of universality in what is inherent (dignity) and promoted (rights) runs counter to the ideology of being person- and context- centred, driven, dependent and determined.

*Divided lobbies:* Many landmark laws, empowering policies and welfare

mechanisms aimed at improving peoples' lives, have worked. This is the result of persuasive advocacy driven by multiple stakeholders who set aside individual differences to ensure larger gains for those whom they serve. In the process, compromises are made – without departing from core principles – in order to accommodate other views. Despite the lack of total consensus, lobbies join together to ensure a balanced approach on vital issues. The Indian mental health lobby remains divided on issues of rights, institutionalisation and access to care. It has been unable to reach a middle path that is acceptable to most stakeholders. Competitive goals and political persuasions sometimes cast advocacy in a particular, non-productive light. The inability to grasp complexities and the obvious discomfort with responses that do not fall into prevalent and populist notions of rights or evidence is a cause for concern. On the other hand, paternalistic approaches to mental health, inhumane practices in institutions and the community, ethical compromises driven by the pharmaceutical industry, watertight categorisation of mental disorders, criminalising legislation, violent 'round-ups' of persons who are homeless and affected by mental health issues, power hierarchies and the overall exclusion of people with differences is equally distressing. However, advocacy is usually driven by urban, English-speaking representatives, who may not be entirely aware of the reality of fellow activists who come from and serve a different or less privileged background/population, and who experience different realities. A middle path is viable, but personal egos often get in the way, making this debate one of personal ideology and achieving success and less about alleviating distress and suffering. Negotiations and conversations rarely take place. Thus such movements, while positive in structure and approach, fail to recognise many local issues, generalise interventions and themes beyond acceptable limits, and assume custody and leadership over large populations. While some of these interventions are meant to dismantle power structures and empower the invisible and voiceless, a top-down approach reinforces power structures.

*The urgency to scale up:* Unless the health system promotes a development-driven agenda, many of the complex issues discussed earlier will become harder to address and redundant, despite the presence of a specific health policy. Health access and infrastructure must necessarily improve in order to facilitate any scaling up. Most models and protocols that are suggested as

replicable have to be tested locally, taking into account context-generated inconsistencies and challenges. Scaling up is essential and needs to be promoted. However, sustainable growth, progress and transformation will only thrive if the uncertainty arising from poverty and its consequences can be mitigated.

*Heightened vulnerabilities within this nexus:* While homeless persons with mental ill health experience extreme distress, equally vulnerable are children living with their homeless parents and also sleeping rough. Young and elderly caregivers are also vulnerable in view of their frailty and inability to cope with the situation. Chronic disability as a result of mental illness affects not just the patient but also the carer.

*Co-morbidity:* Many homeless persons who have mental health issues, men in particular, develop co-morbidity, particularly substance abuse with severe health and socio-economic repercussions as well as greater vulnerability to suicide (Shelton, Taylor, Bonner, & van den Bree, 2009). The strategy and spaces to address this issue are currently either unavailable or inadequate respectively. The homeless and poor are far more likely to attempt suicide than other members of the population (Schutt, Meschede, & Rierdan, 1994).

*Long-term care:* People with mental illness often experience chronic disability and thus require ongoing support over extended periods of time. In the case of homeless persons with mental illness, elderly patients, and those being cared for by elderly parents, spouses, family or friends, their needs are gradually becoming a cause for concern. Many of those with long-term needs are languishing in mental hospitals, jails or on the streets, barely existing, waiting to die. Based on a single-day census, mental hospitals in India recorded a 45% occupancy rate of in-patients with long-term needs. This compelling statistic reflects the nature and extent of the problem: approximately half of those currently being treated in Indian mental hospitals may never leave them (Reddy, 2001). The abysmal state of most mental hospitals further complicates the situation, indicating the possibility of rights violations and the poor quality of life that many of these patients are likely to experience until their death. In addition, many who currently live in their own home are at risk of a similar fate in the absence of safety nets. Often, their only other living options comprise either mental hospitals or the streets.

## **The nature of mental ill health**

While causal factors and phenomenology vary from genetics to social structures, the brain and the mind have always in a sense remained an enigma, despite advances in science and knowledge. There are not always simple solutions to addressing the needs of those who suffer mental ill health. While depression may have a scientific basis, pure sadness as a result of loss – loss of networks, property or identity – cannot be dismissed or ignored. The network of multi-dimensional circuits and paradigms further enhance the extent of complexity attributed to differences in behaviour and perception on account of mental illness. The debate on how personality, genes, social systems, neurotransmitters and imbalances interact continues to resonate with every mental health professional who takes a robust, engaged approach to deal with each patient.

Discussing these challenges brings some issues, visible and invisible, complex and persistent, into our immediate collective consciousness. Based on these considerations, this chapter makes recommendations for research, implementation, policy and training. These recommendations aim to influence the future course of health and well-being and the incidence of mental ill health and homelessness, deprivation and marginality. They aim to address distress at all levels – individual, family, community and society – and respond to conditions that precipitate distress with a firm hand, prioritising goals on the basis of their critical nature.

## **Real-world dilemmas and the way forward: the ostrich syndrome**

Given their complexity, many commentators take a simple approach to issues of homelessness and mental illness. In this situation, there is limited risk-taking in thematic inquiry and implementation; some issues are not adequately researched or addressed; and the obvious is reiterated and studied. This approach also inhibits innovation. Tough questions are rarely asked: under what circumstances can a homeless person with a mental illness be admitted; why do organisations fail; how is the quality of life in institutions assessed, keeping in mind social, economic and ethnocultural considerations; why is community care sacred when rights abuses are as common as in institutions; long-term needs; and patterns of care. In order to achieve any positive movement, this status quo and superficial engagement has to be challenged

and become a deeper, more meaningful commitment. This is a simple, yet essential, first step in a positive direction.

Lack of dialogue and the nature of competitive forces in the real world often get in the way of collaboration and inquiry. Personal aspirations, career paths and disciplinary rivalry are often counterproductive. In keeping with transdisciplinary methods, recognising these barriers and yet cooperating to achieve a greater vision is perhaps the only realistic and optimistic way to move forward. This is relevant in research, practice, teaching and implementation, where individuals and institutions from different schools of thought and with varied strategic visions and ideologies collaborate to address a large and pressing social problem.

*Implications for policy and society:* if reforms in the health, mental health or social sector are to achieve impact in the Indian context, they have to promote some sense of justice, balancing the current skewed pro-growth agenda with development and equitable progress for the majority. While good governance, effective planning, accountability and strategic feedback loops, based on real- world dynamics, will help to build stronger programmes, society at large needs to feel the urgency to pursue these goals more ardently. While the government and CSOs can uphold these goals, other critical players such as the corporate world and society have to feel responsible for building empathy, unity, fair-mindedness and equity. Safety nets have to be strengthened proactively, including unconditional cash transfers, disability allowances, open shelters for the homeless and soup kitchens. At the same time, access to basic services such as education and healthcare is a requirement. In the absence of appropriate delivery mechanisms, the government has to be held accountable. This transition will undoubtedly take time for fruition. All forces and stakeholders, however, have to be encouraged to collaborate to see this process through effectively. In the meantime, efforts to foster community participation and constructive engagement with social problems have to be encouraged in creative ways.

*Implications for research:* In the real world, programme implementation faces many potential interruptions ranging from fragmentation, staff burnout and complex problems, to lack of solutions and resource crunches. In this context, Angus Deaton challenges the Random Control Trial (RCT) - driven

approach to making the transition to scale up, and the over-reliance on this research method (Deaton, 2009). However, this trend is dominant with limited emphasis on practice-based evidence. Is empiricism overvalued with no grounding and valorisation of knowledge in the real world? Is the scientific community lacking not in ideas or research, but in those who can implement these innovations effectively? Most programmes that have been scaled up stagnate at a particular point, since research is often driven by a single agenda of studying a problem, while implementation tends to be neglected.

Broerse and Bunders (2010) discuss this when they speak of an emerging scientific field, namely system transition innovation and transition theory. They say that the central notions in this theory include the ‘multi-level perspective, the multi-phase concept and transition management’ (Broerse & Bunders, 2010, p. 10). Extending this concept to research, they recommend greater inclusion of stakeholders and the application of ‘a typology of experiments of increasing complexity’ (Broerse & Bunders, 2010, p. 14).

The purpose of social research is to have a positive effect on human lives, driving the necessary innovation and pragmatism to address issues that are relevant to the most complex problems. This remains neglected in mental health which demonstrates limited engagement with and insufficient research of critical issues: long-term or respite care; independent living options for persons with low, moderate and high needs; human resource training; performance gaps and burnout; voluntary or involuntary commitment; and caring patterns. Grand Challenges Canada and WHO are working together, inviting practitioners to engage in research and showcase bold ideas and practical interventions. While scientific efficacy is critical to this endeavour, equally important is the idea and the ability to implement it from transition to scale. There is a pressing need for similar funding initiatives and investment from local government and industry.

This argument is based on the hypothesis that the mental health system can only be fixed if well-being improves and poverty is addressed coherently. The discussion is not only about interventions or clinics, it is also about what we eat, the jobs we seek and the life we lead. While we wait for this large-scale transition, an effective way to overcome the ‘chicken and egg’ situation – whether mental illness or poverty comes first - is to address aspects or

elements of the distress of mental illness in part and thoroughly. Several government and CSO initiatives such as The Banyan, Ashadeep, Karuna Trust, TRU, SCARF, Ashwini, Sangath, Koshish, Anjali and Bapu Trust have shown how this can be done.

*Implications for practice and education:* Broerse and Bunders (2010) examine transitions in health systems and speak of the merits of a transdisciplinary approach to and engagement with multiple stakeholders to solve persistent problems, which are often of a complex nature. These insights are to be woven into existing practice codes so that a stronger system and structure of implementation emerges. Issues related to human resource policy and management, including those related to strategic leadership and motivation, status and career paths, have to be discussed in greater detail to ensure continued and deeper participation. In view of the nature of the problems and responses, social work education seems critical for those engaged in mental health practice. How current is such knowledge in the Indian context? What aspects need further development or a rethink from a pedagogical perspective? Is constructivist epistemology a line to pursue? These are crucial discussions that will aid in the development of context-specific training programmes. Education should move out of traditional classrooms into the field. Complex experiments should be treated as training grounds. They should be showcased as demonstrable approaches or responses to serious problems, constructing these in a dynamic and adaptive manner that meets the world's many realities.

*Implications for the rights movement:* Some commentators regard access to care and justice as a primary right, while others set greater store by personhood and legal capacity. Where does the call for constitutional and individual rights meet diverse perspectives and realities? The voices of the global South have not been adequately represented in these debates; this has repercussions for the tone and direction of the discourse.

*Fragmentation of rights versus collective voices in unison:* There have been debates on rights since the beginning of psychiatry in the wake of the inhumane experiments and degrading treatment for the mentally ill. In the process, however, some of the genuine benefits of treatment and safety have been underrepresented because of the dominance of a non-medical, non-

residential care ethos in the rights movement. The debate on admitting a homeless person into a care facility is often brought up as an essential part of the human rights discourse. Elyn Saks – a researcher, psychiatrist, lawyer and user of the mental health system – says, in this context:

If a person is unable to provide protection for himself from the bad elements and from malicious people and no less restrictive alternatives are available, we should be able to civilly commit that person until he can care better for himself, provided that he is impaired, transformed, and treatable. It seems correct, then, to say that the person is dangerous to himself and gravely disabled – he is exposing himself to more than usual harm from being homeless, and he is doing so as a result of his mental illnesses.

(Saks, 2002)

Extremes occur on both sides of the debate around residential and non-residential care. In the name of choice, activists refuse to engage deeply with complexities. As a consequence of this approach, women are raped, men wounded, children lost and lives ruined. On the other hand, society is intolerant of differences and communities are often inclined to clear their immediate vicinity of any such ‘troublesome persons’, more out of the need for personal safety than because of a sense of empathy or justice. Both of these stances are simplistic interpretations of human rights that fail to engage with the varied dimensions of the problem and vicissitudes.

## **Conclusions**

*The poverty–homelessness–mental illness nexus: the triple helix formulation*

Elements both in singularity and in this composition validate the theory of multiple causes, consequences and domain interactions discussed above. The binding and affinity between these independently complex units draws multiple actors into the mix, all representing diverse dimensions – for example, human rights, caste, marginalisation and poverty; gender, poverty and mental illness; migration, homelessness, substance abuse, mental illness and suicidal thoughts or suicide. Each of these variables represents a large disciplinary system – be it the humanities or philosophy, society or sociology,

social sciences or life sciences and health. While interacting with each other, these systems are also autonomous and have a timeline and direction of their own and are thus subject to and exert independent influences.

### *Distress footprinting*

Given the relativity and reflexivity attributed to each of these concepts, the sequence of events is seldom clear. However, a distress timeline can usually be built over a person's lifespan. Distress from a single source is usually less acute and chronic than distress from multiple sources. From this emerges a hypothesis that this composition has a catastrophic impact at multiple levels: individual and in kinship circles, and at the capabilities and social level.

This evidence points in the direction of one clear trend, namely that poverty not only leads to ill health but also stands in the way of seeking health and well-being. Ignoring poverty as the so-called elephant in the room will not make it disappear. Unless poverty-related deprivation or inequity is tackled in a decisive manner, little else can be expected to fall into place, irrespective of attempts, experiments or intentions. As the more persistent problem to address, planners and governments should acknowledge the truth that stares us in the face and respond to it a concerted manner. Equally important is the need to focus on other new and compelling challenges such as long-term care, carers' needs, value-oriented responses, strategic leadership, and so on, before they become intractable, insoluble crises. At the root of these actions are other corresponding benefits.

### *Note*

Since the writing of this article, India has released a new Mental Health Policy for the country that the first author also contributed to as a member of the Policy Group. For the first time, the policy considers the poverty-homelessness-mental ill health nexus, their inter-relational nature and mentions vulnerable populations that require focus including homeless people, those living in poverty, elderly carers and children of parents with mental illness. The focus on marginalisation as a cross-cutting thematic area is retained in several domains of recommended strategic action in the policy with an overall well-being outcome direction. Welfare entitlements and the integration of robust and diverse social care approaches into the service

delivery through strong coordination between various government departments are recommended. Partnerships with not for profit actors engaged in niche experiments to address persistent and complex challenges arising out the nexus feature in the policy. Organisations such as The Banyan, Koshish and the Centre for Equity Studies that work at the intersections of the nexus may thus find avenues to escalate their innovations for larger impact. This development represents a welcome start to more sustained, meaningful change for people with mental health issues further jeopardised by homelessness and poverty.