SSM - Mental Health 7 (2025) 100424

Contents lists available at ScienceDirect

SSM - Mental Health

journal homepage: www.journals.elsevier.com/ssm-mental-health

# From institutions to homes: Evaluation of a housing with supportive services intervention for people with psychosocial disabilities with histories of homelessness

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## ARTICLE INFO

*Keywords:*
mental health
community integration
Housing
Homelessness
social inclusion
Person-centered care

## ABSTRACT

Long-term institutionalisation of people with mental health conditions persists globally despite emerging rights-based reforms and a shift towards community-based care. In India, efforts to facilitate community-based alternatives are emerging. This paper evaluates the outcomes of a multi-site implementation of Home Again, a housing with supportive services intervention developed in India, for people with mental health issues who are long-term residents of state psychiatric facilities. Using a single group repeated measures design, changes in key outcomes were assessed for 214 participants enrolled across nine sites in India and one in Sri Lanka over a 12-month period. Statistically significant improvements were observed in disability, quality of life, community integration, clinical symptoms and hope. Qualitative findings underscore participants' complex experiences navigating the transition, marked by a delicate balance between freedoms and constraints. The study highlights the feasibility of implementing the intervention in diverse settings, its impact on participant outcomes, and the need for comprehensive strategies to address systemic barriers to full inclusion. The experience offers insights for scaling up complex, multi-faceted interventions for marginalised populations in resource-limited settings.

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https://doi.org/10.1016/j.ssmmh.2025.100424
Received 30 October 2024; Received in revised form 5 March 2025; Accepted 7 March 2025

## 1. Introduction

The intersection of homelessness and mental illness is a complex and pervasive issue that has long been met with inadequate and often exclusionary responses. Historically, people experiencing both homelessness and mental health conditions have been subject to criminalisation, marginalisation, and prolonged institutionalisation. In the Indian context, contemporary mental health care is intricately tied to colonial influences, resource limitations, and evolving socio-cultural perspectives.

Colonial-era laws, such as the Indian Lunacy Act of 1912, that began as an effort to harmonise care across the British Empire, eventually perpetuated long-term confinement of people with mental illness, particularly those found wandering the streets. In parallel, the legacy of vagrancy laws, that mirrored pre-welfare state poor relief systems, and sought to control a mobile populace institutionalising in beggar's homes is reflected in contemporary anti-poverty legislation. The combined ramifications have resulted in substantial penalties for homeless people (Raghavan and Tarique, 2018), including those with mental health conditions who navigate a circular path between custodial institutions and the streets. In India, the asylum model, introduced by the East India Company, initially advocated for care and protection in humane environments. Over a period, these spaces became vested with prejudiced ideas of the 'civilised' and 'sophisticated' 'Western mind' vs the 'primitive' and 'gullible' 'native' mind (Radhika et al., 2015). The evolution of asylums in India mirrors the global trajectory, initially established based on the 'moral treatment' paradigm that advocated for humane psychosocial environments. However, by the 19th century, many of these institutions had adopted an exclusionary nature, segregating the 'insane' from the 'sane' in far-removed geographies. The deplorable conditions of these facilities have been consistently noted in reports spanning decades, from Mapother's observations in 1937–1938 to the Moore Taylor report in 1946 (Murthy and Isaac, 2016), the latter of which points out issues of long-term confinement in these institutions.

Following independence, mental health care in India remained under-resourced and predominantly institution based. The scale of oligarchy increased in the 20th century, and with it, the notion of disabled people as a "burden" became prevalent worldwide. This was particularly evident in the post-World War II era, as exemplified by the concept of the global burden of disease. Newly independent colonial societies with little tradition of social welfare outside of religious influence were now part of oligarchic economic patterns as "free economies" that paid little attention to the scale of social welfare required. Efforts were postponed until these societies became "strong economies" or until their oligarchs were well-established, as documented in the Bombay Plan for India's post-independence finance management (Kudaisya, 2014). The constant financial austerity and cutting down of health and social welfare budgets were accompanied by an emphasis on communal and communitarian divisions, negating any space for uniform, accessible, and non-discriminatory care.

Historically, attempts to anticipate and address the entire process of mental health care have been made as early as the 1950s. However, a disconnect has emerged between the "real world" ideas and the "clinical" world ideas. Mental health care aligned itself closely with a medical focus, moving considerations such as social protection measures, service user aspirations for life and carer support including long-term living options to welfare and social work departments.

India's National Mental Health Programme, initiated in 1982, sought to shift care to the community level and increase access. However, implementation has been uneven (van Ginneken et al., 2014). The enactment of the Rights of Persons with Disabilities Act 2016 (Ministry of Law and Justice, Government of India, 2016) has codified rights for people with psychosocial disabilities, including the right to live in the community, but significant disparities persist between policy and practice. Of the approximately 1% of health budgets in India allotted to mental health, the vast majority are allocated to institutionalised care with no resources for initiatives that allow for community re-entry pathways. The lack of community-based alternatives and fragmented social care policies and practices have contributed to long-term institutionalisation in psychiatric hospitals. Additionally, there is lack of coordination between state entities for health and social justice and empowerment, and welfare mechanisms face multiple challenges, including insufficient funding, inadequate planning, limited facilities, and lack of support for crucial services like aftercare, rehabilitation, and community integration programs.

Long-term institutionalisation has proven counterproductive, stripping individuals of their autonomy, disconnecting them from their communities, and leaving facilities open to risks associated with overcrowding (Pfautz and Goffman, 1962; Thornicroft and Tansella, 2003). The issue is further complicated by a lack of substantive action to address the underlying socio-economic determinants that contribute to the nexus of homelessness and mental illness, such as poverty, displacement, family breakdown, violence, prejudice and normative conceptualisations around productivity and inclusion and lack of access to care. The significance of social determinants in precipitating homelessness raises essential questions about the psychiatry driven focus of discourse surrounding mental health care and long-term institutionalisation. What is missing is the substantive role of social sector engagement, and welfare measures in redressing the social exclusion of people with psychosocial disabilities.

The issue of long-term institutionalisation amidst facilities struggling to maintain bare minimum quality has been the subject of several judicial interventions, including attempts at comprehensive mapping of issues and reform actions since the 1946 report of the Bhore Committee and the 1999 report of the National Human Rights Commission (NHRC). In 2017, the Supreme Court of India passed an order directing governments to address the issue of long-stay populations in mental hospitals (Gaurav Bansal vs State of Uttar Pradesh, WP 412/2016). (Supreme Court of India, 2017). A comprehensive survey of 43 state psychiatric hospitals across 24 states in India revealed that 36.25% of service users had been institutionalised for over one year, with a median length of confinement of six years (Narasimhan et al., 2019). The prevailing conditions underscored profound social isolation, with many individuals residing in closed wards and never venturing outside the institutional premises or receiving external visitors. Most occupants did not present with acute care needs that necessitated tertiary psychiatric facility accommodations, and approximately 80% required minimal to moderate support, indicating their capacity to reside independently or with community-based support. More recently, in 2023, the National Human Rights Commission of India took suo motu cognisance based on reports filed by rapporteurs and directed State Chief Secretaries, Secretaries of Health, and Union Territory Administrators must submit to a report detailing how they are addressing "the illegal detention of cured patients in mental hospitals, ensuring their release to homes or halfway houses, and complying with Section 19 of the Act, 2017." (National Human Rights, 2023).

The process of reintegrating long-stay residents from mental hospitals back into families and communities is fraught with numerous barriers and challenges. These include difficulties in tracing and reconnecting with families, negative attitudes and stigma, poverty and lack of continued care, gender-based disadvantages and trauma, limitations of existing treatments, patients' reluctance to return to past traumatic environments, inability to conform to expected social roles, and increasingly fragmented families (Narasimhan et al., 2019). The intersection of social, economic, attitudinal, and clinical factors creates significant obstacles in transitioning long-stay patients back to families and society.

In response to the prolonged institutionalisation of people with mental illness, various institutions and community re-entry interventions have emerged. These include initiatives such as Tarasha, a Tata Institute of Social Sciences community-based recovery project supporting women with mental health conditions in transitioning from institutions to independent living (Maitra and Survase, 2020); Maitri, a collaborative effort between ActionAid and the National Human Rights Commission that reintegrated over 100 long-stay service users (ActionAid India, 2006); and the INCENSE programme, which has piloted a multi-component reform methodology in collaboration with two large mental hospitals in India. (Murthy et al., 2017). These approaches align with global trends in deinstitutionalization, such as the Trieste model in Italy (Mezzina, 2014) and Housing First (Aubry et al., 2015). Research on these models has generally indicated improved outcomes for service users, particularly in terms of quality of life, autonomy, symptom reduction, and community inclusion. Some studies have also suggested increased cost-savings for institutions due to the shift towards supported housing and deinstitutionalization (Ridente and Mezzina, 2016).

In this context, Home Again, a housing with supportive services intervention, developed by The Banyan and recognised by the World Health Organization (World Health Organization, 2021), aims to provide sustainable pathways to full inclusion for people with psychosocial disabilities, particularly those with histories of homelessness who are overrepresented in the institutional long-stay population. The Banyan is a civil society organization founded in 1993 in Chennai, India, to provide mental health and social care services to vulnerable groups. The Banyan directly operates its services in five Indian states and collaborates with nearly 20 partner organisations across ten Indian states and Sri Lanka. Funding is primarily obtained through various philanthropic organisations and corporate social responsibility (CSR) units of companies.

### 1.1. Home Again

Home Again is a housing, mental health and support services intervention that fosters choice-based, inclusive living spaces through rented homes in rural or urban neighbourhoods with a range of supportive services for people with persistent mental health issues owing to long-term institutional living. People come together to form affinity groups and live together in homes in a community, creating a shared space of comfort that mimics a familial environment. Along with housing, the intervention features allied supportive services including social care support and facilitation (opportunities for a diverse range of work, facilitation of government welfare entitlements, problem solving, socialization support, leisure and recreation), access to healthcare, case management (detailed biopsychosocial assessments and personalized care plans), and onsite personal assistance. It also focuses on lived experiences where health is one amongst many priorities to live well and not central to the array of supportive services offered.

Home Again is executed by a multidisciplinary team, a majority of whom are frontline staff trained to function in this context as personal assistants. A typical home has 4–5 people (who were living long term in institutions) with 1–2 onsite personal assistants visiting or living with them based on expressed need. Personal Assistants (PAs) are women, predominantly from rural backgrounds with no formal education in mental health, who are trained and supervised to support service users through individualized processes to achieve recovery consistent with service user priorities.

Home Again was evaluated in two phases using a quasi-experimental two-group design, with one group receiving Home Again as the intervention, and the control group receiving care as usual (CAU) at The Banyan's Emergency Care and Recovery Centres (ECRC) or similar institutional psychiatric facilities. In the first phase, the intervention was implemented in rural neighbourhoods in Tamil Nadu, a state in India. Participants were assigned to either the intervention group or the control group based on their stated preferences. In the second phase, the intervention was evaluated in urban neighbourhoods in Tamil Nadu and rural and urban neighbourhoods in states of Kerala and Assam. In both phases, no community readiness or disability thresholds were placed on participants for transitioning into the intervention. The results of these evaluations demonstrated that Home Again was effective in improving community integration and reducing disability of participants at a fraction of what it would cost for them to continue in institutions. The evaluations also demonstrated that the intervention was feasible to implement in a variety of settings and accommodate participants with a range of clinical needs. Following successful implementations across diverse sites, the intervention has been scaled up to ten sites in India and two low-medium-income countries (LMICS), Sri Lanka and Bangladesh, through local partners. This article presents the findings from the evaluation of Home Again's implementation in select states of India and Sri Lanka between October 2020 to September 2023.

## 2. Methods

### 2.1. Study approach and design

We employed a mixed methods approach combining quantitative and qualitative methods to evaluate outcomes from the implementation of Home Again across the nine states in India (Tamil Nadu, Andhra Pradesh, Odisha, Karnataka, Kerala, Assam, Nagaland, Maharashtra and Gujarat) and in one site at Sri Lanka. Partners were drawn from various networks within India's mental health sector and the state agency in Sri Lanka (see Table 1). Partners were identified based on their work with marginalised populations with mental health conditions, their engagement with government and private mental health institutions, and their ability to sustain the intervention post-trial period. Partners were trained in the intervention protocol via face-to-face and online sessions with scheduled site visits by a senior team from The Banyan and Banyan Academy of Leadership in Mental Health (BALM) to offer supportive supervision during the intervention rollout.

We used a single group pre-post design to measure participants' outcomes and understand changes over a 12-month period. Participants were followed up over a period of 12 months, with repeated measures every six months on outcomes of interest. Primary outcomes of interest were community integration and disability, defined based on the International Classification of Functioning, Disability, and Health (ICF) framework (World Health Organisation, 2001). Community integration included home integration, social integration, and engagement in productive activities, while disability measured levels of functioning across various domains, including cognition, mobility, self-care, interactions with others, life activities, and participation in society and community activities.

Measures and instruments used are presented in Table 2. While formal cross-cultural validation procedures were not implemented for

**Table 1**
Implementation states with partner organization details.

| Study Sites in India/ Sri Lanka | District | Implementing Organization |
|---|---|---|
| Andhra Pradesh | Vishakhapatnam | The Banyan |
| Assam & Nagaland | Kamrup, Chumoukedima | Ashadeep |
| Gujarat | Mehsana | The Altruist |
| Karnataka | Mysuru | Green Dot Trust |
| Kerala | Kottayam | Mariyasadanam, Mehac Foundation |
| Kerala | Kozhikode and Malappuram | The Banyan |
| Maharashtra | Ratnagiri | The Banyan |
| Maharashtra | Thane | The Banyan |
| Odisha | Khurda | Chetana Jewels International |
| Tamil Nadu | Villupuram | Menadora Foundation |
| Tamil Nadu | Tirunelveli | Real Social Organization of Youth Academy (R-Soya) |
| Tamil Nadu | Kancheepuram | Rural Development Council (RDC) |
| Tamil Nadu | Gunaseelam | Prasanna Venkatachalapathy Temple Trust |
| Sri Lanka | Jaffna | Mental Health Society (MHS) |

**Table 2**
Outcome measures and instruments.

| Outcome Measure | Instrument |
|---|---|
| Symptoms | Modified Colorado Symptom Index (CSI) (Conrad et al., 2001) |
| Disability | WHO Disability Assessment Schedule (WHODAS 2.0, 2012) |
| Community integration | Community Integration Questionnaire (CIQ) (Willer et al., 1993) |
| Hope | Herth Hope Index (HHI) (Herth, 1992) |
| Quality of Life | Quality of Life Interview (QoLi) (Lehman et al., 1993) |

each linguistic version of the instruments, we employed a structured protocol to maintain conceptual integrity across diverse implementation sites. All researchers underwent intensive training at a central location where they were thoroughly familiarised with the conceptual underpinnings of each standardised measure. Through detailed discussions and practice sessions, researchers developed a shared understanding of key concepts. The training incorporated case scenarios demonstrating how certain constructs might manifest differently across cultural contexts while retaining their essential meaning. Regular supervision sessions throughout the implementation phase further reinforced this shared conceptual framework through monthly debriefing calls, allowing researchers to discuss translation challenges encountered in the field and develop consistent solutions. While not achieving the methodological rigour of formal linguistic validation, this pragmatic approach balanced implementation feasibility with the need to maintain measurement integrity across the linguistically diverse landscape of nine Indian states and Sri Lanka. This limitation should be considered when interpreting findings.

An embedded process evaluation, consisting of focus group discussions with participants, was employed at six months and at the end of the trial period to gain insight into the experience and meaning of gains associated with the transition process. In addition, as part of routine project monitoring, housing occupancy and service utilisation metrics were maintained for each enrolled service user to track their receipt of the intervention.

### 2.2. Population and sampling

We worked with state-run and non-profit institutional facilities at each site to recruit participants for the study. The main inclusion criteria were that participants: (i) were people living with a mental health condition; (ii) had a duration of more than 6 months of stay at state institutional facilities at these sites; (iii) were over 18 years old; (iv) had not previously enrolled in the Home Again intervention. Group information sessions were conducted, providing verbal information about Home Again alongside a short film to portray its daily life and environment. Subsequently, screening interviews were conducted at each site with people fulfilling the inclusion criteria (n = 577) that also captured service user responses to specific questions regarding their transition choices. This information was triangulated with data from case files and collaborative discussions with each service user's case manager and psychiatrist. A joint decision involving the case manager and service user ultimately determined enrolment into Home Again. Those who met the inclusion criteria and offered written consent (expressed as a signature or thumbprint for those who cannot read or write) to participate in the intervention were enrolled in the intervention (n = 364). Participants were formally discharged from the institution once they moved into a home supported by Home Again. Endline outcome measures were assessed for 214 participants (see Table 3) due to dropouts from the evaluation at various stages (see Fig. 1). For the evaluation, only participants who continued in live in Home Again at month 12 and continued to consent to participate in the research were assessed. The mean tenure of housing for those assessed at endline was 11.55 months (SD = 1.35), while the average stay in housing for those who dropped out was 4.79 months (SD = 3.78, median 4 months, IQR = 7).

**Table 3**
Site-wise final sample (n = 214).

| Site | N | % |
|---|---|---|
| Andhra Pradesh | 10 | 4.7 |
| Assam | 10 | 4.7 |
| Nagaland | 8 | 3.7 |
| Gujarat | 17 | 7.9 |
| Karnataka | 21 | 9.8 |
| Kerala | 26 | 12.1 |
| Maharashtra | 27 | 12.6 |
| Odisha | 5 | 2.3 |
| Tamil Nadu | 60 | 28.0 |
| Sri Lanka | 30 | 14.0 |

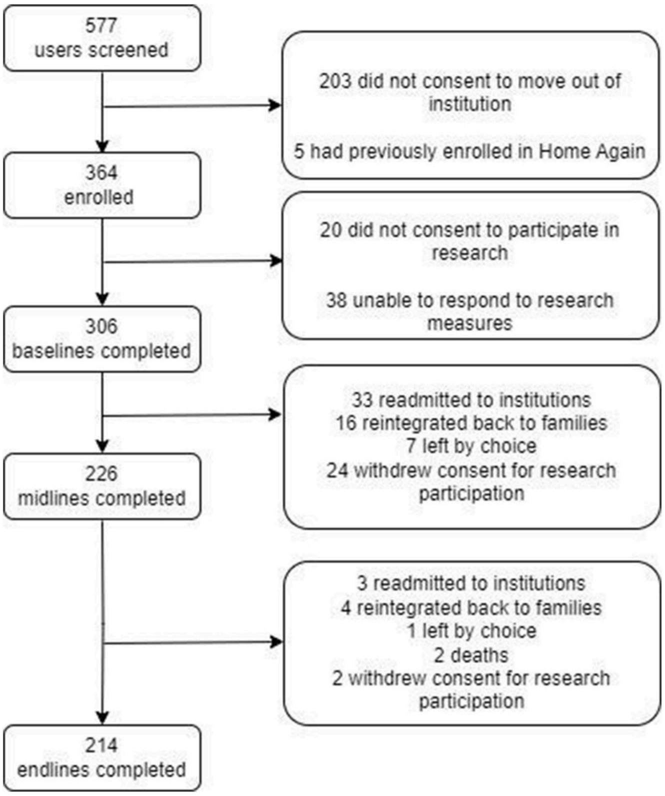

**Fig. 1.** Flowchart for sample participation in evaluation.

### 2.3. Data collection

Trained masters-level researchers who were competent in local languages were assigned to each site. Researchers were familiarised with the tools and the research process. Primary quantitative data were gathered via participant interviews using smartphone or tablet-assisted interviewing, with data being entered into a secured central database via wireless technology at baseline, 6 months, and 12 months. A central team of data managers conducted routine data quality checks, including checking for mandatory values, consistency with data type, sequentially linked items and completion rates. Qualitative data were collected through focus group discussion (FGD) conducted by the same researchers 6 months apart with participants who had been in the intervention for at least 6 months across sites, using a common discussion guide. The final set of FGDs coincided with the 12-month mark of the research period. Focus groups with service users aimed to discuss topics including — life at Home Again (eg: What does routine look like? How do service users feel? How does Home Again differ from homes of origin and institutional facilities?), relationships (eg: How do people form relationships at home and in the community? What is the relationship between service users and personal assistants?), and future aspirations (eg: What do service users hope for in the future?).

Given the potential for power dynamics between service users and service providers, the composition of the groups was homogeneous; that is, FGDs were conducted separately with service users and participants. On average, each FGD included 4–6 participants and lasted between 60 and 90 min. A total of 72 focus group discussions were conducted over a six-month period with 220 participants. The FGDs were audio recorded using recording devices designated for the study. The audio files were transferred to a secured, central database within 48 h of data collection, and no copies were maintained on the researchers' personal devices or on the recording devices.

### 2.4. Data analysis

Statistically significant differences between baseline and endline outcome measures were assessed using the Wilcoxon signed-rank test for non-parametric data. Generalized estimating equations (GEEs) were employed to investigate associations between outcome measures and gender and type of institution exited (government-run vs private-run) while controlling for duration of institutional stay. The geographically dispersed sample ($n = 214$) across diverse implementation sites created natural limitations for multivariate modelling. Duration of institutionalisation emerged as the most theoretically salient control variable, given its documented significance in recovery trajectories following deinstitutionalization. Incorporating additional sociodemographic or clinical covariates may have risked statistical overspecification given our sample parameters. All quantitative analyses were conducted using IBM SPSS Statistics 29.0.

All FGDs were conducted in the sites' local language and subsequently transcribed in local language and translated into English. A back-translation process was conducted to ensure accuracy, minimise misunderstandings, and verify consistency by comparing the English translation to the original language transcript. All transcription and translation were done manually. Qualitative data (FGDs with participants and personal assistants were reviewed independently by six researchers to gain initial impressions and identify potentially rich data segments. All researchers used MAXQDA software to conduct independent open coding on the translated transcripts, identifying and naming recurring themes, concepts, and patterns within the data. Researchers employed Braun and Clarke's (2006) six-step approach to thematic analysis during the coding and analysis process. A codebook was developed and iteratively enriched through consensus, with moderated discussions held to compare and merge individual findings, refine code definitions, and reach consensus. This iterative process ensured data saturation and thematic coherence. To enhance internal validity and trustworthiness, researcher triangulation was employed throughout the process, ensuring agreement and consistency in theme interpretation.

### 2.5. Ethical considerations

The study received clearance from the IRB of the Banyan Academy of Leadership in Mental Health. In addition, the ethical clearance for the Sri Lankan site was sought from the Ethics Review Committee of the Faculty of Medicine, University of Jaffna. (Reference No. J/ERC/21/130/NDR/0264). Prior to seeking written consent, participants were informed about the study's purpose, their rights as participants, and the procedures involved. This included the right to choose participation in the intervention, assurance of data confidentiality, the right to refuse any instrument or question, the right to leave any session at any time, and the right to withdraw their information at a later point. Contact details of a researcher were provided for any inquiries. Due to the ethical complexities of housing interventions, protections for participant choice, and potential adverse events (e.g., death, interpersonal violence), a mental health commission, with service user representation, was established to receive reports on issues and review adverse events.

Raw data used for research purposes were anonymised, removing any personally identifiable information such as names. Access to data during the research was governed by a multi-level permissions protocol based on the need-to-know principle, specifying roles and authorised data access levels. Data use prioritised accruing benefits for participants. Dynamic changes and decisions, such as changing sites for a group of participants, irrespective of the impact on the research process, were made to accommodate emerging participant needs.

## 3. Results

### 3.1. Population characteristics

Demographic and clinical characteristics of the final sample of participants are presented in Table 4.

### 3.2. Pre-post changes in outcomes

Statistically significant differences were observed for all five outcome variables at the two timelines (Table 5). While there were significant increases in quality of life ($z = -4.889$, $p < 0.001$), overall community integration scores ($z = -10.472$, $p < 0.001$) and hope ($z = -5.754$, $p < 0.001$) from baseline to endline, there was also a significant

**Table 4**

Demographic characteristics of the sample of participants ($n = 214$).

| | N | % |
|---|---|---|
| **Geographical Location** | | |
| Eastern | 23 | 10.7 |
| Southern | 117 | 54.7 |
| Western | 44 | 20.6 |
| Sri Lanka | 30 | 14.0 |
| **State-wise distribution** | | |
| Andhra Pradesh | 10 | 4.7 |
| Gujarat | 17 | 7.9 |
| Karnataka | 21 | 9.8 |
| Maharashtra | 27 | 12.6 |
| Assam | 10 | 4.7 |
| Nagaland | 8 | 3.7 |
| Tamil Nadu | 60 | 28.0 |
| Kerala | 26 | 12.1 |
| Odisha | 5 | 2.3 |
| Sri Lanka | 30 | 14.0 |
| **Gender** | | |
| Men | 76 | 35.5 |
| Women | 138 | 64.5 |
| **Marital Status** | | |
| Single | 114 | 53.3 |
| Married | 63 | 29.4 |
| Divorced/Separated | 16 | 7.5 |
| Widow | 9 | 4.2 |
| Not reported | 12 | 5.6 |
| **Psychiatric Diagnosis** | | |
| Psychosis/Schizophrenia | 172 | 80.4 |
| Bipolar Affective Disorder | 21 | 9.8 |
| Intellectual Disability | 18 | 8.4 |
| Others | 3 | 1.4 |
| **Presence of medical comorbidities** | | |
| Yes | 63 | 29.4 |
| No | 151 | 70.6 |
| **Type of institutional setting** | | |
| Government-Run | 81 | 37.9 |
| Private Run | 133 | 62.1 |
| | **Median** | **IQR** |
| Age (in years) | 41 | 14 |
| Duration of hospitalisation (in months) | 29 | 35 |

**Table 5**
Wilcoxon Signed Rank Test for pre-post changes on Outcome measures ($n = 214$).

| | Negative Ranks | Positive Ranks | Test Statistics | | |
|---|---|---|---|---|---|
| | N | N | Ties | Z | p |
| **Disability (Endline) -Disability (Baseline)** | 120 | 71 | 23 | −4.749[a] | 0.000* |
| **Quality of Life (Endline) -Quality of Life (Baseline)** | 72 | 133 | 9 | −4.889[b] | 0.000* |
| **Community Integration (Endline) -Community Integration (Baseline)** | 28 | 177 | 9 | −10.472[b] | 0.000* |
| **Symptoms (Endline) -Symptoms (Baseline)** | 118 | 70 | 26 | −4.444[a] | 0.000* |
| **Hope (Endline) -Hope (Baseline)** | 60 | 135 | 19 | −5.754[b] | 0.000* |

*p value $< 0.005$.
[a] Based on positive ranks.
[b] Based on negative ranks.

reduction in overall disability scores ($z = -4.749$, $p < 0.01$), and clinical symptoms scores ($z = -4.444$, $p < 0.001$). Moderate shifts in distribution were observed from baseline to endline in disability, quality of life, symptoms and hope, while a large effect was observed in community integration.

### 3.3. *Effects of type of institutional stay prior to exit into Home Again*

Generalized Estimating Equations (GEE) were conducted to estimate the effects of type of institution (government-run or privately run institutions) on the outcome measures while controlling for duration of institutionalisation.

Hope was significantly associated with the type of institution participants exited from, with those from government institutions experiencing greater gains in comparison to those who exited privately run institutional settings ($p < 0.01$). Similarly, exiting government-run institutions were significantly associated with community integration, disability scores and symptom indexes (see Table 6). Participants who exited government-run institutions had greater reduction in disability scores ($p < 0.001$) and clinical symptoms ($p < 0.001$) from baseline to endline. However, they showed lower improvements in community integration ($p < 0.05$) in comparison to those who moved out from non-state-run institutions.

### 3.4. *Select qualitative themes from FGDs with participants*

#### 3.4.1. *From institutions to Home Again: experiencing greater freedom*

Participants felt a sense of freedom, opportunities to socialise and develop new skills at Home Again, when compared to their time in a mental health institution. Many were able to travel, make their own routine decisions, interact with people outside their homes, buy things they desired, outside of their daily necessities. Separate beds and fewer people in each room across sites, provided them with more privacy. Many participants enjoyed the companionship of their fellow residents, as opposed to the often-overcrowded spaces of the institutions. Taking up responsibility for various aspects of the home contributed to a sense of autonomy. Some service users were able to engage in training, education and gain employment since leaving the mental health institution. Social interactions and engagements in skill-based activities like farming were observed to be greater towards endline in comparison to 6 months into the program.

**Table 6**
Regression Analysis (Generalized Estimating Equations) for effects of type of institutional settings exited on outcomes.

| Outcomes | Parameter | B (SE) | 95% Wald Confidence Interval | p-value |
|---|---|---|---|---|
| **Disability** | Type of institutional setting = Government Run | −3.322 | −5.182, −1.461 | 0.000* |
| | Duration of hospitalisation (in months) | 0.004 | −0.022, 0.031 | 0.735 |
| **Quality of Life** | Type of institutional setting = Government Run | −0.419 | −1.687, 0.848 | 0.517 |
| | Duration of hospitalisation (in months) | −0.004 | −0.015, 0.007 | 0.494 |
| **Community Integration** | Type of institutional setting = Government Run | −1.114 | −2.116, −0.112 | 0.029* |
| | Duration of hospitalisation (in months) | 0.004 | −0.004, 0.013 | 0.343 |
| **Symptoms** | Type of institutional setting = Government Run | −4.049 | −6.197, −1.991 | 0.000* |
| | Duration of hospitalisation (in months) | 0.017 | −0.037, 0.003 | 0.089 |
| **Hope** | Type of institutional setting = Government Run | 1.449 | 0.471, 2.427 | 0.004* |
| | Duration of hospitalisation (in months) | −0.005 | −0.015, 0.004 | 0.256 |

*p value $< 0.005$.

> ".there was no opportunity earlier, but there is one now to go out and work."

> "[Other resident] and I split the tasks. Sometimes I cut the vegetables or make the rotis or she does it. Then, when I'm not needed in the kitchen anymore, I go and watch television."

The ability to go outside, watch television channels of their choice, or being able to engage in religious/spiritual practices and access places of worship, as opposed to restrictions and limitations at the institutions to do so, are subtle but meaningful modes of autonomy that participants vocalise. In states such as Gujarat, Maharashtra and Kerala, participants have emphasised the level of freedom they experience. While at the institution, there was no scope even to go outside; this reality changed after entering Home Again.

> "There [in the institution] we have to inform or seek permission to go out. Here, I can talk to absolutely anyone."

> "We can sit and gaze outside as well."

For many, freedom appears to be intertwined with the ability to participate in everyday activities and make seemingly minor decisions such as the ability to cook a recipe of choice. Across many service users' narratives, a relational aspect of freedom was also observed, where freedom was not solely viewed as the opportunity to pursue individual goals, but also as the opportunity to foster social connections. The idea of freedom may also be linked to gendered constraints, particularly for women who may have left their own restrictive homes for various reasons. These women express a newfound sense of independence, enabling them to build their own relationships, create families, and live life on their own terms.

> "Since we live here, none of our family members can interfere in our lives. The people who are here make us feel like a family. At our homes, since we are girls, we would get told off a lot, but the women here treat us with respect and don't tell us anything unless absolutely necessary."

In this background, freedom also represents a strong rupture from their previous circumstances, challenging and reshaping the social fabric they were once stifled within.

### *3.4.2. Notions of home: complexities in navigating belonging, comfort and identity*

A sense of belonging and home-like environment arose from feelings of authority over a space and subsequent responsibility taking, freedom to make decisions, culturally familiar environment, and being with people they liked. Many participants spoke about feeling a sense of physical ownership as an important aspect of feeling at home. Apart from the physical ownership of one's home, the autonomy to make decisions in one's own space and to carry out activities as per one's liking and needs was what truly allowed one to feel control over their own space. Personal assistants would engage in discussions with the service users to facilitate this decision-making and sense of ownership. The majority of the service users stated having positive relationships with the personal assistants, who were perceived as part of the making of the home. They often viewed them as a family member, and sometimes as a friend supporting them in everyday tasks, teaching them things they were not aware of, helping them get employed and to ultimately become independent. Some service users also spoke about being encouraged to become peer leaders and personal assistants themselves.

> "[Personal assistant] is like a friend. A sister. I feel a sense of belongingness with her. If I have any problem, I share it with her."

Few participants indicated that personal assistants sometimes emphasised routines and discouraged departures from established schedules. In some instances, in the qualitative data, complex dynamics were observed from intersecting identities of service users and personal assistants that included their caste locations, disability identity and socioeconomics of the neighbourhood. In one site located in a gated higher income community, participants spoke about personal assistants preventing them from speaking with neighbours during walks. There was an instance of a service user refusing to consume food cooked by a personal assistant, from a marginalised caste in another site.

Being able to work, gain employment, practice religion, set up one's house and build a family were all aspects of building one's identity. Participants related these to their sense of self and spoke of their experiences related to identity-building, which could sometimes feel missing in a Home Again, simply because they could no longer experience memories of home and homeland. There seemed to be an implied association between money, freedom, and home. A house became a home when they or their family spent on rent and other essentials, and they had the freedom to do what they wanted.

> "We should take care of the home, pay rent, and purchase all the basic things for home. Buy vegetables, fruits, pulses, rice, ginger, and chillies from the market. This is freedom for me."

While Home Again enabled a certain level of independence, the lack of reconciliation with familial disruptions in their history, the absence of family in a typical sense and the lingering constraints and dilemmas around conforming to social expectations created a complex meaning of "home" and associated identity. Cultural and familial norms often influence notions of the kind of systems one exists within, and in many of these cases, participants may have experienced a conflict not only of what home and a family looks like, but the abandonment that may have brought about the absence of family systems and social roles in their lives. Where Home Again differed from the idea of a home for most of the participants, was primarily due to the absence of family members across sites. For many, the desire to be reunited with their family members was strong and created an aspect of disconnectedness from their time at Home Again. For some participants, home meant having familiar neighbourhoods, childhood friends and family. Feelings of being at home were also based on deep personal connections and growing up in a certain environment.

> "Yes, television and speakers are there but only husband and wife should be there."

Cultural differences were nuanced across the sites, which may have affected how participants experienced belongingness and comfort. Differences in the location of certain homes, whether in rural or urban areas, language and/or cultural relatability issues made it difficult for some participants to experience leisure and the freedom to move around. The difficulties with language and cultural relatability, however, were less frequently reported at endline.

### *3.4.3. Recovery and wellbeing: an uneven terrain of personal priorities, disability and socially determined archetypes*

External notions of recovery also influenced some participants, who relied on past experiences, behaviours and relationships to identify their sense of recovery and comfort. Participants spoke of how family members who visited them could notice change and even improvement in them, hinting at recovery. There was pressure to conform expressed by some participants, who feared being sent back to the institution if they were unable to display a normative sense of recovery and functioning as expected by their neighbourhoods. Moving out of the institution and into Home Again was perceived by some as an acknowledgement of their recovery progress, possibly because discharges in institutions are determined by such readiness parameters. Circumstances of their prior experiences with being admitted to institutions, dictated perhaps by limited acceptance of neurodivergence in communities, were reflected in worries expressed by some participants who did not want to be sent back to the hospitals.

> "We always feel we would be sent back to the mental hospital. That pressure is always there … If I conduct myself in ways that are socially unacceptable, I worry that I'll be sent back to [mental health institution]"
>
> "People from home come to see me. After seeing me, they say, I have changed and also said that they will take me home."

Linked to recovery and well-being were aspects of hope and futures that participants aspired for. While participants expressed their ideal view of the future, some raised doubts. Given the severity of mental or other comorbid ailments that some experienced, there was a sense among them that they would not be able to fit into societal norms or be functional in a way that was expected of them. There were expressed felt barriers due to this in finding employment, building a family with a partner, or even just taking care of themselves daily. While these participants may have felt a sense of some agency, there was an implicit understanding that independence must look a certain way. Some participants felt like they were unable to do things on their own as they did not know how to cook and clean, manage expenses, earn a living, were concerned about not feeling accepted by their neighbourhood due to their social status, and felt like they needed to be dependent upon a carer. This added to their doubts about the future. Some explicitly hoped for a disease-free life.

> "In movies we see beautiful heroes and heroines but in real life it's not like that, we don't even have enough money. People don't have good hearts. Only in movies we see that … in reality, everyone respects only money … We should dress well … and we should speak well … We can't do anything about them [society]."
>
> "I have no dreams, maybe because of my mental illness."

The complex and non-linear nature of treatment and recovery was observed by a few participants, who recognised that it was also a time-consuming process emphasising the fluid nature of care. Some participants noticed how medications also impacted them in different ways, reflecting this non-linearity.

> “We can’t count the change in time measure. Change does not happen in one day. I am able to work sometimes but not able to do it next time.”

Even as the participants felt that these goals were untenable in the present, they envisioned their futures often describing what they desired - such as fiscal independence, the ability to cope with adverse circumstances in the future, seeing themselves gradually adapting to the new environment at Home Again and feeling safe. In the participants’ narratives, intersectional realities resided within recovery and well-being. Wellbeing was expressed in terms of the ability to form relationships, pursue purpose and meaning, and feel a sense of independence and communal belongingness, amongst others. Many participants saw this through their newly acquired skills and relationships that they could build in the home and with staff on site.

> “We can learn a lot of things here. I don’t know much about household work; I had not done anything before marriage. After coming here, I have learned everything from cooking non-veg items to all household work. I didn’t even know how to grind the batter. I observed all the personal assistants when they did the work and learned all the work. Each one of them had a different talent. I looked at them working, observed their work and learnt from them.”

Overall, the language around health and wellbeing was not confined to a specific ailment but tied to an idea of holistic well-being. Emotional and behavioural changes were perceived differently than tangible physical ailments, highlighting the need to recognise psychosocial aspects of disability that cannot be seen through the linear lens of medical conditions alone.

## 4. Discussion

Evaluation of changes among participants in Home Again over a 12-month period highlights significant and comprehensive improvements across multiple outcome measures, across sites in India and one location in Sri Lanka, from baseline to endline. While community integration, hope and quality of life improved, participants experienced reduced symptoms and disability. These findings are consistent with previous studies evaluating outcomes of housing services for homeless people with mental health conditions and deinstitutionalization of people with mental health conditions (Hudson, 2019; McPherson et al., 2018) and in contrast to a systematic review of similar interventions in high-income countries (Aubry et al., 2020) changes in mental health and quality of life-related outcomes are observed.

Our findings suggest that lower duration of institutionalisation at baseline was an important predictor of effects on disability. Analysis also indicates that participants who exited from government-run institutions were more likely to experience lowered disability levels. This suggests that part of disability in long-term institutionalisation may be accrued due to prolonged environmental or structural factors of institutionalisation, which remit more effectively when participants transition to the community early. Participants from government-run institutions experienced greater gains in hope, in comparison to those who enrolled from private-run institutions, perhaps indicating the degree of change in environment facilitating a renewed outlook towards the future. This offers valuable insight for developing bespoke transition plans and enhancing support systems to meet the diverse needs of individuals transitioning from different types of settings.

Qualitative data help interpret and contextualise these quantitative results, illustrating how statistical improvements in domains like community integration or quality of life manifest in participants’ daily lives and subjective experiences.

### 4.1. *Complex transition experiences and community integration*

Qualitative findings underscore that the transition from homelessness and institutionalisation to community living is a complex journey fraught with challenges. Participants report navigating a delicate balance between newfound freedoms and lingering constraints, institutional identities and community belongingness, internal doubts and external expectations. Transitioning from institutions to community is expressed not as a linear process but marked by a continuous negotiation of freedoms and social sanctions, capabilities and barriers, identity and belonging. These experiences emphasise the need to create enabling environments that offer opportunities for independent and collective reflection and meaning making amongst mental health service users. Participants’ varied notions of ’home’, the emphasis on family, concerns about community acceptance, and struggles with independence highlight how mental health recovery intersects with broader social structures and cultural norms in the Indian context.

Qualitative findings illustrate the temporal nature of gains on community integration, which evolve over a period with participants and personal assistants building familiarity with the community and the neighbourhood shifting their orientation, indicating a slow, gradual process. The experience also highlights how despite gains in community integration, there may be limits placed on full inclusion due to barriers in the socio-economic system such as paid employment, developing viable and deep connections outside of a cohort of people with shared disabilities and so on. Participant narratives about recovery and future hopes reveal ambivalence—desires for independence coupled with recognition of ongoing support needs and uncertainty about attaining socially valued roles. These tensions reflect broader societal barriers facing people with psychosocial disabilities, including stigma, economic marginalisation and limited opportunities for meaningful participation. This points to the necessity of initiatives that work to radically shift and effect broader systemic barriers to full inclusion of people with mental health conditions. Mayer et al. (2021) discuss the role that community-based housing can play in asserting citizenship by claiming material and symbolic space in the home and its surroundings. Further insights into mechanisms and processes involved in traversing diverse environments and detailing successful reclaiming of space and shifts in attitudes in the broader community may support the development of targeted components that can accelerate inclusion.

### 4.2. *Home, identity, and belonging*

Participants’ experiences of navigation of home and belonging reveals how housing interventions may be more than physical relocation, involving processes of identity reconstruction. The study reveals multiple, sometimes competing, facets that contribute to feeling at home, including physical ownership, decision-making, cultural familiarity, and meaningful relationships. Feedback from some participants highlighted the lack of adequate support, staff competencies and broader environmental accommodations for those who had challenges due to limited physical mobility or high clinical mental health needs. Further qualitative analysis indicates that participants experienced many freedoms, but some reported constraints placed on their full autonomy due to lack of adaptations for high needs, logistical priorities and recovery realities being determined by conformity to social archetypes. Lashewicz et al. (2021) highlight how home can provide opposing feelings such as safety and non-safety or comfort and discomfort based on the nature of the disability, organisation of the home, and understanding of their disability-related needs by the caregiver. The importance of everyday places as therapeutic landscapes in supporting mental health recovery was emphasised in another study that examined the transition from supervised to supported housing (Piat et al., 2017). Within intervention processes, therefore, it may be important to consider not only what home means but ways to achieve meanings of such a place within present circumstances.

### 4.3. Implications for practice

The study's strengths include its implementation across multiple cultural and geographical contexts, the involvement of diverse stakeholders including government and civil society organisations, and its person-centered approach to recruitment and consent processes. These features support the relevance of these findings for scaling up similar interventions in comparable settings. The successful implementation across diverse settings demonstrates the intervention's adaptability, while the attrition patterns—with some participants returning to institutions or families—highlight the non-linear nature of transition processes and the need for flexible, individualized approaches that accommodate diverse preferences and trajectories.

The findings underscore the importance of addressing both individual support needs and structural barriers to inclusion. While Home Again demonstrated effectiveness in improving individual outcomes, participants' narratives about societal discrimination and limited opportunities point to the necessity of concurrent efforts to transform community attitudes, increase economic opportunities, and strengthen social protection systems.

## 5. Conclusion

The multi-site, multi-partner implementation of Home Again across diverse sites of India and Sri Lanka offers some insights from the experience of scaling up a complex, multi-faceted mental health intervention for marginalised populations. The experience points to the need for collaborative oversight and knowledge production mechanisms that monitor progress, synthesise field learnings and make changes that are responsive to emerging trends across sites. Such mechanisms may need to be supported by a dynamic implementation support infrastructure, stakeholder alliances, and an adaptive leadership model that enables consistency and contextualisation in diverse locations. In this context, common purpose and guiding principles shared across sites, teams, and partners, may provide cohesion and motivation to persist despite complexities. Thorough onboarding and ongoing job-embedded supervision must be emphasised to build competencies in the intervention, ethos, values, and skills necessary for quality implementation, including cultural competence for acceptability and meaningful utilisation in diverse populations and communities. Finally, effective leadership may be key in securing buy-in, working through resistance from entrenched structures, and steering radical change necessary to embed new practices.

### 5.1. Limitations

Due to access restrictions and lockdown measures (travel restrictions and closure of institutional facilities to visitors) implemented during the COVID-19 pandemic, intervention rollout was delayed and when resumed recruitment efforts were significantly hampered. This resulted in an insufficient sample size at each site level, limiting site-specific analysis and cross-site comparisons, even when clustered into geographical groups. The pandemic hindered the establishment of a matched control group as institutional facilities had continued access restrictions, making follow-up difficult. The absence of a control group makes it difficult to determine whether observed changes in participants were due to the intervention, or other factors like natural recovery or concurrent interventions. This limits the ability to draw causal conclusions about the program's effectiveness. The non-random sampling based on the choice to exit institutions may be a source of selection bias, potentially overestimating or underestimating the program's true impact. Similarly, the attrition of nearly 40% from the evaluation raises the possibility of attrition bias as there is a significant difference in duration of hospitalisation between the two groups. Those who had dropped out had been in the institution for a significantly shorter period ($z = -2.339$, $p < 0.05$). The dynamic nature of the program, allowing participants to move between settings, presents challenges for attributing observed changes to specific program components or phases. This complexity poses limitations on the extent to which changes may be attributable to the intervention. The one-year duration of the study may not be sufficient to capture the long-term impacts of complex interventions like Home Again. Further studies, with longer duration and with a larger sample size may help clarify these aspects.

## CRediT authorship contribution statement

**Vandana Gopikumar:** Writing – review & editing, Supervision, Methodology, Funding acquisition, Conceptualization. **Lakshmi Narasimhan:** Writing – original draft, Funding acquisition, Formal analysis, Conceptualization. **Deepika Easwaran:** Writing – original draft, Investigation, Formal analysis. **Apurva Srinivas:** Writing – original draft, Formal analysis, Data curation. **Keerthana R:** Project administration, Investigation. **Parsana Moideen:** Project administration, Investigation. **Sambasivamoorthy Sivayokan:** Writing – review & editing, Supervision, Project administration, Investigation. **Pallavi Rohatgi:** Project administration, Conceptualization. **Archana Padmakar:** Project administration, Conceptualization. **Vanitha Rajesh:** Project administration, Conceptualization. **Mrinalini Ravi:** Project administration, Conceptualization. **Preetha Krishnadas:** Conceptualization, Project administration. **Amali Margaret:** Project administration. **Milesh Hamlai:** Writing – review & editing, Project administration. **Chandana Sharma:** Project administration. **Santosh Joseph:** Project administration. **Chitra Venkateswaran:** Project administration. **Kantharaju Ck:** Project administration. **Saravanan Sn:** Project administration. **Gowri K:** Project administration. **Pichumani Iyengar:** Project administration. **Ratheesh Kanakode:** Project administration. **Shyapin Bhaskar:** Project administration, Investigation. **Bincy Chacko:** Project administration, Investigation. **Gayathri Kanappan:** Project administration. **Dhivya Ethiraj:** Project administration. **Nirupama Maddi:** Project administration. **Aishwariya Ramesh:** Writing – original draft, Investigation, Formal analysis. **Akshata Chonkar:** Writing – original draft, Investigation, Formal analysis. **Andrew C. Willford:** Writing – review & editing, Supervision. **Kishore Kumar Kv:** Conceptualization, Project administration. **Sanjeev Jain:** Writing – review & editing, Supervision. **Lakshmi Ravikanth:** Writing – review & editing, Supervision, Methodology, Conceptualization.

## Funding

The study was conducted as part of the transition to scale of Home Again funded by Grand Challenges Canada (GCC) and The UK's Department of Health and Social Care using UK aid through the National Institute for Health and Care Research (NIHR).

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## Acknowledgments

We would like to thank and acknowledge the role of project leads and teams across our partner implementing organisations whose persistence and support has made this multi-site evaluation of Home Again possible. Our gratitude to Rural India Support Trust (RIST), Azim Premji Foundation (APF) and TVS Sundram Fasteners Limited whose funding sustains part of the operational expenses of Home Again.

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