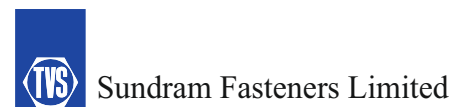


# The Banyan's Approaches at Scale: Longitudinal Outcomes and Partner Perspectives from Residential Services for Homeless People with Psychosocial Disabilities in India





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## Introduction

The intersection of homelessness and serious mental illness (SMI) represents one of the most pressing yet inadequately addressed public health and social crises of our time. Globally, people living with psychosocial disabilities who become homeless face compounded vulnerabilities represented by cycles of episodic mental health and social crisis that is accompanied by longitudinal social disadvantage and exclusion, and institutional neglect that diminish both dignity and life opportunities. In India, this assumes particular significance with an estimated 7 out of 10 people with SMI remaining out of the care they need.

The trajectory of mental health care and welfare interventions for psychosocial disabilities and homelessness in India has been shaped by colonial legacies, resource constraints, and evolving policy frameworks. The array of institutional responses with lack of supports to shift structural factors responsible for producing social drift against the background of persistent mental health conditions has often meant that people face extensive social exclusion and journey through a circuitous path between various spaces ranging from psychiatric facilities to beggars homes to homelessness, or enter pathways of long-term institutionalisation. Recent legislative and judicial developments represent a commitment to transforming this landscape. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), ratified by India, articulates in Article 19 the right of persons with disabilities to live independently and be included in the community. The Rights of Persons with Disabilities Act, 2016 enshrines protections against obligatory living arrangements and guarantees access to community support services. The Mental Healthcare Act, 2017 (Section 19) states that every person with mental illness has the right to live in and be part of society and shall not remain segregated in mental health establishments due to lack of family support or homelessness. The Supreme Court of India, in its 2017 order in the Gaurav Kumar Bansal case, directed state governments to address long-stay populations in mental hospitals, while the National Human Rights Commission in 2023 called for reports on the release of persons detained beyond medical necessity (Supreme Court of India, 2017; NHRC, 2023).

It is within this context that The Banyan has, over three decades, developed approaches to address the needs of homeless people with psychosocial disabilities, from crisis intervention to acute care and community re-entry through Emergency Care and Recovery Centres (ECRCs) to sustained community living through the Home Again approach. These approaches, now implemented across multiple states in India and internationally through partnerships with civil society organisations and government bodies, seek to demonstrate that recovery and community inclusion are achievable even for those with the most protracted histories of homelessness and institutionalisation.

This report presents longitudinal outcomes and partner perspectives from these residential services, drawing on programmatic data spanning 1993 to 2025 and qualitative insights from practitioners and service user vignettes across sites, offered as an account to provoke shared reflection on what has been learned, what challenges persist, and what possibilities remain for realising full participation for all people with psychosocial disabilities. This report draws primarily from service utilisation data of the ECRC and Home Again programmes maintained as part of the Monitoring and Evaluation system across sites. Additionally, data gathered as part of the outcomes evaluation of the Home Again program funded by Grand Challenges Canada that has received ethical clearance from the IRB

of The Banyan and Banyan Academy of Leadership in Mental Health and clearance from the Health Ministry Screening Committee (HMSC).

## The Banyan's Approaches: An Overview

The Banyan's response to the needs of homeless people with psychosocial disabilities operates through two complementary intervention models: the Emergency Care and Recovery Centre (ECRC) for crisis intervention and acute care, and Home Again for sustained community-based housing with supportive services. Together, these approaches constitute a continuum of care that seeks to address both immediate needs and long-term pathways to participation.

### Emergency Care and Recovery Centres

The ECRC approach evolved through The Banyan's direct service provision over three decades and has been adapted for replication across diverse contexts. ECRCs provide a phased approach to care: street-based outreach and crisis intervention; acute care addressing immediate medical and psychiatric needs; stabilisation through collaborative care planning and peer support; recovery-focused interventions centred on valued social roles; and discharge planning leading to community re-entry through family reunification, independent living, or supported housing arrangements. Care is delivered by multidisciplinary teams comprising social workers, psychologists, nurses, healthcare workers, and psychiatrists and physicians, with an emphasis on person-centred protocols, trauma-informed engagement, and social architecture that affords dignity and choice within residential spaces. The ECRC approach has been scaled across Tamil Nadu, Karnataka, Kerala, Maharashtra and Odisha through multiple modalities - expansion of direct sites, embedding as part of the public health system, as co-run centers with select civil society partners (CSOs) and through technical partnership with established CSOs in certain sites (See Table 1).

#### *Embedding within the National Health Mission*

A significant development in the scaling of the ECRC approach has been its integration within the public health system through a public-private partnership with the National Health Mission (NHM), Government of Tamil Nadu (Health and Family Welfare (EAP II-2) Department, Government of Tamil Nadu, 2019). This partnership, initiated in 2020, situates ECRCs within District Hospital premises as a step toward inclusive, community-proximate care.

The partnership operates through a tripartite arrangement wherein NHM provides dedicated infrastructure within the District Hospital, medical and psychiatric consumables, utilities, and modifications to meet the social architecture requirements of ECRCs. The average cost per service user is between INR 12,000/- to INR 15,000/- per month, with NHM budgets covering approximately 50% of costs toward medical and psychiatric care. Grants from the Azim Premji Foundation to local civil Society Organization (CSO) partners meet the remaining costs toward additional staffing and social care needs, including reintegration support. The Banyan serves as the primary capacity-building partner, providing structured training, ongoing review systems, and quality audits to ensure fidelity to the intervention's values and protocols.

As of December 2025, this model operates across 31 districts in Tamil Nadu, with local CSO partners identified through a due diligence process that evaluates organisational capacity, experience in residential care, leadership, and financial governance (Health and Family Welfare (EAP-I-2)

Department, Government of Tamil Nadu, 2025). The NHM partnership has demonstrated the feasibility of locating crisis and recovery services for homeless people with mental illness within the mainstream public health infrastructure, while maintaining the person-centered protocols central to the approach. A similar replication has been enabled by companion organization Aaladamara Foundation, a collaborative initiative of the Azim Premji Foundation and The Banyan, in Karnataka with the Health Department embedding ECRCs within the public health system (Department of Health and Family Welfare Services, Government of Karnataka, & Aaladamara Foundation, 2024).

**Table 1: Emergency Care and Recovery Center Sites and Partners (The Banyan)**

S.NO	District	Run by	Year of commencement	Modality
1	Chennai	The Banyan	August'1993	Direct run
2	Chengalpattu	The Banyan	October'2005	Direct run
3	Chennai	The Banyan	October'2012	Direct run
4	Sivaganga	Vazhai Foundation	December'2020	Govt supported & Partner run
5	Madurai	M.S Chellamuthu Trust and Research Foundation	February'2021	Govt supported & Partner run
6	Erode	Atchayam Trust	February'2021	Govt supported & Partner run
7	Thanjavur	Social Health and Education Development India (SHED)	February'2021	Govt supported & Partner run
8	Nilgiris	Nilgiris Adivasi Welfare Association (NAWA)	March'2021	Govt supported & Partner run
9	Tirunelveli	Real Social Organisation of Youth Academy (R-SOYA)	March'2021	Govt supported & Partner run
10	Tiruchirappalli	Prasanna Venkatachalapathy Temple Trust	June'2021	Co-Run
11	Thiruvallur	Menadora Foundation	September'2021	Co-Run
12	Malappuram	The Banyan	April'2022	Direct run
13	Thoothukkudi	Real Social Organisation of Youth Academy (R-SOYA)	May'2022	Govt supported & Partner run
14	Thiruvallur	Dream India Network (DIN)	October'2023	Govt supported & Partner run
15	Krishnagiri	Rural Development Council (RDC)	July'2024	Govt supported & Partner run
16	Kancheepuram	Menadora Foundation	June'2025	Govt supported & Partner run
17	Dindigul	Helping Hearts	July' 2025	Govt supported & Partner run

S.NO	District	Run by	Year of commencement	Modality
18	Karur	Helping Hearts	August'2025	Govt supported & Partner run
19	Kanyakumari (Nagercoil)	Manolaya	October'2025	Govt supported & Partner run
20	Cuddalore	Oasis Trust	December'2025	Govt supported & Partner run
21	Viluppuram	Oasis Trust	January'2026	Govt supported & Partner run
22	Bangalore	Hazrath Bismillah Shah Hospital (HBS) (Aaladamara Foundation)	August'2022	Partner run
23	Dompada	Jewels International	February'2024	Partner run
24	Bangalore	Thanal (Aaladamara Foundation)	July'2024	Partner run
25	Bangalore	Sir CV Raman Government Hospital (Aaladamara Foundation)	October'2024	Partner run
26	Mysore	Karuna Trust (Aaladamara Foundation)	November'2024	Partner run
27	Mumbai	Eduljee Framjee Allbless Niramay Niketan (EFAAN)	August'2025	Co-Run
28	Ahmedabad	Altruist	September'2025	Partner run
29	Yadgir	Manovruksha (Aaladamara Foundation)	October'2025	Partner run
30	Bangalore Rural	Gramina Abyuday Seva Samsthe (GASS) (Aaladamara Foundation)	December'2025	Partner run

## Home Again

Home Again is a housing with supportive services intervention designed for people with persistent mental health conditions who have experienced prolonged institutionalisation and/or homelessness. The approach situates small groups of residents, typically four to five individuals who form affinity groups, in rented homes within ordinary rural or urban neighborhoods. Residents receive a constellation of supportive services including social care facilitation, access to healthcare, case management through detailed biopsychosocial assessments and personalized care plans, and onsite personal assistance. Personal Assistants (PAs), predominantly women from local communities trained to offer support consistent with service user priorities, provide day-to-day accompaniment. Weekly case manager visits, quarterly reviews with service users, and structured feedback mechanisms enable responsive, bespoke support. The intervention has been recognised

by the World Health Organization in its technical guidance on community mental health services as an exemplar of person-centred, rights-based supported living (WHO, 2021).

### *Evidence from Home Again Evaluations*

Home Again has been subject to systematic evaluation across three phases spanning a decade (2014–2023), employing quasi-experimental and pre-post designs across sites in Tamil Nadu, Kerala, Assam, Maharashtra, Karnataka, Gujarat, Andhra Pradesh, Odisha, Nagaland, and Sri Lanka.

In the initial seed grant phase (2014–2016), a two-group quasi-experimental study with 53 participants in each arm found a significant main effect of Home Again on community integration ( $\beta = 5.66$ ,  $p < 0.001$ ) and a significant interaction effect with time on disability scores at 18 months (mean difference =  $-6.58$ ,  $p < 0.05$ ) compared to care as usual in institutional settings. Qualitative findings highlighted emerging experiences of family-like belonging, expanded social connections, and civic participation including exercising voting rights (Narasimhan et al., 2018).

The Transition to Scale 1 phase (2016–2018) expanded the sample to 113 participants per arm and demonstrated significant improvements in community integration, disability, psychological wellbeing, housing satisfaction, and availability of choice at 6 and 12 months. Social distance among community members decreased significantly, suggesting shifts in neighbourhood attitudes toward residents with mental illness. Qualitative data documented the emergence of valued social roles, as neighbours, caregivers, and participants in religious and cultural life (The Banyan, 2018).

The Transition to Scale 2 phase (2021–2023) employed a single-group pre-post design with 214 participants across 10 sites. Significant improvements were observed in quality of life ( $z = -4.889$ ,  $p < 0.001$ ), community integration ( $z = -10.472$ ,  $p < 0.001$ ), and hope ( $z = -5.754$ ,  $p < 0.001$ ), with corresponding reductions in disability ( $z = -4.749$ ,  $p < 0.01$ ) and clinical symptoms ( $z = -4.444$ ,  $p < 0.001$ ). Recovery orientation among Personal Assistants also increased significantly over the study period. Qualitative insights underscored the non-linear nature of recovery, the importance of physical ownership and domestic belonging, and the gradual shift in PA attitudes from paternalism toward allyship (Gopikumar et al, 2025).

The scale up and evaluation of the Home Again intervention was and is supported majorly by Rural India Supporting Trust (RIST) and Grand Challenges Canada with additional funding from the state and other philanthropies.

### *Government-Supported Home Again Replication*

Parallel to the ECRC expansion, Home Again has been replicated through government partnership in Tamil Nadu, with support from the Department of Social Defence and linkages with the District Differently Abled Welfare Offices (DDAWOs) (Directorate for Welfare of the Differently Abled, Government of Tamil Nadu, & The Banyan, 2024). These replications, marked as "Govt supported" sites, operate in districts including Chengalpattu, Trichy, Thiruvallur, Coimbatore, and Thoothukudi.

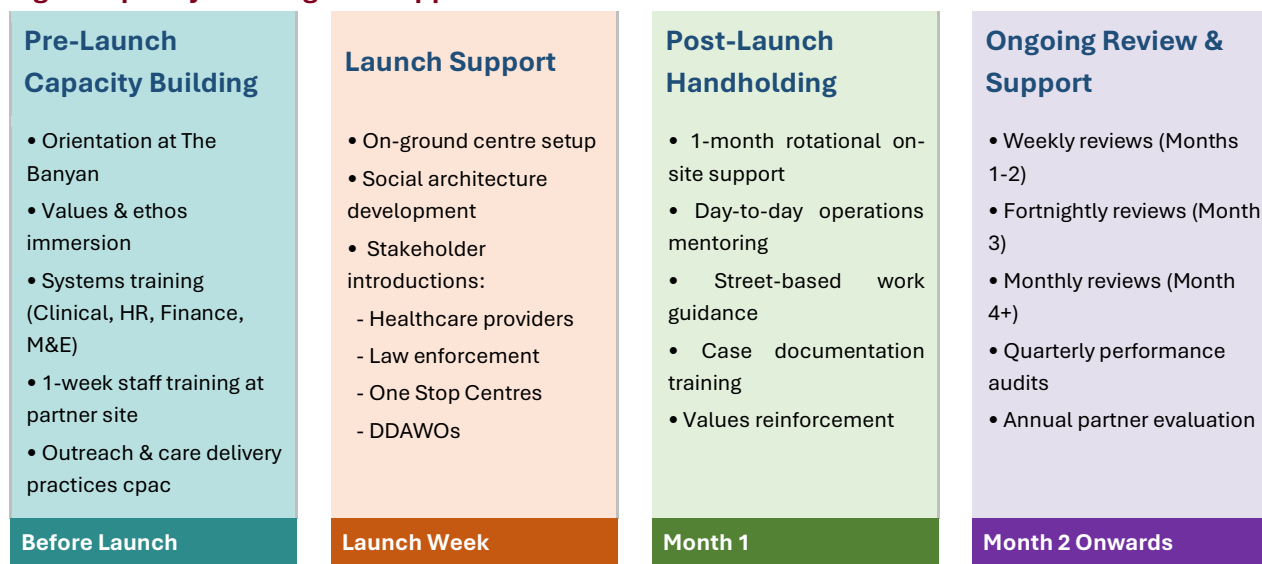
This strategy positions Home Again within the broader welfare policy for persons with disabilities, enabling access to government entitlements, housing subsidies, and coordination with district-level disability welfare mechanisms. Implementation is undertaken either directly by The Banyan or through trained CSO partners, with capacity-building support, periodic quality audits, and integration with aftercare services through the District Mental Health Programme.

**Table 2: Home Again Sites and Partners**

S.no	District	Run by	Year of commencement	Modality
1	Chengalpattu	The Banyan	February'2014	Govt supported & Direct run
2	Chennai	The Banyan	March'2014	Direct run
3	Tiruchirappalli	The Banyan	November'2016	Direct run
4	Malappuram	The Banyan	March'2017	Direct run
5	Thrissur	The Banyan	June'2022	Direct run
6	Kozhikode	The Banyan	August'2022	Direct run
7	Ratnagiri	The Banyan	March'2019	Direct run
8	Visakhapatnam	The Banyan	October'2021	Direct run
9	Tiruchirappalli	Prasanna Venkatachalapathy Temple Trust	August'2022	Govt supported & Co-Run
10	Tirunelveli	Real Social Organisation of Youth Academy (R-SOYA)	August'2022	Co-Run
11	Kancheepuram	Rural Development Council (RDC)	September'2022	Partner run
12	Villupuram	Oasis Trust	May'2022	Co-run
13	Thiruvallur	Aadharavu Illam	December'2024	Govt supported & Partner run
14	Coimbatore	Helping Hearts	December'2024	Govt supported & Partner run
15	Thoothukkudi	Anbu Ullangal	December'2024	Govt supported & Partner run
16	Alappuzha	Mariyadanam	March'2022	Partner run
17	Malappuram	Mariyadanam	August'2022	Partner run
18	Palakkad	Mariyadanam	September'2022	Partner run
19	Kottayam	Mariyadanam	August'2022	Partner run
20	Mysore	Green Dot Trust	November'2021	Co-run
21	Mahesana	The Altruist	February'2022	Partner run

S.no	District	Run by	Year of commencement	Modality
22	Indore	Gramin Adivasi Samaj Vikas Sansthan (GASVS)	February'2023	Partner run
23	Cuttack	Chetna Jewels International	October'2022	Partner run
24	Kamrup	Ashadeep India	August'2022	Partner run
25	Chumukedima	Ashadeep India	August'2022	Partner run
26	Jaffna	Mental Health Society of Jaffna (MHS)	July'2022	Partner run
27	Habiganj & Manigunj	Sajida Foundation	November'2022	Partner run

**Fig 1: Capacity Building and Support Framework**



**Continuous Support**



The partnership framework provides a structured, phase-wise approach to building and sustaining community mental health centers and represent standard level of support which is tailored and stepped up or down based on partner’s need. Partner’s needs broadly fall into three categories (A, B, C) based on maturity, determining the frequency of oversight visits, from intensive monthly engagement for new partners to standard orientation followed by strategic annual reviews for established ones, ensuring tailored support that evolves with each partner's sectoral maturity and growth trajectory.

The general support structure begins with pre-launch capacity building, including values immersion, systems training, and staff orientation, partners receive intensive launch support for on-ground setup and stakeholder engagement. Post-launch handholding ensures operational stability through mentoring, documentation training, and values reinforcement. As partners mature, ongoing reviews transition from weekly to monthly cadence. Throughout the partnership lifecycle, continuous support spans crisis management, clinical oversight, compliance assurance, and sustainability planning, alongside proactive government liaison.

The intensity of support and monitoring is determined by partner maturity and operational stability:

<b>Visit Type</b>	<b>Category-A (Intensive Support)</b> Partners new to the work or those requiring intensive support	<b>Category-B (Standard Support)</b> Partners established with operations requiring oversight	<b>Category-C (Sustained Support)</b> Mature partners requiring strategic engagement only
<b>Cluster Point of Contact</b>	Monthly (Months 1-3) → Quarterly (Months 4-12)	Quarterly	Annually
<b>Senior Management</b>	Quarterly	Quarterly	Annually
<b>Board</b>	Biannually	Biannually	Annually

## Programme Outcomes

Over the period spanning 1993 to 2025, a total of 5420 homeless people with mental illness were admitted to Emergency Care and Recovery Centres across three distinct operational modalities: directly operated sites (n=3282), co-run sites (n=728), and National Health Mission sites (n=1410). Table 3 summarises key background characteristics of this cohort. The mean age at admission was 41.5 years (SD 16.0), with comparable distributions across site types, with differences in the gender composition of service users across modalities wherein directly operated sites served women predominantly (75.2%), whereas NHM sites admitted more men (54.33%). These differences are likely to due the fact that direct sites include The Banyan’s centers in Mogappair and Kovalam which cater to women. The median duration of homelessness prior to admission was marginally shorter at

directly operated sites (4 months, IQR 23) compared with co-run sites (6 months, IQR 47) and NHM sites (7 months, IQR 22), potentially indicating more rapid identification and engagement through established community outreach mechanisms at longer-running facilities.

**Table 3: Background Characteristics of Admissions to Emergency Care and Recovery Centers (ECRCs) (1993-2025)**

Characteristic	Direct Sites (N=3282)	Co-run Sites (N=728)	NHM Sites (N=1410)	Total (N=5420)
<b>Age in Years at Admission - Mean (SD)</b>	40.9 (17.33)	42.13 (16.01)	42.63 (16.1)	41.5 (16)
<b>Duration of homelessness in months- Median (IQR)</b>	4(23) N=759	6(47) N=181	7(22) N=385	6(23) N=1325
<b>Gender</b>				
Man	814 (24.8%)	324 (44.51%)	766 (54.33%)	1904 (35.13%)
Woman	2468 (75.2%)	403 (55.36%)	644 (45.67%)	3515 (64.85%)
Genderqueer	0 (0%)	1 (0.14%)	0 (0%)	1 (0%)
<b>Type of Admission</b>				
Independent admission	1046(26.08%)	570(14.21%)	1015(71.99%)	2631(48.54%)
Supported admission	1939(48.35%)	96(2.39%)	189(13.40%)	2224(41.03%)
Not recorded	297(7.41%)	62(1.55%)	206(14.61%)	565(10.42%)
<b>Mode of referral</b>				
Community Outreach	258(7.86)	212((29.12)	437(30.99)	907(16.74)
Other institution	173(5.27)	223(30.63)	252(17.87)	648(11.96)
Public	220(6.70)	40(5.49)	75(5.31)	335(6.19)
Police	164(4.99)	95(13.04)	96(6.80)	355(6.55)
Other Government officials	67(2.04)	25((3.43)	178(12.62)	270(4.98)
Staff	197((6)	27(3.7)	9(0.64)	233(4.29)
Self/Family	33(1)	53(7.96)	3(0.22)	89(1.64)
Not recorded	2170(66)	53(7.96)	360(25.54)	2583(47.65)
<b>Marital Status</b>				
Never Married	731(22.27%)	265(36.40%)	552 (39.15%)	1548(28.56%)
Married	1271(38.73)	193(26.51%)	510 (36.17%)	1974(36.42%)

Characteristic	Direct Sites (N=3282)	Co-run Sites (N=728)	NHM Sites (N=1410)	Total (N=5420)
Separated/Divorced	232(7.07%)	74(10.16%)	73 (5.18%)	379(6.99%)
Widowed	210(6.40)	49(6.73%)	45 (3.19%)	304(5.60)
Not recorded	838(25.53)	147(20.19%)	230 (16.31%)	1215(22.41%)
<b>State of Origin</b>				
Tamil Nadu	1682 (51.25%)	234(32.14%)	1183 (83.9%)	2991 (55.18%)
Kerala	74 (2.25%)	8 (1.10%)	10 (0.71%)	91 (1.68%)
Karnataka	58 (1.77%)	334(45.88%)	16 (1.13%)	407 (7.51%)
Andhra Pradesh	160 (4.88%)	16 (2.20%)	18 (1.28%)	192 (3.54%)
Maharashtra	65 (1.98%)	10 (1.37%)	7 (0.5%)	81 (1.49%)
Other States	356 (10.85%)	55 (7.55%)	63 (4.47%)	468 (8.63%)
Not recorded	887 (27.03%)	71 (9.75%)	113 (8.01%)	1190 (21.96%)
<b>Psychiatric Diagnosis</b>				
Schizophrenia	974 (29.68%)	443 (60.85%)	1006 (71.35%)	2423 (44.70%)
BPAD	176 (5.36%)	60 (8.24%)	164 (11.63%)	400 (7.38%)
Intellectual Disability	225 (6.86%)	64 (8.79%)	59 (4.18%)	348 (6.42%)
Dementia	17 (0.52%)	12 (1.65%)	30 (2.13%)	59 (1.09%)
Substance Use	71 (2.16%)	56 (7.69%)	36 (2.55%)	148 (2.73%)
Others	70 (2.13%)	46 (6.32%)	32(2.27%)	163 (3.01%)
Not recorded	1749 (53.29%)	47 (6.46%)	83 (5.89%)	1879 (34.67%)
<b>Concurrent Physical Health Conditions</b>				
Yes	729(22.21%)	294(40.38%)	125 (8.87%)	1148(21.18%)
No	215(6.55%)	152(20.88%)	976 (69.22%)	1343(24.77%)
Not recorded	2338(71.24%)	282(38.74%)	309 (21.91%)	2929(54.04%)

The comorbidity profile of this cohort reveals a diverse range of health conditions affecting the service users. Metabolic and endocrine disorders are notably present, with diabetes, thyroid conditions, and hypertension documented across the service users. Anemia appears to be a recurrent nutritional and hematological concern. Neurological manifestations are evident, including seizure disorders and various neurological impairments. Infectious diseases are found in the cohort, with cases of tuberculosis, HIV, and sexually

Characteristic	Direct Sites (N=3282)	Co-run Sites (N=728)	NHM Sites (N=1410)	Total (N=5420)
transmitted infections documented. Weight-related issues, including underweight conditions and obesity, indicate nutritional challenges at both ends of the spectrum. Trauma and physical injuries, orthopedic conditions, and dermatological issues are also present. Ophthalmological problems, particularly cataracts, and sensory impairments affecting vision and hearing are also observed.				

The pathways to care differed substantially across operational models. NHM sites demonstrated the highest proportion of independent admissions (71.99%), a direct reflect of the 2017 Mental Health Care Act that whereas directly operated sites that operated pre-2017 when Magistrate detention was mandatory has substantial supported admissions (48.35%). Referral patterns were also distinct. Community outreach served as the primary documented referral source at NHM sites (30.99%) and co-run sites (29.12%), whilst directly operated sites exhibited a notably high proportion of unrecorded referral sources (66%), reflecting historical data collection practices that have since been strengthened.

Psychiatric diagnostic profiles revealed important inter-modality variations with implications for service design and resource allocation. Schizophrenia was the predominant diagnosis across all sites, yet its prevalence varied markedly from 29.68% at directly operated sites to 60.85% at co-run sites and 71.35% at NHM sites. This gradient may reflect differences in admission criteria, diagnostic practices, or the clinical severity of populations reached through different referral networks. Conversely, intellectual disability was more frequently documented at directly operated sites (6.86%) compared with NHM sites (4.18%), whilst substance use disorders were most prevalent at co-run sites (7.69%). The substantially higher rate of unrecorded psychiatric diagnoses at directly operated sites (53.29%) compared with co-run (6.46%) and NHM sites (5.89%) reflects improvements in clinical documentation systems over the programme's evolution.

Documentation of concurrent physical health conditions similarly varied across modalities. Co-run sites recorded the highest prevalence of physical comorbidity (40.38%), whilst NHM sites documented the lowest (8.87%). However, when accounting for the proportion of cases without recorded physical health status, which was substantially higher at directly operated sites (71.24%), these differences may partially reflect documentation practices rather than true epidemiological variation. Where documented, the comorbidity profile encompassed metabolic and endocrine disorders, anaemia, seizure disorders, infectious diseases including tuberculosis and HIV, nutritional extremes, and sensory impairments—underscoring the medical complexity of this population.

**Table 4: Reintegration and Transition Outcomes at ECRCs** (1993-2025)

Exit Pathway	Direct Sites (N=3282)	Co-run Sites (N=728)	NHM Sites (N=1410)	Total (N=5420)
Reintegrated to Family	1835 (55.91%)	339 (46.57%)	673(47.73%)	2847 (52.52%)
Referred to Residential Facility run by Other NGOs	259 (7.89%)	123 (16.9%)	288 (20.43%)	670 (12.36%)
Moved to Home Again or Hostels	239 (7.28%)	54 (7.42%)	70 (4.96%)	363 (6.69%)
Reintegrated to Work with Housing	7 (0.21%)	0 (0%)	4 (0.28%)	11 (0.2%)
Walked out of facility	405 (12.34%)	55 (7.55%)	145 (10.28%)	605 (11.16%)
Deceased	287 (8.74%)	4 (0.55%)	29 (2.06%)	320 (5.9%)
Continues as Inpatient (Currently Under Care)	188 (5.54%)	153 (21.02%)	201 (14.26%)	542 (10%)
MCU/GCU Facility	44 (1.34%)	-	-	44(0.81)
Status not recorded	18 (0.55%)	0 (0%)	0 (0%)	18 (0.33%)
<p><b>Direct sites:</b> Within an Emergency Care and Recovery Centre (ECRC), the Medical Care Unit (MCU) and Geriatric Care Unit (GCU) play a vital role in ensuring comprehensive and inclusive care. The MCU provides comprehensive clinical management, stabilization, and continuous monitoring for acute health needs. The GCU delivers age-sensitive care focused on dignity, comfort, and functional recovery of older adults.</p>				

Reintegration outcomes demonstrated both consistency and divergence across operational models (see Table 4). Family reintegration remained the most common positive outcome across all site types, achieved for 55.91% of service users at directly operated sites, 46.57% at co-run sites, and 47.73% at NHM sites. The higher reintegration rate at directly operated sites may reflect more established family tracing systems developed over three decades of operation. Referral to other NGO residential facilities was most frequent at NHM sites (20.43%) and co-run sites (16.90%), suggesting a preference for referrals via inter-organisational linkages.

Mortality rates differed substantially: 8.74% at directly operated sites compared with 0.55% at co-run sites and 2.06% at NHM sites. This disparity likely reflects the longer operational history and thus longer follow-up periods at directly operated sites, as well as their role in providing end-of-life care through Medical Care and Geriatric Care Units.

Length of stay analyses revealed that temporal patterns of care varied by discharge pathway and site type (see Table 4A). Individuals reintegrated to family departed most rapidly from co-run and NHM sites (median 2 months) compared with directly operated sites (median 5 months), potentially reflecting differences in case complexity or family tracing efficiency. Those transferred to Home Again or hostel accommodation demonstrated substantially longer stays at directly operated sites

(median 26 months, IQR 138.5) compared with co-run (median 5 months) and NHM sites (median 11 months), indicating that directly operated sites may serve a population requiring more intensive rehabilitation prior to supported living.

**Table 4A: Reintegration from ECRCs and length of stay (In months)** (1993-2025)

Exit Pathway	Direct Sites Median (IQR)	Co-run Sites Median (IQR)	NHM Sites Median (IQR)	Total Median (IQR)
Reintegrated to Family/ work with housing	5(15)	2(4)	2(5)	3(8)
Referred to Residential Facility run by Other NGOs	8(19.25)	2(4)	5(12)	5(12)
Moved to Home Again or Hostels	26(138.5)	5(5)	11(6.5)	15(54)
Walked out of facility	1(5)	1(4)	0(2)	1(4)
Deceased	12(58)	7.5(16.25)	1(3)	6.5(30.5)
Continues as Inpatient (Currently Under Care)	19(35.5)	4(7.5)	4(9)	6(17)
MCU/GCU Facility	47(258.25)	-	-	47(258.25)

Among NHM sites operating from 2020 to 2025, considerable inter-district variation was observed in reintegration outcomes (see Table 4B), ranging from 11% in Kanyakumari (newest site yet to reach tenure wherein exit pathways become possible) to 64% in Krishnagiri. Aftercare data indicated sustained engagement with 76% of discharged clients, while 17% were lost to follow-up, 5% were deceased, and 2% required readmission (see Table 4C) indicating the extent of feasibility of community-based aftercare within public health system frameworks.

**Table 4B: NHM Sites Reintegration and Transition Outcomes at ECRCs** (2020-2025)

District	Admission	Reintegrated to Family/work with housing	Referred to Residential Facility run by Other NGOs	Moved to Home Again or Hostels	Aftercare Active
Thanjavur	270	143(53%)	73(27%)	2(1%)	137(63%)
Nilgiris	180	87(48%)	48(27%)	0(0%)	107(79%)
Erode	177	75(42%)	36(20%)	11(6%)	94(77%)
Madurai	170	85(50%)	44(26%)	0(0%)	114(88%)
Sivagangai	157	69(44%)	26(17%)	21(13%)	88(76%)
Tirunelveli	118	60(51%)	15(13%)	25(21%)	70(70%)
Tiruvallur	87	44(51%)	25(29%)	2(2%)	50(70%)

District	Admission	Reintegrated to Family/work with housing	Referred to Residential Facility run by Other NGOs	Moved to Home Again or Hostels	Aftercare Active
Krishnagiri	87	56(64%)	10(11%)	0(0%)	61(92%)
Thoothukudi	83	41(49%)	8(10%)	9(11%)	45(78%)
Dindugal	22	4(18%)	0(0%)	0(0%)	3(75%)
Kanchipuram	22	7(32%)	0(0%)	0(0%)	5(71%)
Kanyakumari	18	2(11%)	1(6%)	0(0%)	3(100%)
Karur	14	3(21%)	1(7%)	0(0%)	3(75%)
Cuddalore	5	1(20%)	1(20%)	0(0%)	3(100%)
<b>Total</b>	<b>1410</b>	<b>677(48%)</b>	<b>288(20%)</b>	<b>70(5%)</b>	<b>783(76%)</b>

**Table 4C: NHM Sites Current Aftercare Engagement Status of Service Users (2020-2025)**

Status	N	%
In aftercare	783	76%
No Contact	175	17%
Missing	8	1%
Deceased	53	5%
Readmission	16	2%
<b>Total</b>	<b>1035</b>	<b>100%</b>

**Table 4D: NHM Sites Quality Audit (2020-2025)**

S.No	Site	Total no of visits
1	Sivagangai	14
2	Madurai	8
3	Erode	10
4	Thanjavur	25
5	Nilgiris	14
6	Tirunelveli	23
7	Thoothukkudi	20
8	Thiruvallur	19
9	Krishnagiri	7
10	Kancheepuram	4
11	Kanyakumari	1

Home Again served 1320 residents between 2014 and 2025 (see Fig 2). For this analysis, data of 1240 residents were considered, excluding select sites where current data are not aggregated by The Banyan. Comparison between directly operated (n=684) and partner-operated (n=556) sites revealed important operational differences. Partner-operated sites served a higher proportion of men (41.19% versus 23.57%) and individuals with schizophrenia (77.70% versus 63.01%), while directly operated sites accommodated more residents with intellectual disability (18.42% versus 6.12%) and documented physical comorbidity (54.82% versus 20.14%). The median duration of prior institutionalisation was substantially longer for residents at directly operated sites (29 months, IQR 134) compared with partner sites (14 months, IQR 35), suggesting these facilities serve individuals with more protracted histories.

**Table 5: Background Characteristics of Home Again Residents** (2014-2025)

Characteristic	Direct Run (N=684)	Partner Run (N=556)	Total (N=1240)
<b>Age at the Time of Entry (in Years)</b>	42.61 (11.43)	41.59 (11.16)	42.15 (11.32)
<b>Current Age (in Years) - Mean (SD)</b>	48 (12)	44 (11)	46 (11.7)
<b>Duration of Institutionalization (Months) - Median (IQR)</b>	29 (134)	14 (35)	20 (64)
<b>Gender</b>			
Man	162 (23.57%)	229 (41.19%)	391 (31.48%)
Woman	522 (76.43%)	327 (58.81%)	849 (68.52%)
<b>Diagnosis</b>			
Schizophrenia	431 (63.01%)	432 (77.7%)	863 (69.60%)
BPAD	102 (14.91%)	47 (8.45%)	149 (12.02%)
Intellectual Disability	126 (18.42%)	34 (6.12%)	160 (12.90%)
Others	20 (2.92%)	17 (3.06%)	37 (2.98%)
Unknown	5 (0.73%)	26 (4.68%)	31 (2.50%)
<b>Concurrent Physical Health Conditions</b>			
Yes	375(54.82)	112(20.14)	487(39.27)
No	274(40.06)	444(79.86)	718(57.90)
Not recorded	35(5.12)	0	35(2.82)
<b>Institutional Setting Exited From</b>			
Private Facility	441(64.47)	378(67.99)	819(66.05)
State Psychiatric Facility	237(34.65)	106(19.06)	343(27.66)

Characteristic	Direct Run (N=684)	Partner Run (N=556)	Total (N=1240)
District Hospital	6(0.88)	72(12.95)	78(6.29)
The background characteristics excluded for 80 service users of Assam, Bangladesh Home Again Sites			

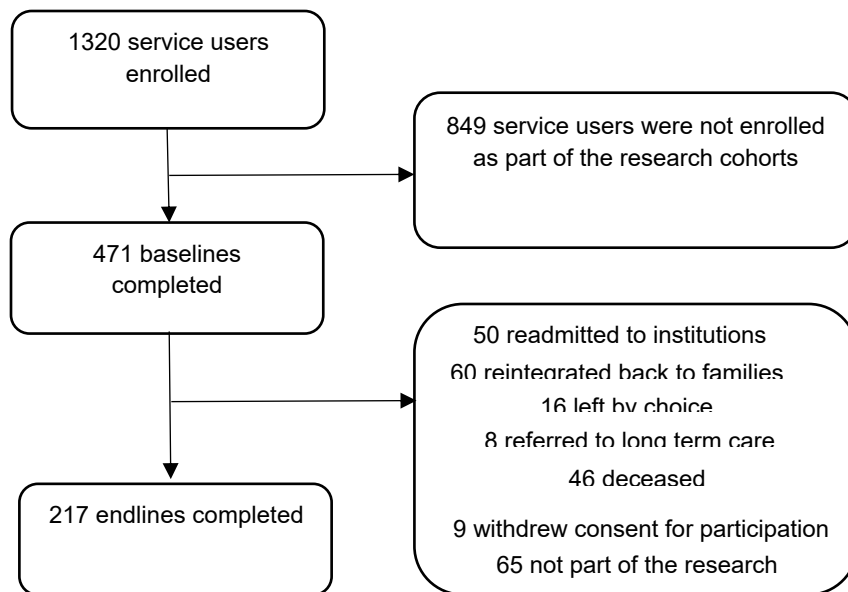
**Table 5A: Housing Stability, Reintegration and Transition Pathways for Home Again Residents**

2014-2025

Pathway	Direct Run (N=684)		Partner Run (N=556)		Total (N=1240)	
	N (%)	Duration of stay (in months) (Median/IQR)	N (%)	Duration of stay (in months) (Median/IQR)	N (%)	Duration of stay (in months) (Median/IQR)
Continue at Home Again	329 (48.10%)	53(54)	332 (59.71%)	38(22)	661 (53.31%)	41(38)
Reintegrated to Family	112 (16.40%)	10(23)	94 (16.91%)	7(13)	206 (16.61%)	9(17)
Referred to Residential Facility run by Other NGOs	23 (3.37%)	41(57)	7 (1.26%)	7(17)	30 (2.42%)	29(51)
Walked out of Home	23 (3.37%)	9(22)	22 (3.96%)	7(25)	45 (3.63%)	7(23)
Deceased	83 (12.13%)	20(45)	10 (1.8%)	13(9)	93 (7.51%)	18(42)
Returned to Institutional Mental Health Facility	114 (16.70%)	8.5(43)	91 (16.40%)	5(14)	205 (16.53%)	8(25)

Outcome trajectories in Home Again revealed divergent patterns (see Table 5A). Housing retention rates were higher at partner-operated sites (59.71%) compared with directly operated sites (48.10%), mortality was substantially elevated at directly operated sites (12.13% versus 1.80%). This reflects the longer duration of programmatic implementation, both aging over time and the older age profile, longer institutionalisation histories, and higher physical morbidity burden of residents at directly operated sites, rather than differential quality of care. Rates of return to institutional mental health facilities were comparable across both modalities (approximately 16.5%), suggesting similar challenges in maintaining community tenure regardless of operational structure.

**Fig 2: Flow Chart of Sample in Ten-year pre-post outcomes analysis**



Pre-post outcome analyses conducted with 217 participants (see Fig 2) demonstrated statistically significant improvements in community integration. The sample included variegated tenure with 33 participants enrolled in 2015, 50 participants in 2017 and 134 who moved between 2021-2022. Home integration scores increased from a mean of 0.9 (SD 1.52) to 2.4 (SD 1.84) ( $z=8.180$ ,  $p<0.001$ ), social integration improved from 1.9 (SD 2.03) to 2.87 (SD 1.66) ( $z=5.749$ ,  $p<0.001$ ), and composite community integration scores rose from 4.3 (SD 3.79) to 6.9 (SD 4.24) ( $z=6.989$ ,  $p<0.001$ ) (see Table 6A and 6B). Disability scores and work integration did not demonstrate significant change, suggesting that while social participation and domestic functioning improved, work participation remains an area requiring enhanced programmatic attention.

**Table 6: Background Characteristics of Participants with Outcome Measures**

Characteristic	N = 217	%
<b>Gender</b>		
Men	58	27%
Women	159	73%
<b>Diagnosis</b>		
Schizophrenia	142	65%
BPAD	28	13%
Intellectual Disability	43	20%
Others	4	2%
<b>Exit Pathways</b>		
Home Again /LTC	185	85%
Family Reintegration	1	1%

Characteristic	N = 217	%
Other NGO	2	1%
Readmission	29	13%
<b>Presence of physical health conditions</b>		
Yes	119	55%
No	98	45%
<b>Disability Level</b>		
No Disability	68	31%
Mild Disability	78	36%
Moderate Disability	55	23%
Severe Disability	16	7%
	<b>Mean</b>	<b>SD</b>
<b>Age</b>	49	11.6
	<b>Median</b>	<b>IQR</b>
<b>Duration of institutionalization (in months)</b>	39	125

**Table 6A: Pre-Post Outcomes - Descriptives** (Disability and Community Integration (N = 217))

Outcome measures	Baseline		Endline	
	Mean (SD)	Median (IQR)	Mean (SD)	Median (IQR)
Disability Score	8.78(8.8)	7(12)	9.45(9.58)	7(12)
Home Integration Score	0.9(1.52)	0(1)	2.4(1.84)	3(3)
Social Integration Score	1.9(2.03)	1(3)	2.87(1.66)	3(3)
Work Integration Score	1.5(1.52)	2(3)	1.65(1.94)	1(3)
Community Integration Score	4.3(3.79)	4(6)	6.9(4.24)	7(7)

**Table 6B: Pre-Post Outcomes - Wilcoxon Signed Rank Test** (Disability and Community Integration (N = 217))

Outcome Measure	Negative Rank	Positive Rank	Ties	z	p
Disability (Baseline vs Endline)	101	99	17	-0.684	0.494
Home Integration (Baseline vs Endline)	30	139	48	8.180	0.000*
Social Integration (Baseline vs Endline)	53	130	54	5.749	0.000*
Work Integration (Baseline vs Endline)	72	82	63	0.447	0.655
Community Integration (Baseline vs Endline)	55	144	18	6.989	0.000*

\*  $p < 0.001$

## Partner Perspectives: Emergency Care and Recovery Center

Thematic analysis of interviews with practitioners and implementing partners across 14 NHM ECRC sites yielded seven principal themes characterising the operational philosophy and experiential dimensions of service delivery. The following section summarises these themes along with selected case vignettes and illustrative quotes that are presented verbatim.

### Theme 1 - Recognition of Personhood in Crisis Encounters

Practitioners described outreach as a process centered on acknowledging subjectivity prior to clinical intervention. They reported that engagement strategies had evolved to prioritise listening over immediate action.

*"Earlier they used to go, bringing the client. But now sitting on the streets listening to their stories is new" ( Kanyakumari ECRC)*

Individuals encountered during street outreach frequently articulated complex self-narratives that resisted reduction to diagnostic categories.

*"Don't take a pic of my face, but you can take a pic of my watch, coz the watch only belongs to me not the time" (Service User from Kanyakumari ECRC)*

*"Even if I am alone, I live like a king" (Service User, Kanyakumari ECRC)*

Attachments to objects and rituals carried profound meaning.

*"I walk nearly 10 kilometers everyday to pay homage to my wife and my backpack looks so heavy because it is loaded with memories" (Service User, Cuddalore ECRC)*

These extended to emotional connections experienced through non-human relationships.

*"I always hold on to this parrot because I feel that only plants and animals are capable of reciprocating the love and when I hold on to this parrot, I feel that I hold on to love" (Service User, Kancheepuram ECRC).*

Material practices signaled anticipated personhood. As one practitioner from Kanyakumari ECRC noted, "Welcome kit concept was new", a tangible indication that people were expected and prepared for a care journey rather than being administratively processed as case. The culmination of engagement was articulated by one service user,

*"I think I am a freedom fighter because I fought for my freedom. Freedom is when you are able to design your own life without any fear."*

#### **The Man Who Stopped to Pray**

They found him in Kanyakumari, walking.

Mr. P had been travelling a long time. Before this, he had moved with holy men, following their routes. When the outreach team asked him why he was here, at land's end, he said, "God brought me. I came to see God."

He agreed to go with them. There were papers to be done at the police station first, as this was always required before someone can enter care.

In the parking lot, waiting, Mr. P did not stand idle.

From a small bundle he carried, he took out incense sticks and camphor. He arranged them carefully on the ground, of dust and parked vehicles, and began his puja.

The team stepped back. The paperwork could wait. For those few minutes, the parking lot was where this man was speaking to his God.

After the camphor had burned down, after the incense smoke had thinned into the air, they proceeded inside for the rest of the mundane charade of paperwork.

But he walked into the system of care on his own terms.

## Theme 2 - Relational Engagement and Ethical Withdrawal

A recurrent theme concerned the tension between providing care and recognizing choice even in times of crisis. Practitioners described extended periods of non-intrusive presence that often preceded engagement that turned into access to care.

*"For four days, we followed her from a distance. Whenever we tried to talk to her, she shouted, accused us, and chased us away. Still, we did not give up. Instead of forcing her, we came every day with hot tea and food" (Karur/Dindugal ECRC)*

*"One value system they follow is ensuring that the client's dignity and autonomy are maintained" (Madurai ECRC)*

Individuals encountered during outreach were perceived to often express preference for street life, presenting practitioners with ethical complexity.

*"During the outreach most of the people says that they prefer to stay on the streets as they feel free here—'I can do whatever I want in the streets'" (Karur/Dindugal ECRC)*

Many practitioners reported that formalised consent processes were novel.

*"For the Social Workers here, the word consent itself was new for the first time" (Kanyakumari ECRC)*

Practitioners also described decisions to withhold intervention. One such instance involved an elderly man regarded by the community as spiritually significant.

*"Community members stated that they regarded him as spiritually significant. The team made an ethical decision to temporarily withhold intervention... recognizing that respectful withdrawal can sometimes be a more ethical step than enforced care" (Case Note, Kancheepuram ECRC)*

In contrast, where individuals expressed willingness, voluntary pathways were facilitated.

*"He expressed willingness to receive care and consented to voluntary admission" (Case Note, Kanyakumari ECRC)*

### **The Gate and Red Cars**

At the care facility, everyone knew about Ms. S and the gate. Every day, she would sit there. Near the main entrance, facing the road. She would not join the tailoring class. She would not come for the group activities. She would only sit.

The staff had stopped asking why. "She is like that," they said. Some called it laziness. Some called it stubbornness. After a while, they simply walked past her.

One day, a social worker decided to sit down next to her.

She did not ask Ms. S to come inside. She did not ask her what was wrong. She just sat there, looking at the same road, watching the same vehicles go by.

Two hours passed. Neither of them spoke.

Then Ms. S turned to her and asked, "What did you see?"

The social worker did not answer. Instead, she asked, "What did you see?"

Ms. S said, "I saw so many red cars."

She kept looking at the road.

"One day, I will travel with my husband in a red car. People here think I am lazy because I sit at this gate and refuse to work. But they don't know that I am building my future."

After that, the social worker kept coming back to the gate and sat with Ms. S. They would watch the road together. They would talk about the cars. They would talk about the cars. About where a person might go in a car like that. About the man she was waiting for. About what it means to wait for something

The gate became a place for conversation, for memory, but also for a hopeful future, a possibility moving past, in red, every single day.

### **Theme 3 - Spatial Configuration of Care Environments**

The physical and relational characteristics of ECRC facilities were perceived as an important facet of therapeutic engagement. Spatial design and use was noted as facilitating multiple modes of recovery. These spatial configurations were described as enabling both therapeutic work and the restoration of personal agency through freedom of movement and choice between public and private areas

*"Most of the people have commented on their infrastructure—Meditation, recreation, nursing room etc" (Madurai ECRC)*

Post reintegration, when families encountered the ECRCs, they reportedly perceived these as distinct from conventional psychiatric settings.

*"The family feels that it is not a typical hospital setting and they have the space to move around and feel 'free' away from all stigmas" ( Tiruchendur ECRC)*

Practitioners emphasised what one termed the "social architecture" of spaces.

*"When the family visit our ECRCs they feel that the social architecture of the ECRC is nice and conducive for sessions" ( Krishnagiri ECRC)*

## Theme 4 - Liberation from Physical Restraints

Practitioners reported several instances of ECRCs intervening with individuals who were chained and bringing them into care and noted that many also had histories of being chained.

*"10% of the homeless population come to our ECRC with histories of being chained. Most of them are men" ( Krishnagiri ECRC)*

*"Even now they get referrals where people are chained" ( Madurai ECRC)*

Case documentation exemplified the severity encountered. One account described,

*"The client was chained in the hall of the house. He was nude and had passed urine and motion in the same place where he was eating and sleeping. He had been chained in this condition for more than three years. After the rescue, his chains were removed, and he was taken to Irumbu Patrai, where the iron rings on both his legs were removed." (Gunaseelam ECRC)*

Practitioners attributed chaining to intersecting factors including family desperation and community pressure in contexts of absent mental health infrastructure.

One account documented community members instructing a father,

*"Unnoda pullaiya yen velila vidura? Katti vai paithiyatha" [Why are you letting your son go outside? Tie up that mad person]*

Additionally, community-led responses sometimes involved harmful ritual practices.

*"Community-led attempts to 'treat' him through ritual practices, including confinement and burial-like acts, caused further trauma" (Case note, Erode ECRC)*

These accounts illustrated how families became reluctant agents of containment in the absence of accessible alternatives.

### **A Student Chained for Ten Years**

Mr. S was the first person in his family to go to college.

He came from a village, and he went to Madurai Kamaraj University to study English.

A Bachelor of Arts. In his first year, he did well. His teachers saw promise in him.

In his second year, something changed. He could not concentrate. His thoughts became scattered, diffused. He grew agitated. His behaviour alarmed those around him. Eventually, he could not continue. He left the university and returned home.

Then came the deaths. First, his father died by suicide. Later, his sister did the same.

His mother was left alone with him. There was another sibling, who was also unwell and could not help. There was no one else. There was no psychiatric hospital nearby. No mental health worker who came to the village. No money for private treatment. No one to advise the mother on what to do.

Mr. S had begun to wander. Sometimes he would hurt himself. His mother did not know how to keep him safe. So she did the only thing she could think of. She chained him inside the house.

Ten years passed this way.

A mother, alone, with no support, trying to keep her son alive, using chains as a measure of her desperation. A metaphor for what happens when there is no system to turn to, when a family is left to manage severe illness with nothing but their own hands and fear.

One day, a local television channel reported on his situation. The story reached the Emergency Care and Recovery Centre team in Madurai. They went to the village. They brought him out.

Today, Mr. S lives in a care facility. He is no longer in chains. He sleeps in a clean room. He eats regular meals. He receives necessary mental health support. Slowly, he is beginning to speak with others again, finding his way back to young man who once read English literature at Madurai Kamaraj University. He is learning, once more. It is early still. But he is recovering.

## Theme 5 - Transformation of Stakeholder Practices

Practitioners described operating within extensive stakeholder networks beyond health department that included auto drivers, police, one stop centres, revenue department, various vendors association and media.

Practitioners reported observable shifts in the perceptions of police, emergency services, government health staff, and community members over time. For instance, changes in referral language were noted.

*"The referral calls they get now, the team feels that the narratives have changed, it starts with 'We have seen a person with mental health issues'" (Krishnagiri ECRC)*

Specific practice changes were documented across multiple institutional actors.

*"Earlier the police see any homeless with mental health issues they just board them into random trains—that has changed now" (Madurai ECRC)*

Requests for coercive intervention had ceased.

*"Earlier they used to ask the team to inject on the road itself, but now that has changed" (Thanjavur ECRC)*

Emergency services had adopted new approaches.

*"Earlier red cross used to tie client's hand and bring but now after engaging with us their approach is completely person centred" (Thanjavur ECRC)*

Relationships with government health staff were reported to have evolved from distance to celebrating festivals together. Community attitudes were also described as shifting from aversion toward nascent responsibility.

*"Earlier the community [saw] the homeless people as torture, but now they say that 'I want to help but don't know how'" (Tirunelveli ECRC)*

However, systemic discontinuities presented persistent challenges.

*"Frequent transfers of Deans and senior officials disrupt continuity. Each change requires rebuilding rapport and institutional relationships" (Nilgiris ECRC).*

*"Rapport built with supportive police officers or inspectors often needs to be rebuilt when personnel change" (Erode ECRC)*

## **A Leg to Stand On**

They found her in Kumbakonam market, crawling on all fours, pushing away anyone who attempted to help. She was in her fifties.

Much later it came to light that when she had lost her husband, her mind began to diffuse, and she wandered away from home frequently. A road accident during one such episode left her without a leg. Her daughter tried to care but was overwhelmed with no support, no one to explain to her the two labels her mother had come to occupy, a woman with a mental illness with a physical disability.

When Ms. S came to the Thanjavur ECRC, the team recast her suffering in the vocabulary of a world not built for her, no prosthetic, no ramp, no daughter who had been given the tools to stay.

They arranged an orthopaedic consultation. They connected her with Freedom Trust and the District Disability Welfare Office. A free artificial limb camp was being held in Thanjavur. They watched as she gained a prosthetic limb.

It let her stand in spaces that had been closed to her. The team took her to Kallanai dam, an outing, one of the many as a small return to the world. They then sat with her

daughter and over many visits and gradual contacts explained the illness, showed what support may look like when care is shared.

Ms. S is home now as a grandmother.

## Theme 6 - Complexity of Family Tracing and Kinship Reconstruction

Family reunification processes revealed heterogeneous responses reflecting the relational ruptures occasioned by prolonged separation and untreated illness. Family tracing sometimes yielded unexpected discoveries with sometimes families shifting materially, relationally and emotionally in absences.

*"After a prolonged period without information, [the family] presumed him deceased and conducted funeral rites" (Nilgiris ECRC)*

*"His family was traced successfully... It was learned only then that Mr. Ram is married and has five children" (Thiruvallur ECRC)*

Families expressed variable capacity and willingness to resume care. One case documented,

*"His mother is unable to provide care due to her advanced age, and the sister and uncle expressed unwillingness to take responsibility" (Krishnagiri ECRC)*

Where reunification occurred, it frequently required preparatory work addressing past trauma.

*"Daughter initially hesitated due to past traumatic experiences. Psychoeducation provided regarding mental illness, treatment, and recovery. After visiting, the daughter became emotionally overwhelmed and expressed happiness at seeing her mother's improvement" (Thanjavur ECRC)*

### **Bringing a Mother Home**

They found her in Singara Thoppu, Tiruchirapalli, visibly distressed, standing alone in a public space with nowhere to go. Someone called the 181 Women's Helpline.

When the ECRC team came to meet her, they did not rush her. They instead sat with her for two hours. No forms, no questions at first. Just presence, until she was ready to speak.

Ms. A was 35. She spoke in Tamil and Urdu. She had been married, had children, then she developed a mental illness. She recalled interrupted treatment, moving in and out of various mental states. Somewhere along the way, she became separated from her family.

At ECRC, she began to find her footing. She helped with office work, joined the cooking, sat with others. One of the staff members was pregnant. As Ms. A watched her, the longing for her own children surfaced.

The team held space for that grief that still had a measure of hope. Using what Ms. A had shared, they traced her family. The day of the visit home turned out to be her daughter's birthday.

Ms. A is home now, living again within a joint family. She does housekeeping work, earns a small income and accesses aftercare services through ECRC Gunaseelam. Her children get educational supplies through the NALAM implementation in Tiruchirapalli.

## Theme 7 - Collective Care Practices and Practitioner Transformation

ECRCs were described as sites of collective solidarity extending beyond individual case management. For instance, two sites reported facility-wide fostering arrangements for infants.

*"The entire ECRC came forward to foster care for one of our clients who delivered a child and the entire ECRC took care of that child for one and a half months" (Tiruchendur ECRC)*

*"Even in this ECRC the entire ECRC foster cared for a client who came into the ECRC with a 5month baby and they reintegrated her in Bihar" (Thanjavur ECRC)*

Facilities were also mobilised frequently during community emergencies.

*"When the district is in crisis, the ECRC responds, such as the support during floods" (Tirunelveli ECRC)*

In this context, practitioners also described personal and professional transformation through their work in such collective care. A shift in framing was noted, indicating evolution from charitable or spiritual motivation toward professional identity.

*"The staff has moved from the zone of seeing this as 'service' or 'puniyam' [merit/blessing] to 'work'" (Tirunelveli ECRC)*

Practitioners identified relational dimensions as particularly meaningful.

*"The favorite part of the work is the bonding the clients share with them and to see clients who have been chronically ill for a long time recover fast" (Madurai ECRC)*

Several accounts illustrated reciprocal relationship formation that disrupted conventional carer-service user binaries. These encounters sometimes generated sustained reciprocal relationships.

*"During one of the outreaches (sic), I met this man, and I used to meet him regularly and we developed a bond. During one of the interactions, when I was about to sit next to him he stopped me for a minute and spread a new towel on the road and asked me to sit on that saying that I am his brother and he can't see his brother sit over the dirt. At that moment I felt overwhelmed" (Tirunelveli ECRC)*

### **The Nose Pin and the Phone Call**

It was a routine outreach at the railway station. I met Ms. A there. She was 70.

I did not start with the assessment form. I told her I liked her nose pin. Her smile changed. She told me she had pledged her jewels once, for someone who never paid her back. A story of betrayal, sitting in a piece of gold I had only meant to admire.

She spoke of Ayyappa and Shivan as companions she talks to daily. Her faith seated in the ritual of conversations.

Ms. A lives in a rented room. She survived by begging. But when she spoke, it was not what she lacked.

An hour after I left, my phone rang. It was her. She wanted to know if I had reached home safely. She calls regularly now. Just to ask how I am.

Before I left that first day, she pressed vibuthi on my forehead as her blessing. She said, "I see Yaman in all forms, but I refuse to let go of this life, because there is so much of love surrounding."

Yaman, the god of death, she sees him everywhere, and still she stays.

## Partner Perspectives: Home Again

Thematic analysis of interviews with practitioners, implementing partners, and residents across Home Again sites yielded ten principal themes characterising the experiential and operational dimensions of supported housing. Verbatim quotations are presented to preserve participant voice.

### Theme 1 - Home and Domestic Belonging

Residents and practitioners described the transformation of spaces into places of dwelling imbued with personal meaning. The intentionality of domestic environment was articulated as foundational.

*"Creating a home-like environment for clients is central to Anbu Ullangal's Home Again work and is a key source of motivation for staff, as it allows clients to experience safety, dignity, and belonging."*

Community perceptions were reported to have shifted accordingly,

*"The change in the community what they witness is the way they address our home again from 'KaaPgam' [shelter/institution] to 'antha veedu' [that house]" (Gunaseelam HA)*

The presence of companion animals emerged as significant across multiple sites. Residents at Villupuram lived with "dog, love birds, rabbit and fish." One resident articulated the depth of these attachments,

*"The cat in my house has given birth to two kittens. I want to have a name keeping ceremony for my cats. They are more like my children" (Kovalam HA)*

Another resident challenged visitors' recognition practices,

*"When somebody comes to our house, you introduce me, but you fail to introduce my friend (pointing to the dog HA)..He is my best friend, almost like my personal diary" (Villupuram HA).*

Practitioners framed these relationships therapeutically.

*"Caring for these furry and feathered friends is more than a hobby—it's therapy, reducing stress and forging bonds" (Villupuram HA)*

Residents articulated experiences that exceeded clinical frameworks, encompassing spiritual, existential, and relational dimensions. One resident described gender and protective symbolism,

Survival was framed in terms of grace and witnessing,

*"I have seen the worst that life could offer, and I feel that my survival itself is an act of God's grace. Being able to share my experiences with you, and knowing they were received with care, gives me comfort and renewed hope" (Kovalam HA)*

The burden of dependence was also articulated

*"Although family and friends are available to call, the burden of having to ask can be heavy, and at times, asking itself can be deeply painful."*

### **A Thali and the Kitchen**

In Vadanemmeli village, Ms. L was first hired locally as domestic help for ₹50 a day. The wages were exploitatively low, the hours long, and many employers treated her poorly. But she persisted as these jobs connected her to people. She walked children home from school, got invited to family functions, attended the village monthly meetings.

She saved what she could. First, she bought herself earrings. Then a nose pin. Then a thali.

A thali is given to a bride by her husband at the wedding marking her as married. Ms. L bought hers herself, for herself.

Eventually, she found work at a local hotel for ₹150 a day. In the kitchen there, she picked up cooking again, a skill she had lost during harder years. She watched the cooks, memorised recipes, and started making them at home in her kitchen for herself and others like her who lived with her.

Now she has her own place. She cooks her own meals, a thali she wears for herself.

## **Theme 2 - Transition from Service User to Neighbour**

A consistent theme across sites concerned the reconstitution of social identity from service recipient to community member. One practitioner reported,

*"The community has started to see them as 'neighbours' instead of clients. When one of the residents go out to buy provisions for their own house, the neighbours request them to buy for their house also and vice versa" (Sri Lanka HA)*

*"Earlier, the community held very conservative and biased perceptions about people living with mental health conditions. Now, community members invite our clients to temples, local vegetable shops interact with them warmly" (Coimbatore HA)*

Social inclusion extended to religious and cultural participation. Residents were *"invited for 'Golu' (Dasara) where the clients go to other community member houses to offer prayers" (Tirunelveli HA)*. Integration into ritual life was noted, *"The clients perform poojas in the temple" (Sri Lanka HA)*. Social invitations reflected growing acceptance, *"Clients who do work are sometimes invited to community events such as weddings" (Thoothukudi HA)*.

### **Ms. S who remembers everyone's name**

Ms. S came to the Tirunelveli Home Again after years of homelessness and subsequent long stay at an institutional mental health facility. Her husband had left her. She was raising her son alone. She already lived with a mental health condition that later sent her into the streets.

When she first came to Home Again, she saw herself as someone who needed medication, regular meals, a place to stay.

Then she started helping in the kitchen. She was good at it and she didn't stop there. She looked after other clients. She remembered everyone's name. If someone needed something, she was the one who said yes. When a staff member had a baby, Ms. S gave silver bangles. When another got married, she gave money. When a colleague's mother fell sick, she visited with fruits and Boost.

Ms. S earns today and saves, with every penny aside being earmarked for her son's future; she is clear about this. She talks to her father regularly. Her son is supportive. She hopes that one day they will live together again.

## **Theme 3 - Reciprocal Community Value**

Residents were described as contributing to neighbourhood improvement rather than solely receiving support. For instance, behavioural influence was noted,

*"Seeing the residents clean their house often the neighbours have also started to focus more on cleanliness" (Sri Lanka HA)*

Shared resource management emerged,

*"In one of the home again, there is a common well used by our resident and the neighbour and since we spoke about chlorinating the water, the neighbours have also started to contribute to the expense" (Sri Lanka HA)*

Civic engagement was documented, *"The HA team and the clients have approached the municipality for waste disposal and now every Tuesday van comes to collect the waste" (Sri Lanka HA)*

Economic impact on the surrounding area was also reported, though with ambivalent implications, *"Many brokers have explicitly informed that the increased rent is due to the home again" (Tirunelveli HA)*

## Theme 4 - Employment Pathways and Economic Participation

Employment outcomes were documented across sites, reflecting diverse occupational integration. In Sri Lanka, *"6 clients are employed—3 of them work in a company that produces organic powder, one work in private pharmacy (The HA team took all effort to help her register in the Srilankan Medical council to work on pharmacy HA); one work in grinding mill... and one of them work in the Government Sector in the Divisional Secretary department."* At Tirunelveli, *"One client is working in a college in a canteen; Three clients are attending type writing class; One client works in a supermarket."* Kancheepuram documented, *"One of the clients is engaged as PA; 7 male clients have engaged in construction work; Two female clients have engaged in the house keeping work; 4 clients have attended the beautician course."*

However, practitioners reported persistent challenges regarding fair compensation. Initial employer resistance was common,

*"Initially the supermarket owners refused to pay salary saying he can come and just like that get trained but later seeing his ability they began to pay him salary" (Tirunelveli HA)*

Systemic undervaluation was noted,

*"Clients who do work are often underpaid, which discourages participation and causes emotional harm due to the undervaluation of their labour" (Anbu Ullangal HA)*

Social enterprise models offered alternatives.

*"We also started making idlis. The money earned from selling them is given directly to the clients, who can decide how to spend it" (Coimbatore HA)*

### **The Mill, the Wound, and the Road Back**

The grinding mill starts early. By six in the morning, the machines are already humming, and he is there among them, measuring grain, checking the stone, sweeping flour dust from the floor. This had become his rhythm. A job that gave some shape to his days.

Then one morning, the machine took a piece of him. A finger, caught in the works.

There was blood, there was chaos, and then the hospital with surgery, bandages, hours of a body learning to mend. The team at Sri Lanka Home Again watched with worry. Would he want to go back? Would the fear consume his will to work?

He was not alone in that hospital bed. His friends from Home Again came. Weeks passed. The wound closed. And then, he began asking about the mill again. When could he return? Could he go back to the same place?

*"Accidents can happen anywhere," he said, "We cannot stop living because of them."*

He went back.

Today, he rides a two-wheeler to the mill, weaving through morning traffic, flour dust waiting for him at the other end. The scar on his hand has healed. It was never just about the job. It was about continuing to show up, even when no one would have blamed him for walking away.

## Theme 5 - Non-Linear Recovery and Emergence of Voice

Practitioners articulated recovery as cyclical rather than progressive.

*"Recovery is understood as a non-linear process. Progress often unfolds in cycles rather than straight paths, requiring patience, flexibility, and continuous engagement.....Independence is not limited to employment or financial stability; it is also reflected in small, daily choices such as using a phone, watching television independently, or managing routine activities" (Mehac & Mariyasadanam HA).*

A central indicator of recovery was the emergence of capacity to articulate preference, enact on it.

*"Most of our clients... have experienced prolonged mental abuse and deprivation, to the extent that they initially struggle to even articulate what they want. Over time, however, they begin to express their needs clearly by saying this is what I want or this is what I need. That shift, for me, is extremely important" (Coimbatore HA)*

*Ms. L progressed from earning ₹50/day doing household work to ₹150/day at a hotel, rediscovering cooking skills and purchasing her own jewelry—"it boosted her confidence. It helped her rediscover a forgotten joy" (Chengalpattu HA)*

Residents also articulated complex relationships with uncertainty and hope.

*"Though he has abandoned me, I still wait. Not knowing if he will return, I find that waiting itself can offer solace, and the hope it carries helps me endure."*

## Theme 6 - Peer Leadership and Collective Advocacy

Formalised peer support structures were documented across sites.

*"There are 16 peer leaders in the home again. The clients feel so much included in the community to the extent that if something is not ok in the community, they voice it out (Eg, broken windows etc HA)" (Tirunelveli HA).*

Peer leaders assumed operational responsibilities.

*"There are two peer leaders, and they play an active role when it comes to dr rounds and escalating any issues pertaining to home management" (Villupuram HA)*

Individual residents emerged as resources for others with expertise also shared beyond the programme.

*"She has emerged as a peer lead, inspiring others with her resilience" (Villupuram HA)*

*"One year back 5 people from the community attended the tailoring training organized by the home again and one of our clients was one of the resource person" (Kancheepuram HA)*

*"Our clients accompany the social workers during outreach" (Tirunelveli HA)*

*"The existing clients in the ECRC accompanies the Social Workers for after care visits and meet their friends" (Thanjavur HA)*

### **The One Who Remembers**

Her name is not on the staff register at the Coimbatore home. She came here as a resident, with a degree in Chemistry and a mind that oscillated between lucidity and confusion.

She did not go back to her previous job in a factory. Settling into the rhythms of the home, she found another kind of work organically. One that needed the same careful eye, an unvarying patience for small, exact things.

It began with watching. Who takes the yellow tablet in the morning. Who needs the small white one before sleep. What were the names of these pills, what salts did they contain. Whose hands shake a little when they hold the glass. She remembered it all, names, doses, timings, without writing anything down.

Now, she is the one who hands out the medicines.

She knows every person's routine the way a mother knows her children's faces. If someone forgets, she is there with a quiet word. If the stock is running low, she tells the staff before anyone has to ask. Nothing slips past her.

She does not give instructions or force anyone. Instead she sits with people and explains why she believes medicines can be part of one's world. She has been through it herself and knows the fear far more intimately than anyone ever could. She makes it smaller.

## **Theme 7 - Relational Continuity and Practice of Slow Care**

Personal Assistants (PAs HA) were described as central to care continuity due to their knowledge acquired through relational attunement that helps them know intuitively what to do and expect.

*"Personal Assistants play a critical role in continuity of care, as their consistent presence and understanding of clients enable trust to develop over time" (Anbu Ullangal HA).*

Practitioners reported their own transformation through this work.

*"The PAs have also witnessed a change in the way they approach people and sit with their emotions" (Sri Lanka HA)*

Conversely, programme maturation was also reflected in reduced support requirements.

*"From 11 PAs they have come down to 4 PAs (as most of the clients can take care of themselves HA). The number of team meetings has also come down because the PAs are owing the program" (Sri Lanka HA)*

Engagement was characterised by temporal patience.

*"Since 2023, challenges have been addressed through 'slow work', emphasising patience, time, and relationship-building. Rapport is built gradually, including during everyday routines such as personal care and cleaning" (Anbu Ullangal HA)*

## Theme 8 – Navigating Dignity and Safety within Duty to Care

Practitioners described tensions between protection and autonomy. One instance of navigating a service user's smoking illustrated the counterproductivity of restriction,

*"We understood that restriction was not working; instead, it was pushing the behaviour into secrecy... Once restriction ended, excess was reduced. J stopped hiding, he stopped borrowing money... For us, this experience reinforced a core Home Again principle, protection is not restriction, protection is dignity, trust and supported choice" (Mehac HA).*

However, safety concerns sometimes necessitated transfer to more supervised settings. Practitioners reflected on this balance between duty to care and protect and person's freedom.

*"Given the home-like and less intensively monitored nature of Home Again, the team made the ethical decision to transfer the client to another NGO where closer supervision could be provided, prioritising safety" (Anbu Ullangal HA).*

*"An important reflection emerging from practice is the distinction between protection and restriction. While ensuring safety is essential, unnecessary restrictions can limit dignity and autonomy" (Mehac HA)*

In this light, a reorientation of care was described, wherein approach was characterised as,

*"deeply person-centred, with emphasis placed on individuals and their lived realities rather than only on measurable outcomes" (Mehac & Mariyasadanam HA).*

*"Instead of working around the medicines, we started to work around their needs, triggers, happiness and what heals them. At the end of the day we understood that the residents are not apprehensive but we are" (Sri Lanka HA).*

### **When Mr. J Stopped Asking**

When Mr. J began selling lottery tickets at the junction, it was a moment of celebration. For a man living with a mental illness, this meant standing among people again as a part of a town's daily commerce.

But every morning, he would find his personal assistant and ask, "Chechi, can I smoke?"

The answer was always a no. The team meant well. Smoking was harmful, and saying no was their duty to care.

Mr. J began borrowing a few rupees from strangers. He smoked in secret, behind buildings, more cigarettes than before. Furtive moments that soon became laden with debts.

When the team found out, they changed course. They sat with him and talked about health, money, choice. They came to an agreement, no borrowing, but he could smoke at fixed times. A small additional personal allowance, his to spend as he liked.

The secrecy ended. So did the constant asking. His smoking reduced on its own. Safety built through control had failed. Trust built through respect had worked.

## Theme 9 - Complexity of Family Relationships and Reintegration

Family contact generated heterogeneous outcomes. Positive perceptions of safety were reported,

*"Whenever the families visit our Home again, they feel that their daughters are 'safe'" (Villupuram HA).*

*"During one of the FGD they also stated that sometimes they also get a feel that 'atleast she is fine now'" (Kancheepuram HA).*

Reconnection carried emotional weight. One resident *"became emotional seeing her son now grown from a young child to young adult" during a video call (Chengalpattu HA)*. Another resident derived comfort from maintained connection,

*"His father is regularly coming to HA to meet with him... He is now reassured that his family members are in his hometown, which has brought him considerable happiness" (Tirunelveli HA)*

However, family rejection remained a significant risk.

*"Family reintegration is often complex. In one case, a client in remission and otherwise stable was not accepted back by his family. After being provided a phone at his request, he contacted his family and received abusive responses, which triggered suicidal ideation" (Anbu Ullangal HA)*

### **The home she found before she could go home**

Ms. K had been sent back to institutional care many times.

After her husband died. After her son went to prison. After the disputes with her in-laws. Each time, someone decided she should return to her family, the return did not last. Soon, she would find herself in another shelter, another rehabilitation centre, another bed in another institution.

By the time she reached Home Again in Villupuram district, her body had begun to speak what her words would not. She complained of persistent aches that seemed to settle everywhere. She kept to herself.

In the kitchen, Ms. K began to cook. She made meals for the other women. She noticed who was eating, who wasn't. She looked after the programme staff when they visited, the other residents when they struggled. Then the silence began to loosen, she had found something that had eluded her through years of being placed and replaced, a semblance of a family that that she had in her own way chosen.

Then her son, the one who drove for a living, the one not in prison, began visiting every month. These visits had once been difficult, shaped by old tensions and unresolved grief. But in the neutral space of the home, away from the weight of institutionalisation and family history, the visits became ordinary. They sat together and talked. The relationship, frayed by years of turmoil, began to repair itself in small, unremarkable ways.

When Ms. K finally spoke of going to her son's home for a visit, there was no dread in it. She had plans. She wanted to buy clothes for her grandchildren.

It was a small intention. But it marked a reversal of so much that had come before. She was no longer the woman being returned, the difficult relative, the unresolved case. She was a grandmother preparing gifts.

## Theme 10 - Political Agency and Civic Participation

Residents' participation in formal governance structures was documented with participation of residents in Gramasabha meetings across sites. Practitioners identified expansion of such opportunities as a priority.

*"A key need identified is for greater community interaction led by clients themselves. Opportunities for clients to participate in public celebrations, government meetings, and community forums could enable them to represent" (LTC Cumbum)*

Community belonging was expressed through civic engagement.

*"The clients feel so much included in the community to the extent that if something is not ok in the community, they voice it out" (Tirunelveli HA)*

### The Signature

Plastic chairs were arranged in rough rows, a table laden with files and papers was laid out in the front the Gramasabha. By afternoon, the heat has begun to loosen its grip on Thoothukudi, and people began to drift in, farmers still in their work clothes, a few women from the self-help group, the provisions store owner who always sits near the back. She came with other residents from the hostel that catered to women in psychosocial distress. They sat together, slightly apart from the others, wondering what this space held different from the sessions and review meetings she had been part of before as a service user whose case was being discussed.

Once the conversations began, they were all too familiar. A water line that had been in disarray for weeks, a road littered with potholes. Someone stood up to complain

about infrastructure, while some others laughed, the village assistant took notes; small, routine, expected negotiations of village life conducted in the open air.

"I didn't say anything," she said later. "I just watched."

When the business concluded, the assistant picked up the attendance register and began making his way through the crowd. A necessary record of participation. Each person signed or marked their thumb. The register moved from hand to hand.

He reached her. Held out the pen.

She looked down. The column header read - Name of the village member.

"My hand was shaking," she recalls, "I kept thinking, I was counted. For the first time in years, an official document carried my name not as a file number, but as a constituent"

Signatures as a record of presence in the Gramasabha for her denoted both her consent but also an acknowledgment of citizenship. The attendance register made no distinction between the farmer who owned six acres and the woman who lived in the hostel. Both were village members. Both signed.

The meeting dispersed into the evening. The chairs were stacked against the panchayat wall.

She walked back to the hostel with the others. The register, closed and filed, held her signature alongside many others, a small mark, bureaucratically mundane, that said she belonged to this place; she was also a village member.

## Theme 10 - Mutuality of Care and Caregiver Experience

Care was explicitly framed as bidirectional, "*Caring is mutual*" (Kancheepuram HA). Practitioners described personal transformation.

*"The program coordinator feels that being with clients have helped her shed her ego a lot. She feels that care and learning have become mutual in home again" (Tirunelveli HA)*

Residents challenged asymmetries in understanding, with one stating to the Programme Coordinator,

*"When you are not married how can you understand the pain of married woman."*

The epistemic gap between lived experience and professional understanding was articulated by one resident,

*"I know you are trying your best to understand my pain. But there is a subtle difference—you are paid to understand my pain, while I am the one living in it."*

Reciprocal care among residents was observed. However, caregiver burden was acknowledged.

*"Caregiver burden is significant, especially for those assisting with Activities of Daily Living. The repetitive and demanding nature of the work can lead to emotional and physical exhaustion...caregivers often feel the need for greater institutional support, as their labour is essential yet emotionally taxing" (Anbu Ullangal HA)*

Despite these demands, practitioners expressed fulfilment.

*"I feel that I am able to truly implement my ideology here... There are no unnecessary restrictions" (Coimbatore HA)*

*"What stands out most is the opportunity to engage with people as humans first, where dignity, individuality, and personal values are central to care and support" (Mehac & Mariyasadanam HA)*

These themes in the background of quantitative data presented across the ECRC and Home Again spotlight an overarching approach of integrated interventions delivered via sustained relational presence that enables residents to reconstitute identity, belonging, and social participation after prolonged exclusion. Yet the accounts also reveal challenges, fractured family relationships that are complex to repair, employment pathways constricted by discrimination and structural barriers, the demands placed on mental health professionals who work within these constraints. These successes and limitations together inform the reflections that follow.

## Reflections and Implications

The data presented in this report offer an opportunity for reflection in terms of what has been accomplished, what remains unresolved, and what implications emerge for policy, practice, and the reconceptualisation of community mental health services in India and comparable contexts. The outcomes documented across Emergency Care and Recovery Centres and Home Again sites, spanning three decades and multiple implementation modalities, present both the possibilities and persistent challenges in addressing the intertwined marginalities within homelessness and psychosocial disabilities.

## Reintegration Outcomes

The family reintegration rate of 52.5% achieved across ECRC sites corresponds closely with outcomes reported from other Indian institutions serving homeless populations with mental illness. A retrospective study from the National Institute of Mental Health and Neurosciences (NIMHANS) documented family reintegration in 51.3% of homeless people with mental illness, with 21.8% referred to other residential facilities and 19.2% to state-run homes (Gowda et al., 2017). Similar patterns have been reported in smaller studies in the Indian context (Kumar et al., 2019; Singh et al., 2016; Tripathi et al., 2013) and globally (McPhail et al., 2025). The evidence across different institutional contexts suggests that approximately half of homeless individuals with mental illness who access formal care in India can be reunited with families when systematic family tracing and engagement processes are implemented. This rate, while representing preferred pathways for many

individuals, simultaneously spotlights the need for alternative arrangements for the rest, whether supported housing, continued placement in geriatric or medical care, or independent living with support, a conclusion that is reflected also in global literature on the heterogeneity of housing needs among people with severe mental illness (Keller et al., 2013; Richter et al., 2017; Rog et al., 2014; Tsai et al., 2009).

The median duration of homelessness prior to admission across sites (6 months, IQR 23) indicates how early homelessness trajectories the outreach and identification mechanisms operationalised through ECRC networks are able to intervene. The inter-site variation, wherein directly operated sites with more established outreach demonstrated shorter median durations (4 months) compared with newer NHM sites (7 months), may indicate that programmatic maturity enhances early identification. This temporal dimension carries clinical significance as shorter durations of homelessness are associated with better clinical outcomes (Adair et al., 2016; Fazel et al., 2014), and possibly therefore higher reintegration success as well as reduced risks for accumulation of physical health comorbidities, suggesting that investment in robust outreach infrastructure yields dividends beyond immediate crisis intervention.

### Aftercare Retention and the Challenge of Continuity

The sustained aftercare engagement of 76% among those discharged into the community from NHM sites is higher than those reported in studies from high-income contexts that document follow-up rates between 10% - 65% within 7 to 30 days of psychiatric discharge, with substantial attrition thereafter (Hermer et al., 2021; Hugunin et al., 2023). Among homeless populations specifically, follow-up engagement is typically lower, with one Canadian population-based study finding that individuals discharged to homelessness were significantly less likely to receive outpatient psychiatric follow-up compared with housed counterparts (Laliberté et al., 2020). Literature documents how competing priorities, chaotic circumstances secondary to mental illness and substance use, stigma, and fragmented service systems combine (Canavan et al., 2012; Skosireva et al., 2014) and may be engaged in producing high rates of disengagement from post-discharge care among homeless populations. Against this backdrop, the 76% retention rate suggests that the integration of ECRCs within public health infrastructure, combined with structured aftercare protocols and linkage to district-level services, possibly creates conditions more conducive to sustained engagement.

Nevertheless, the 17% lost to follow-up and 2% readmission rate documented across NHM sites indicates that nearly one-fifth of those discharged experience discontinuity of care. The qualitative accounts of family tracing reveal how prolonged separation and untreated illness fracture kinship bonds in ways that require attention and time to repair. Aftercare, therefore, must be conceived as sustained relational work that attends to the reconstitution of social ties disrupted by illness and homelessness, alongside clinical follow up, similar to the emphasis in studies on critical time intervention post discharge as a bridge between institutional and community care (Herman et al., 2011; Susser et al., 2011).

## Housing Stability and Community Integration

Home Again outcomes present patterns that are both similar and different when placed in the context of the comparable Housing First intervention and its evidence base that has largely shaped policy discourse in high-income settings. Systematic reviews of Housing First programmes report housing retention rates typically ranging from 66% to 90% (Roggenbuck, 2022), while findings on health and social outcomes beyond housing stability have been mixed (Aubry et al., 2015; Woodhall-Melnik & Dunn, 2016). The At Home/Chez Soi trial in Canada, the largest randomised evaluation of Housing First involving over 2,000 participants across five cities, found significant improvements in housing stability but inconsistent or attenuated effects on community integration, substance use and psychiatric symptoms (Aubry et al., 2016; Stergiopoulos et al., 2015, 2019). A systematic review examining randomised controlled trials concluded that while Housing First effectively reduces homelessness and improves housing stability, evidence for broader health improvements needs more investigation (Baxter et al., 2019).

In Home Again, continued tenure in the community was overall at 69.9% (those who remained in Home Again or returned to their families) which is comparable to lower thresholds of Housing First benchmarks, though both the tenure of follow up and the populations served differ. Participants in Home Again have median institutionalisation histories of 20 months (IQR 64), with those at directly operated sites having substantially longer histories (29 months). This population, characterised by protracted institutionalisation, high physical comorbidity burden, and often decades of exclusion from community life, differs from populations enrolled in most Housing First trials, which typically focus on those experiencing episodic or chronic street homelessness (Aubry et al., 2015; Goering et al., 2014). Moreover, the return-to-institution rate of approximately 16.5% across both directly operated and partner sites reflects the reality that supported housing, even with comprehensive on-site assistance, is unable to meet the needs of all individuals, particularly those experiencing acute psychiatric decompensation or requiring intensive medical care.

The pre-post outcome analyses documenting significant improvements in home integration, social integration, and composite community integration scores provide evidence that the intervention achieves its intended effect of fostering community participation over long tenures with sample representative of participants who had enrolled anytime since 2014. These findings align with qualitative research from Housing First indicating that housing is connected to participants' sense of safety, ontological security, and community belonging (Padgett, 2007; Yanos et al., 2004), though quantitative evidence for community integration improvements in Housing First trials has been varying (Quilgars & Pleace, 2016). The qualitative transformation from service user to neighbour, documented across sites through accounts of residents being invited to religious festivals, consulted on community matters, and addressed as fellow community members rather than clients, speaks to the quality of integration that standardised measures may not capture. When community members shift their language from *kaapgam* (shelter/institution) to *antha veedu* (that house), or when a resident participates in Gramasabha meetings and signs the attendance register as a village member, these represent moments of citizenship reconstituted after prolonged exclusion, what Ware and colleagues (2007) term 'connectedness' as a dimension of recovery.

## Episodic Crisis within Longitudinal Trajectories: Toward an Integrated Continuum

A central conceptual contribution of the approaches documented here lies in recognising that episodic mental health crisis occurs within longitudinal trajectories of social advantage and disadvantage. The homeless person encountered during street outreach arrives at that moment through compounding events such as family separation, treatment discontinuity, economic precarity, and social network dissolution, all of which constitute a history that shapes their present mental health experiences. This perspective aligns with life-course approaches to homelessness that emphasise cumulative disadvantage and the interaction of structural and individual factors over time. The crisis intervention that initiates engagement through ECRC admission represents an entry point into a longer trajectory that may include acute stabilisation, family reunification, aftercare engagement, and for some, transition to supported housing through Home Again.

This framing carries implications for how community mental health is conceptualised in policy frameworks. The dominant community mental health services model in many contexts, has been oriented primarily toward treatment delivery, with emphasis on reducing the treatment gap through outpatient services and essential medication provision. While necessary, this orientation may be insufficient to address the circumstances of those whose mental illness has precipitated or been compounded by homelessness. The National Mental Health Survey of India documented substantial treatment gaps (Gautham et al., 2020), but the 'treatment gap' framing may itself be limiting when the challenges facing homeless populations extend beyond treatment access to encompass housing, livelihoods, family relationships, and social inclusion. For this population, community mental health may need to include housing support, family engagement, livelihood facilitation, and sustained case management that can respond to the non-linear, often recursive nature of recovery from combined homelessness and serious mental illness.

The integration of ECRCs within the National Health Mission infrastructure in Tamil Nadu represents one component of such an approach for operationalising this expanded conception. By embedding crisis intervention and recovery services within district hospitals, linking those discharged to aftercare through the District Mental Health Programme, and creating pathways to supported housing for those requiring alternatives to family reunification, the approach constructs a continuum that can address both episodic crisis and longitudinal social disadvantage. The replication across districts, with sustained government financing and civil society implementation, demonstrates feasibility at scale within public health system constraints.

## Relational Attunement and Implications for Workforce Development

The qualitative accounts from practitioners across both ECRC and Home Again sites converge on the perspective that care for this population rests fundamentally on relational attunement. The practitioner who sits for two hours at a railway station without asking assessment questions, the Personal Assistant who learns to recognise the meaning of a resident sitting daily at the gate watching for red cars, the outreach worker who spends four days following a woman from a distance

before she agrees to engagement, all of these accounts describe a mode of practice predicated on patience, presence, and responsiveness to the particular rather than the standardised. This finding resonates with the broader recovery literature's emphasis on relationships as central to recovery processes (Davidson et al., 2005; Topor et al., 2011), and with research on therapeutic alliance showing that relationship quality predicts outcomes in mental health interventions (Horvath et al., 2011).

This has direct implications for workforce development and professional education. Standard curricula in mental health professions typically emphasise diagnostic assessment, treatment protocols, and time-limited interventions. The competencies required for effective work with homeless populations experiencing severe and persistent mental illness, including tolerance for ambiguity, capacity to maintain engagement across extended periods without evident progress, skill in reading meaning from behaviour sans conventional clinical interpretation, and ability to work at the pace set by the person rather than the service, receive less systematic attention. Research on peer support workers and community health workers in mental health contexts suggests that lived experience and community embeddedness may be as important as formal training for effective engagement with marginalised populations (Chinman et al., 2014; Patel et al., 2010, 2017). The capacity-building framework documented in this report, with its emphasis on values immersion, ongoing mentoring, and structured reflection, represents one approach to developing these competencies, but more systematic attention to relational practice in mental health education is warranted. This also needs further attention to the dynamics of mutual transformation through care relationships, reflecting what Kleinman (2012) terms the reciprocity of caregiving that resists reduction to technical competencies.

## Policy Implications: Licensing, Regulation, and Provider Accountability

The Mental Healthcare Act of 2017 and Rights of Persons with Disabilities Act of 2016 establish rights frameworks that mandate community living options and prohibit segregation in mental health establishments due to lack of family support or homelessness. These provisions align with Article 19 of the UNCRPD, which articulates the right of persons with disabilities to live independently and be included in the community with access to support services. Translating these rights into reality requires regulatory frameworks that enable rather than constrain the development of community-based services. Current mental health establishment licensing requirements in many Indian states are oriented toward inpatient and institutional rehabilitation models, specifying bed counts, physical infrastructure, and staffing ratios appropriate for hospitals rather than community housing.

The Home Again model, with small groups of residents living in rented homes within ordinary neighbourhoods supported by personal Assistants and visiting case managers, does not fit easily within such frameworks due to incompatibility between regulatory oversight emphasising facility licensing rather than service norms and community integration. Yet the absence of regulatory oversight creates risks of exploitation and harm, as documented histories of abuse in unregistered care homes demonstrate (Human Rights Watch, 2014).

What may be needed is a differentiated regulatory approach that establishes accountability for service providers without coercing compliance with facility-based licensing models inappropriate to community housing. This may include registration requirements for organisations providing supported housing services, standards for staff training and supervision, protocols for person-centred care planning and periodic review, grievance mechanisms accessible to residents, and outcome monitoring, elements that the quality assurance frameworks described in this report incorporate. Such an approach would hold providers accountable for the quality and safety of services while permitting the flexibility in physical arrangements that community integration requires. International guidance from the World Health Organization (2021) on community mental health services could inform such regulatory development.

## Work Participation: Persistent Barriers and Required Investments

The outcome data reveal that while Home Again achieves significant improvements in home and social integration, work integration scores did not demonstrate significant change. Though many studies in the community in India show higher rates of work participation among people with serious mental illness compared to the global north counterparts (Evensen et al., 2016; Khare et al., 2021; Marwaha & Johnson, 2004), studies specific to Housing First programmes have similarly found that housing stability does not automatically translate into employment gains (Poremski et al., 2015; Tiderington et al., 2020). Barriers include stigma, symptom-related functional limitations, benefit disincentives, employer discrimination, gaps in work history, lack of references, criminal records, and trauma responses that complicate return to workplace. The qualitative accounts from Home Again sites show how these barriers operate in the Indian context. Employers initially refusing to pay wages because they viewed work as training rather than employment, residents receiving lower pay than others for equivalent work, and families expressing satisfaction that their relative is safe while remaining indifferent to questions of economic participation, these accounts reveal how devaluation of labour performed by people with mental illness operates across multiple sites.

Addressing this gap requires substantive investments beyond what housing with supportive services alone can provide. Individual Placement and Support (IPS), the evidence-based supported employment intervention, achieves competitive employment rates of 40-60% in controlled trials with populations having severe mental illness, substantially outperforming conventional vocational rehabilitation (Bond et al., 2008; Cook et al., 2005). A Cochrane systematic review indicated the superiority of supported employment approaches over traditional prevocational training though quality of evidence was low (Kinoshita, Y et al., 2013). However, IPS has been minimally adapted and evaluated in low-resource contexts, and its integration with housing interventions serving formerly homeless populations remains underdeveloped. Preliminary evidence from the Netherlands suggests IPS can be effectively implemented within supported housing settings with comparable outcomes to mental health service contexts (Roeg et al., 2021). Social enterprise models, as documented at some Home Again sites, offer alternative pathways to meaningful economic activity, though questions of scale, sustainability, and whether such employment constitutes exploitation or opportunity require ongoing scrutiny. Initiatives that emphasise skills

training and employment linkage, including programmes operated through the National Urban Livelihoods Mission, represent promising directions requiring systematic evaluation and investment commensurate with the magnitude of the employment gap.

## Reconceiving Community Mental Health: Covering From Treatment to Full Participation

The findings documented in this report suggest that community mental health services oriented toward closing the treatment gap, while necessary, are insufficient to address the circumstances of those whose mental illness has precipitated or been compounded by homelessness and prolonged institutionalisation. For this population, treatment alone, even when accessible and continuous, does not address the accumulated social disadvantages that accompany prolonged illness and exclusion such as the dissolved family ties, the absence of housing, the erosion of work skills and employment history, the loss of identity documents and social entitlements, the attenuation of social networks and community belonging. This aligns with critiques within the global mental health field that have called for greater attention to social determinants and structural interventions alongside clinical care (Mills, 2014).

What these approaches demonstrate is that addressing the nexus of homelessness and psychosocial disability requires interventions that operate across multiple domains simultaneously. Crisis intervention and acute care must be linked to family tracing and engagement. Discharge planning must include not only clinical follow-up but housing arrangements, entitlement facilitation, and livelihood support. Supported housing must be accompanied by sustained social care that can respond to the emergent needs of community living. And throughout, the pace and direction of intervention must be responsive to the priorities and choices of those served, recognising that the restoration of agency after prolonged loss of control over one's circumstances is itself a recovery outcome of fundamental importance (Leamy et al., 2011; Slade et al., 2014).

The qualitative accounts of residents purchasing their own jewelry, caring for pets they describe as their children, signing attendance registers at village meetings, and buying gifts for grandchildren they will visit articulate forms of agency and participation that exceed what clinical outcome measures typically capture. They are manifestations of lives being lived with meaning, connection, and purpose after periods when such possibilities seemed impossible. Community mental health policy that takes seriously the commitment to community living articulated in Article 19 of the UNCRPD and Section 19 of the Mental Healthcare Act must encompass such outcomes within its conception of what services should achieve. As Kleinman (2009) indicates, caregiving that matters attends not only to disease but to what matters most in the lives of those who suffer.

## Conclusion

Over three decades, the approaches documented in this report have reached more than 5,400 homeless people with psychosocial disabilities through Emergency Care and Recovery Centres and

over 1,300 through Home Again. More than half of those accessing ECRCs have been reunited with families, with three-quarters of those discharged from NHM sites maintaining engagement with aftercare services. Home Again residents demonstrate sustained improvements in community integration, with qualitative of expanded participation in neighbourhood, civic, and economic life. These outcomes, achieved with populations characterised by severe mental illness, prolonged homelessness, and extensive institutionalisation histories, demonstrate that recovery and community inclusion are possible even for those whose circumstances might suggest otherwise—affirming the principle articulated in global consensus frameworks that all people with psychosocial disabilities can live in the community with choices equal to others.

Yet this report also documents what remains unresolved. Nearly half of those who access ECRCs cannot be reunited with families and require alternative arrangements that remain insufficiently available at scale. Work participation among Home Again residents has not improved significantly despite gains in other domains of integration, reflecting barriers that housing with supportive services alone cannot overcome. Mortality rates, particularly at directly operated sites serving the most complex populations over the longest periods, point to the fact that the work occurs against a backdrop of compromised physical health and shortened life expectancy documented for people with severe mental illness globally (Walker et al., 2015).

The implications for policy are several. First, addressing homelessness among people with psychosocial disabilities requires interventions that span the continuum from crisis response through sustained community support, integrated within public health and welfare systems rather than operating as standalone projects. The embedding of ECRCs within National Health Mission infrastructure and linkage of Home Again with District Disability Welfare mechanisms in Tamil Nadu demonstrate one component of a much broader approach needed to such integration. Second, regulatory frameworks must be developed that establish accountability for service providers appropriate to community housing using a differentiated approach that protects rights while enabling innovation. Third, substantive investments in employment support, including adaptation and evaluation of evidence-based approaches such as Individual Placement and Support and development of social enterprise models, are required to address the persistent gap in work participation. Fourth, workforce development must attend to the relational competencies that effective work with this population demands, moving beyond technical skill training to cultivate the patience, presence, and responsiveness that practitioners identify as central to their practice.

Finally, these findings invite reflection on what community mental health services should encompass and what outcomes they should pursue. Realising possibilities that progressive legislative framework for mental health and disabilities entail for those who have experienced the compounded vulnerabilities of homelessness and psychosocial disability requires that services orient toward the reconstruction of lives, the restoration of social connections, the creation of alternative belonging where families cannot be found or cannot provide care, the facilitation of economic participation and civic engagement, and the recognition of personhood that the accounts presented here reveal as foundational to all else. The approaches documented in this report represent one contribution to this larger endeavour, offered as an ongoing effort rather than any set

solution, that will always be learning and evolving, towards the goal of full participation of people with psychosocial disabilities.

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