Supporting Women with Severe Mental Illnesses Experiencing Homelessness:

A Policy Project with The Banyan

Reem Assi, Leo Biehl, Charlotte Brown, Aravind Krishnan

Perry World House

22 April 2025

Supporting Women with Severe Mental Illnesses Experiencing Homelessness

Homelessness and severe mental illness pose significant obstacles to preserving health and wellbeing, and their impact is exacerbated when they intersect. They can create a self-perpetuating feedback loop, from which individuals often struggle to escape. Insufficient financial resources, limited social services, and relational disruptions can compound these issues. However, promising programs have been implemented to address these barriers.

In South India, The Banyan has played an essential role since 1993 in providing mental health care and housing for women experiencing these dual challenges. The Banyan's model provides essential care in a hospital-based setting but also effectively transitions individuals to home-based care, outpatient clinics, and community-based mental health care services. The Banyan has achieved a substantial impact with its programs to date, but like other institutions working on similar challenges worldwide, is operating in the dynamic context of intersecting political, social, economic, and demographic factors that impact its mission.

This report highlights key aspects of The Banyan's mission, beginning with background about the Banyan's evolution over time and the legal and social context of homelessness and severe mental illness in India. Next, the report focuses on three key factors in understanding SMI and homelessness in India: how relational disruptions affect Indian women, how mental illness is viewed as a disability compared with countries around the world, and how caste affects mental health. The report concludes with three recommendations for organizations promoting health and wellbeing of women who experience severe mental illness and homelessness.

Background Research

Introducing The Banyan

The Evolution of the Banyan's Model Over Time

Contributed by Reem Assi

The Banyan has evolved its model significantly over the years to encompass comprehensive and adaptive care strategies. The organization's journey is marked by its responsiveness to socio-political and cultural challenges, driving systemic change in mental health services for marginalized groups.

The Banyan's evolution can be described as multiple lifecycles, in which each lifecycle leads to reflections which establish an improved plan for the next. The Banyan began as a crisis intervention center for homeless women with mental illness in Chennai, providing emergency care and rehabilitation (Narasimhan et al., 2019, The Banyan, 2023). Thus the organization's first life cycle, from 1993 to 1996, focused on immediate shelter and reuniting individuals with their families, exposing them to the larger scope of homelessness within India and the need for reintegrative care. This initial approach established the groundwork for the Banyan's user-centered philosophy, which tailors services to meet the unique needs of each client (Narasimhan et al., 2019). During this period, The Banyan's emergency care and recovery services were pivotal, with a 120-bed facility offering multidisciplinary interventions aimed at reintegration into familial or community settings (Narasimhan et al., 2019).

Increasing numbers within the Banyan services highlighted a greater need for local and national governmental recognition of the rights of homeless persons, as hundreds of individuals were either unable to successfully exit the system or were left without proper care or support after their completion of the Banyan's programs. Thus, in its second life cycle from 1996 to

2004, The Banyan expanded its services to include systematic aftercare, employment opportunities, and partnerships with external organizations. Programs like the Rural Mental Health Program and DIAL 100, a helpline for homeless individuals with mental illness, highlighted the organization's commitment to accessibility and community integration (The Banyan, 2023). This phase also saw the establishment of clustered group homes for individuals requiring long-term care, addressing gaps in India's mental health infrastructure (Radhakrishnan et al., 2021).

In its third lifecycle between 2004 and 2012, The Banyan's focus shifted toward inclusive living and community-based programs for those who could not return to their families after the programs completion. This shift in focus to long-term, continuous care led to the greater social interventions, such as providing employment, education, disability allowances, and more. Initiatives like the "NALAM" community mental health program and shared housing models emphasized personalized care and socio-economic support for those at risk of institutionalization (Narasimhan et al., 2019). Collaboration with government agencies and local organizations, such as the state mental health facility and other NGOs, enhanced the scalability of these programs, allowing The Banyan to greater address structural poverty and exclusion barriers within the context of the resources available to them (Radhakrishnan et al., 2021). This also included facing the resource limitations in personnel training and the necessary education to provide these services. This led to the establishment of The Banyan Academy of Leadership in Mental Health (BALM), in 2007, which offers graduate programs and research initiatives with a focus on training.

The focus on providing user needs and rights among human resources identified various human resource deficits within the mental health sector, both in terms of numbers and core values and skills. These reflections led to changes in service integration during the fourth lifecycle since 2012. Partnerships with the Tamil Nadu government and organizations like the Azim Premji Foundation have supported the expansion of Emergency Care and Recovery Centers (ECRCs) and the “Home Again” program that provides both housing and various forms of support with an emphasis on “facilitating socio-economic-political participation of users in communities” (Narasimhan et al., 2019). This innovative model established non-clustered housing units, promoting independence and reducing stigma through community integration. Quality assurance systems were implemented by underscoring privacy and dignity during bathing and ensuring access to basic amenities, such as properly fitted and coordinated clothing. These efforts have enabled decentralized, cost-effective care while aligning with governmental priorities and community needs. These efforts were also heavily successful–nearly half of the participants transitioned to independent living (Radhakrishnan et al., 2021).

Defining Homelessness and Severe Mental Illness

Indian Policy related to Homelessness and Severe Mental Illness

Contributed by Charlotte Brown

India faces a complex political landscape surrounding women with severe mental illness who are homeless. India’s laws are transitioning to support the rights and dignity of people with severe mental illness who experience homelessness, however change is slow. There are still social and political barriers to putting these laws into practice, especially in rural communities. The major policies comprising India’s approach to people with severe mental illnesses who are homeless include the National Mental Health Program of 1982, the Mental Healthcare Act of 1987 (revised in 2017), the District Mental Health Program of 1996, and the National Mental Health Policy of 2014.

The older iterations of these policies and programs focus on encouraging community-based services and interventions. They tend to address mental health from a disease perspective and do not recognize the complex social determinants of health which can interact with and exacerbate mental illnesses (Tripathi et al., 2021). The Mental Healthcare Act of 1987 also allowed police officers to take people in public who they deemed mentally ill “into protection.” These individuals were brought before a magistrate who would decide whether or not to admit them to a mental health facility (Swaminath et al., 2019). One of the concerns this act inspired regards the many individuals who were homeless but not mentally ill and were also involuntarily admitted by magistrates without a mechanism for release (Tripathi et al., 2021). Such concerns have spurred updated policies which better support the rights of individuals with severe mental illness and those who are homeless.

Newer policies (the National Mental Health Policy of 2014 and the 2017 revision of the Mental Healthcare Act) add protections and reinforce rights of persons with mental illness and those who experience homelessness. While the Mental Healthcare Act of 1987 specified that individuals with mental illness must not be treated with indignity or cruelty and their human rights must be honored, the 2017 update added necessary requirements to how this should be followed (Swaminth et al., 2019). The update placed increased responsibility on the state to prove the person’s capacity, not via a magistrate but with the help of a medical officer. It also prohibited the use of prisons for detainment of someone under protection and required the detaining officer to make an attempt to locate and notify the individual’s family of their whereabouts. The act was also updated to establish a right to free legal aid, a right to the least restrictive and most dignified treatment possible, a right to living in the community, and a right to reintegration into the family home, and a right to universal access to care (Tripathi et al., 2021). It specified that individuals who are homeless and have mental illness have the same rights as anyone else with mental illness.

The National Mental Health Policy of 2014 made a similar movement towards supporting the complex needs of women with severe mental illnesses who are homeless. This policy addressed the complex interaction of homelessness and mental illness, emphasizing the importance of both housing and mental health care in addressing this issue (Tripathi et al., 2021). The policy works to address social exclusion by discouraging stigma and discrimination while recommending poverty reduction measures and improvement of living conditions. The 2014 National Mental Health Policy also highlights community participation as an important right and emphasizes the right to universal access to healthcare.

While the legal groundwork is laid to support the rights of women with severe mental illnesses who are homeless, the implementation of the policies varies across India and there remain significant barriers to putting policy into practice on the ground (Kaur et al., 2023). These barriers include affordability, lack of infrastructure, and perceptions of people who are homeless or have severe mental illness (Arahanthabailu et al., 2024).

Interaction of Homelessness and Serious Mental Illness

Contributed by Leo Biehl

The relationship between homelessness and serious mental illness (SMI) has been extensively researched, but remains misunderstood. SMI includes major mental illnesses or disorders accompanied by a decrease in functioning, which often manifests through active psychiatric symptoms (Montgomery et al. 2013).

SMI is neither sufficient nor necessary for the onset of homelessness (Montgomery et al. 2013). Studies have found that housing unaffordability and other structural factors remain the primary cause of homelessness in the United States, rather than mental illness (Shinn and Khadduri, 2020). People with SMI nevertheless remain at increased risk of homelessness due to factors such as increased unemployment, familial estrangement, and increased health expenses. Homeless people with SMI are significantly more likely than those without mental illness to receive government benefits, such as SSDI, SSI, and Medicaid (Sullivan et. al, 2000). This reality has led some scholars to claim that in the United States, SMI could be a protective factor against homelessness in some localities.

Rates of mental illness are significantly higher among those who are homeless than "housed," but people with SMI still constitute a minority of the homeless population. Studies have demonstrated that around 25-30% of the homeless population has a SMI (Padgett, 2020). The prevalence of SMI in the general population remains significantly lower. There is not comprehensive evidence on the prevalence of homelessness and SMI in low and middle income countries (LMIC). One review found an association between homelessness and SMI in LMICs, but noted significant methodological gaps in the literature. Additional research is needed in this field to understand the specific challenges facing LMIC in addressing mental illness.

People with SMI who become homeless face significant challenges. One study found that people with SMI were at elevated risk of long-term homelessness (Fazel et al., 2014). After becoming homeless, SMI can also exacerbate symptoms of other physical health issues (Smartt et al., 2019). Homeless people with SMI are often assessed to have a lower quality of life than those without SMI (Sullivan et. al, 2000). The harsh realities of being homeless may even prompt or exacerbate symptoms of mental illness, thereby making it more difficult to adapt to life on the streets.

Montgomery et al. (2013) describe a multifaceted approach to address homelessness among people with SMI, which includes primary, secondary, and tertiary approaches. Primary approaches include increasing disability income for people with SMI, while secondary approaches focus on providing supportive services and relocation assistance. Tertiary approaches would be the most intensive intervention and include significant housing subsidies and ongoing mental health treatment. Interventions like Housing First have shown promise in helping people with SMI exit homelessness. Housing First provides immediate access to permanent housing with supportive services, rather than requiring sobriety or mental health counseling services. This model has shown that Housing First is often more successful at helping those with SMI exit homelessness than traditional approaches (Aubry et al., 2015). These findings reflect the need for individual countries to explore Housing First approaches and adapt them to the specific demands of each region and locality.

Homelessness and Severe Mental Illness: The Indian Context

Dynamics, Causes, and Changes to Homelessness and Serious Mental Illnesses in India

Contributed by Reem Assi

Homelessness and serious mental illnesses (SMIs) in India are deeply intertwined issues, influenced by a combination of social, economic, and cultural factors. While extensive research on these dynamics has been conducted in Western contexts, studies focusing on India highlight unique challenges and intersections, particularly with poverty, stigma, and gender.

A critical examination of homelessness among women with mental illnesses, such as that conducted at The Banyan, reveals stark disparities in quality of life and access to services (Krishnadas et al., 2021). Homeless individuals with SMIs in India face compounded vulnerabilities, including social deprivation and limited educational attainment. Over 32% of women surveyed in one study reported experiencing homelessness at least once, with factors such as relational disruptions and low education being statistically significant predictors. For example, women with fewer than five years of education had nearly three times higher odds of homelessness compared to those with more schooling, emphasizing the role of educational inequities (Krishnadas et al., 2021). Age also played a role, as older individuals were more likely to have experienced homelessness, potentially due to prolonged struggles with mental illness.

Beyond individual factors, broader sociocultural influences significantly shape outcomes for women with SMIs. Family rejection, often stemming from stigma and cultural expectations, is a recurring theme. Unlike in Western societies, Indian culture places a high value on collectivism and familial ties, which makes abandonment due to mental illness particularly devastating. Women with SMIs are frequently subjected to stereotypes, prejudice, and discrimination, leading to their exclusion from familial and social networks (Moorkath et al., 2019). For instance, the stigma surrounding mental illness often manifests as perceptions of women being burdensome, unfit for marriage, or unable to contribute to family life. Such stigma not only isolates women but also contributes to cycles of poverty and homelessness. Another contributing factor for homelessness in women is the underlying gender disadvantage in educational opportunities and access for women that is exacerbated amongst women of particularly disadvantaged castes, as low educational attainment and relational disruptions were greatly associated with higher odds of experiencing homelessness (Krishnadas et al., 2021).

Stigma is also a structural issue, perpetuating economic and social marginalization. Studies show that individuals with SMIs in India are more likely to be unemployed and multidimensionally poor as a result of poverty's high association with stigma (Trani et al., 2015). Multidimensional poverty was proven to be strongly associated with not only stigma, but also scheduled castes/ tribes, mental illness, and the female gender. Thus, both public stigma and multidimensional poverty linked to individuals with SMIs are pervasive and intertwined. This deprivation is exacerbated for women, who face compounded discrimination due to their perceived gender roles and caste. For instance, women from disadvantaged castes with SMIs were 9.61 times more likely to experience multidimensional poverty than male counterparts from higher castes (Trani et al., 2015). This is firstly because women with SMIs are unable to fulfill familial and social roles, leading them to be considered as “burdens” for their families. Secondly, the negative public perceptions that stem from traditional beliefs (such as SMI being a punishment for previous lives lived, evil eye, etc.) lead to increased discrimination and sometimes violence against women with SMIs, increasing the chance of homelessness. Studies also highlight the role of domestic violence and family breakdown as key triggers for homelessness among women. Escaping abusive relationships often leaves women with no support network, increasing their risk of homelessness (Krishnadas et al., 2021). Additionally, systemic failures, such as inadequate welfare programs and de-institutionalization, have worsened conditions for individuals with SMIs, as evidenced by historical and global trends (Singh et al., 2018).

The geographical and economic conditions in India further shape the prevalence and distribution of homelessness. Urbanization has led to significant increases in homelessness in cities, with rural-to-urban migration contributing to the strain on housing and social services (Singh et al., 2018). This increase in population density in urban areas is attributed to the search for employment, thus urban centers often become "service ghettos," where homeless populations cluster due to the availability of emergency shelters and other services. However, the lack of coordinated care systems that address both clinical and social needs often leaves these individuals vulnerable to recurring cycles of homelessness and mental health crises.

In addressing these challenges, researchers emphasize the need for integrated, multidimensional approaches that address both social and clinical determinants. Eliminating gender-based disparities in education, enhancing social support systems, and reducing stigma are critical steps toward breaking the cycle of homelessness and SMIs. Furthermore, policies that recognize the intersectionality of caste, gender, and poverty are essential for fostering equity and inclusion in care delivery.

Demographics of Homelessness and Severe Mental Illness in India

Contributed by Leo Biehl

Homelessness and SMI both represent significant challenges facing India. According to the 2011 Census, there are 1.77 million homeless people in India, which accounts for 0.15% of the total population (Banerjee and Bhattacharya, 2020). There remains significant debate about the accuracy of these numbers. Scholars have noted that organizations responsible for enumerating homelessness often reach different estimates. In Delhi, for instance, the Census, Indo-Global Social Service Society, and Delhi Development Authority all reached markedly different estimates regarding prevalence of homelessness (Banerjee and Bhattacharya, 2020). This reality is partially due to a lack of clear definition for homelessness, which was formerly a significant debate in the European Union and United States.

Scholars have noted that the majority of the homeless population in India consists of daily wage workers, migrant laborers or beggers (Banerjee and Bhattacharya, 2020). The official definition used by the Indian government for homelessness is someone who does not live in a “census house,” which is defined as a structure with a roof and with ‘‘a building or part of a building having a separate main entrance from the road . . . used or recognised as a separate unit'" (Wardhaugh, 2012). As a result, this reality means that people who would likely be classified as homeless in the United States are not in India (Wardhaugh, 2012). Bannerjeree Das (2001) categorized homelessness in India using six subcategories, which include destitutes, migrants, pavement dwellers, inmates of institutions, occupants of emergency camps, and street children. Scholars have argued that there is an "urgent" need to redefine homelessness in India to collect more reliable data (Kaur and Pathak, 2016).

There remains a significant population of hidden homeless in India, including in rural areas (Wardhaugh, 2012). Namibar et al. (2023) conducted a qualitative study of homeless individuals in Delhi, noting that the population often faces increased susceptibility to disease, physical injuries from automobiles, and poor nutrition. The same study found high rates of both tuberculosis and HIV among people at a homeless recovery shelter. SMI is also a significant issue facing the homeless population in India. Estimates indicate that around 20-25% of the Indian homeless population suffers from severe and persistent mental illness (Gopikumar et al. 2015).

Mental health is a key concern in India. Gopikumar et al. (2015) describe how there are significant gaps in access to mental health care in India, noting that the nation has one of the highest rates of suicide in the world. The Global Burden of Disease Study estimated that 197.3 million people had mental disorders in India, with depressive disorders constituting the highest proportion (Sagar et al. 2020). This reality means that in 2017, nearly one in seven Indians were affected by mental disorders of varying severity. Significant challenges remain toward expanding access to mental health services and implementing them consistently across all states.

Barriers to Accessing Existing Care

Contributed by Charlotte Brown

Women with severe mental illness who are homeless in India face intersecting challenges which block access to mental health services. These challenges can be sorted into three categories: social, infrastructure, and health-related barriers.

Social barriers involve challenges related to family and community relationships which may be negatively impacted by severe mental illness. Severe mental illness may be considered a spiritual ailment, even as a punishment for wrongdoing. This can contribute to stigma, especially if the individual is unable to fulfill expected roles of a wife and mother. These factors can contribute to families and communities abandoning women with severe mental illnesses, leaving women economically and legally vulnerable without a way to provide for themselves (Bharadwaj & Koujalgi, 2024; Koul, 2022). Women with severe mental illness experience higher rates of domestic violence and divorce or separation. This loss of family and unsafe home life can lead to homelessness when women do not have alternate resources to turn to (Koul, 2022).

Infrastructure barriers include the resources necessary for successful treatment. Rural communities may not be able to access services based in urban centers, and individuals with severe mental illnesses may not cooperate with being transported by family members or caregivers to these urban centers (Arahanthabailu et al., 2024). There are also insufficient care centers and psychiatrists for the needs of the population, with only 0.3 psychiatrists for every 100,000 people (Radhakrishnan et al., 2021). Since there are not enough resources, caregiving may fall to elderly parents (Bharadwaj & Koujalgi, 2024). Insurance may not cover the expensive medications and treatment for mental health concerns, and hospitals require caregivers to pay to stay and care for their loved ones (Arahanthabailu et al., 2024). These costs can be crippling to families, especially in combination with the lost work time. Care is further complicated by confusion about the road to accessing resources, since there is no clear roadmap to know how, where, or what resources are available (Radhakrishnan et al., 2021). This makes it harder for caregivers and individuals with severe mental illness to access the resources they need.

Health-related barriers are the third category. Severe mental illness may limit the individual's insight into their health and needs (Arahanthabailu et al., 2024). They may refuse medications and health care believing they do not need them. There can also be challenges when care does not have its anticipated effect. Medications may not always work as intended, which can be frustrating and may discourage people from continuing to seek expensive care (Arahanthabailu et al., 2024). People also may have negative past experiences and mistrust of healthcare providers accentuated by a history of institutionalizing and forcibly restraining individuals with severe mental illness (Roy et al., 2024). Some individuals may also prefer to seek care from traditional healers and spiritual leaders (Arahanthabailu et al., 2024).

When combined, social, infrastructure, and health-related barriers prevent many women with severe mental illness who are homeless from seeking and finding appropriate care. These barriers speak to both inadequate resources for care and insufficient support to access existing care. Such intersectional barriers require multi-faceted approaches to care, involving policies and programs to fight stigma and encourage communities to support individuals with severe mental illness in order to keep people housed and healthy.

Addressing Homelessness and Severe Mental Illness

Existing Models

Contributed by Aravind Krishnan

Globally, models for addressing the co-occurring challenges of homelessness and severe mental illness (SMI) have been implemented, to varying degrees of success based on their structure, financing, patient outreach, and other aspects. These models include Housing First, Assertive Community Treatment (ACT), Intensive Case Management (ICM) and Critical Time Intervention (CTI), all of which share the commonality of the provision of community-based types of support, either on an ongoing or time-limited basis (Kerman & Stergiopoulos, 2024). Notably though, these vary in how significant their support is—with ACT, ICM, and CTI being most appropriate for higher and long-term, moderate, and lower and short-term needs during service transitions, respectively. Crucially, policy and service implementation failures have precipitated and perpetuated homelessness among people with mental illness in some settings. One common pitfall is high-income countries not effectively monitoring homelessness rates at the population level, leading to opacities regarding the extent of the problem and the effectiveness of current interventions.

One model that has achieved increasing traction due to its demonstrated benefits is the “housing-first” approach, prioritizing the provision of housing as a primary form of care—this takes the form of permanent supportive housing (Brousseau, 2009). Permanent supportive housing is found to be of particular importance in supporting individuals who face the dual challenges of homelessness and SMI. One organization that has achieved success in this regard is the Corporation for Supportive Housing (CSH), which since 1991 has guided the development and implementation of this supportive housing model. They have also crucially engaged in efforts enabling policy change on the local, state, and federal level in the U.S., which has allowed for the development of their housing united in communities of need nationwide. There are some particular elements which CSH has found to be essential in developing permanent supportive housing—research to pinpoint specific disparities and understand the nuances of homelessness and SMI in different communities, working closely and collaboratively with policymakers to advance housing development goals, and engage with the public to build popular support for these initiatives, particularly given emerging sentiments against public investments for affordable housing in one's own local area. Importantly, permanent supportive housing is not the most appropriate model for all unhoused individuals with SMI, as some require more intensive treatment, but one-year retention is 80% on average and long-term outcomes after supportive housing are positive for most residents, indicating the benefits of this model (Brousseau, 2009).

The debate over treatment- vs. housing-first models has generated much contention, but a closer analysis indicates that both are appropriate for different populations (Henwood, 2011). This depends on factors such as degree of SMI and other clinical needs, and individuals can be transitioned to greater independence as their health needs are resolved. Overall, prevention is the best leverage point to achieve significant progress in simultaneously meeting both health and housing needs (Fowler, et al., 2019). This can be done through public-private partnerships, connections with academic and service organizations, and through improved community education to families or groups who may be concerned an individual they know may be at risk. Lastly, effective case management can enable successful long-term outcomes, particularly through the use of assertive community treatment, which includes a multidisciplinary team, low client/staff caseloads that enable more intensive contact, community-based services that are directly provided rather than brokered to other organizations, and 24-hour coverage by the treatment team (Coldwell and Bender, 2007). By integrating both effective prevention, targeted interventions that are appropriate to each individual over a monolithic approach, and implementing long-term case management, successful long-term outcomes can be achieved, as shown by these and other precedents worldwide.

Financing of Care Models

Contributed by Aravind Krishnan

Care models for individuals who are experiencing homelessness and/or SMI have over the past several decades have increasingly become viewed as a public good. Beginning with the popular emergence of this view during the early-20th century Progressive Era in the US and into LBJ's Great Society, social support for publicly funding for these models experienced a growth, but has recently come under greater scrutiny over concerns of not achieving positive long-term outcomes—these necessitate developing more robust and efficient financing models of support programs.

A key aspect of this is the dilemma between financial investments and generating a higher-quality of life for users of these programs. Full-service partnerships, which engage clients in treatment while providing housing, were found to reduce annual days spent homeless from 191 to 62, and the necessity of receiving inpatient, emergency and justice system services by 14, 32, and 17 percentage points, but had variable financial impacts. Namely, outpatient costs increased by $9180; inpatient costs declined by $6882; emergency service costs declined by $1721; jail mental health services costs declined by $1641; and housing costs increased by $3180, all statistically significant (Gilmer, et al., 2010).

Another model implemented in the US is the HUD-VA Supported Housing (HUD-VASH) program, for veterans. While achieving significant improvements in outcomes, such as with participants being 16% more housed than the case management-only group and 25% more than the no-intervention group, the program was $6,200 (15%) more costly than standard care

(Rosenheck, et al., 2003). This raises the importance of quantitatively comparing costs and benefits of financing different housing and treatment models for unhoused individuals with SMI.

To do this, case studies of different models in demographically and societally similar settings are informative. Comparing different support programs for unhoused individuals with SMI in the New England states, one consideration that arises is the use of requests for proposals (RFPs) by different service providers. A key barrier to cost-effectiveness is the risk of unobservable quality variation of different bidders for a service contract, leading to an adverse selection phenomenon where states may not be able to choose the best balance between quality and cost (Stephens and Hodgkin, 1992). In order to circumvent this, policies mandating greater information-sharing by service provision bidders and phased implementation of contracts without permanent long-term binding can be effective.

An additional area of need expressed by unhoused individuals with SMI here in Philadelphia and other settings is greater autonomy, which can be addressed by innovative models like self-directed care financing. With such programs, individuals can be granted a monetary allowance from public funds to purchase goods and services allowing them to remain outside of institutional settings. This program was found to be budget-neutral, thus achieving neither higher or lower costs, but resulted in superior client outcomes and greater satisfaction with mental health care. Actively involving users in guiding their treatment via programs like cash and counseling (C&C) and personal assistance services (PAS) empower individuals to make their own treatment decisions, while being cost-neutral or even more efficient in costs.

Further Focus

This section considers three important factors for understanding the challenges faced by women with severe mental illnesses who experience homelessness. Relational disruptions and caste dynamics each play a crucial role in women's access to resources and their risk for developing SMI or becoming homeless. The case studies provide valuable insight into how the global community thinks about mental health as a disability, allowing comparison by which to better understand the Indian context.

Effect of Relational Disruptions for Women

Contributed by Charlotte Brown

Relational disruptions create a serious risk of homelessness for many Indian women. Women typically rely upon their husband’s family for economic security and are expected to manage their home and children. Relational disruptions due to disagreement, abuse, or the death of their husband can leave women highly vulnerable to abandonment and homelessness (Koul, 2022). If they experience health or other challenges which prevent them fulfilling social expectations, they may be at higher risk of domestic violence or abandonment (Bharadwaj & Koujalgi, 2024; Koul, 2022). Further, mental illness and the associated stigma may prevent women from being married at all, which can result in great distress for the woman and her family if she is considered unsuitable for marriage (Raghaven et al., 2022). This could result in shame and abandonment if it is perceived that the woman is unable to uphold her duties as a woman and member of society.

Stigma and shame frequently lead to family abandonment, alongside decreased ability to fill expected roles (Rhaghaven et al., 2022). If a woman experiences family abandonment and becomes homeless, this can also further exacerbate mental illness, creating a cycle of vulnerability. Indian women with SMI are more likely to have experienced marital separation or divorce, increasing the stigma they face (Riley et al., 2022). This dynamic may be exacerbated by an understanding of the mental illness disease process in spiritual terms which suggest the woman did something wrong and is being punished with her illness. This spiritual understanding can also bring shame upon the family, contributing to stigma. Evidence shows there is an additional lack of awareness and priority surrounding mental illness in India which increases stigma surrounding SMI (Arahanthabailu, et al., 2024).

Studies show rates of domestic violence (DV) are increased for women with SMI (Riley et al., 2021).Women with SMI who experience DV are also less likely to seek help for either their mental illness or the abuse they experience. This could be due to a lack of support from family members to seek medical help, but it may also be because they are legally vulnerable and fear retribution or abandonment leading to homelessness. Domestic violence can push a woman into homelessness in order to flee, or women may be forced to undergo sexual and domestic violence out of a lack of other housing options. (Koul, 2022). Many women may stay for fear of leaving or her children or exposing them to the dangers of homelessness. Children who are exposed to domestic violence in the home are also more likely to experience or contribute to continued cycles of domestic violence in the future (Oram et al., 2022).

Multi-faceted solutions involving medical, policy, and social solutions are necessary. Literature shows the importance of involving survivors of abandonment and domestic violence in developing supportive programming and policies to support other women (Oram et al., 2022). Evidence shows best practice is to use trauma-informed care in medical and social work settings and to assume anyone may have experienced domestic violence, mental illness, or relational disruptions. Primary care should involve screening for domestic violence and risk of becoming homeless or experiencing abandonment (Riley, et al., 2022).

How Mental Health is Viewed as a Disability

Contributed by Leo Biehl & Aravind Krishnan

Other countries may offer lessons for designing frameworks that classify mental illness as a disability and help provide effective coverage for homeless populations. These classifications could lead to significant practical developments, such as more generous welfare benefits, higher quality health care, and stronger social protections. This section will profile several countries' efforts to classify mental illness, in the hopes of providing the Banyan with a global overview of policy developments.

South Africa

South Africa has made notable progress in recent years toward improving its mental health policy approach. With the passage of the Mental Health Care Act No. 17 of 2002, the country adopted an approach grounded in ten basic principles established by the World Health Organization (Szabo & Kaliski, 2017). The framework outlines best practices for several categories of patients, including those receiving voluntary, assisted, and involuntary treatment (Dlamini, 2023).

Involuntary commitment involves multiple procedural safeguards, such as an initial assessment, a recommendation from the head of a health establishment, a mandatory 72-hour observation period, and documentation completed by two independent mental health practitioners (Szabo & Kaliski, 2017). Even after these steps, patients retain the right to appeal their status, which requires clinicians to justify the decision before a local mental health review board.

Despite these legal safeguards, South Africa continues to face criticism for inadequately addressing mental illness. The most recent national prevalence study—conducted in 2004—estimated that 30.3% of South Africans experience a mental disorder in their lifetime (Morar et al., 2024). Additionally, individuals with psychosocial disabilities face pervasive stigmatization, and mental health remains a low policy priority (Kleintjes et al., 2013). Structural barriers also hinder access to care. The South African Depression and Anxiety Group estimates that only 27% of people reporting severe mental illness receive treatment (SACAP, 2024).

Although the Mental Health Care Act ostensibly advocates for care in the least restrictive setting possible, the practical implementation of this principle has proven challenging. Resource limitations and administrative burdens make it difficult to realize the law's goals. Scholars have further noted a widespread consensus that mental health review boards are ineffectively managed, undermining procedural protections (Swanepoel, 2025).

In an effort to address these challenges, the government launched the National Mental Health Policy Framework and Strategic Plan 2023–2030, which aims to deliver "comprehensive, high quality, integrated mental health promotion, prevention, care, treatment, and rehabilitation for all in South Africa by 2030." While this framework builds on the country's previous policy approach, it places renewed emphasis on implementation monitoring and community-based service expansion (Morar et al., 2024). In April 2023, the government also partnered with mental health professionals to host the country's first national mental health conference in Johannesburg, signaling greater political commitment (Morar et al., 2024).

South Africa provides financial assistance to individuals with severe mental illness through a disability grant program. Citizens may qualify for this grant if they have a physical or mental disability that prevents them from working for six months or more (South African Government, 2019). The maximum monthly grant is 2,310 Rand (approximately $123). These grants can be especially impactful for individuals with severe mental illness. A study of the Xhosa people, one of South Africa's largest ethnic groups, found that 57% of respondents with schizophrenia received disability grants, which were associated with increased household wealth and stability (Wootton et al., 2023).

While challenges remain in expanding access and reducing stigma, these recent policy developments reflect a growing recognition of the importance of mental health. South Africa's evolving approach may offer useful lessons for other middle-income countries seeking to balance rights-based frameworks with resource constraints.

Germany

Germany offers a unique case study of mental health policy due to its broad constitutional protections and decentralized structure. On the federal level, Germany's constitution prohibits discrimination on the basis of a disability. A person is considered disabled "if their physical, mental, intellectual or sensory capacities are highly likely to deviate for more than six months from a state that is typical for their age, and they may thus – in interaction with various barriers – be prevented from equal participation in society" (Federal Anti-Discrimination Agency, 2025). The degree of disability is assessed by a pension office, with an ultimate goal of allowing those with disabilities to participate fully in society. The Neuntes Buch des Sozialgesetzbuches provides specific guidance to take the needs of disabled women and children into account.

Mental illness can lead to exclusion from German society. Government data indicates that people with disabilities are significantly unrepresented in the job market. Mental illness represents a significant barrier for the homeless population in Germany, who also face challenges in accessing disability benefits. One meta-analysis estimated a mental illness rate 3.8 times higher than the general population. Additionally, bureaucratic hurdles can often prevent those with mental illness from accessing disability grants.

Germany's approach to mental illness prevention is largely decentralized and left up to each of the sixteen states. Scholars have noted that there are measurable differences in mental health policy between the states (Salize et al., 2007). These differences allow states to have flexibility regarding a number of mental health issues. (Zielasek & Gaebel, 2015). There is no National Health Service managed by a federal authority. This reality leads to a complex organizational structure for financing and implementation. For instance, a supra-regional authority is responsible for funding stationary housing, while municipalities and counties fund ambulatory housing (Bramesfeld et al., 2004).

Despite structural differences between Germany's and India's mental health systems, Germany's approach may serve as a model for Indian states seeking to tailor interventions to specific regional problems.

Sweden

While Scandinavia and Northern Europe more broadly are recognized for comprehensive legal protections for individuals with serious mental illness (SMI) through classification as a disability, Sweden in particular has led legal progress in implementing these protections. First, there is a strongly entrenched legal framework for disability rights at the national level. The 1994 Act Concerning Support and Service to Persons with Certain Functional Impairments provided individuals with SMI and other significant disabilities support to continue living independently, through offering support like counseling, personal assistance, specialized housing, and companionship services (Government of Sweden, 2025). By enshrining in law the right of individuals with significant disabilities to live independently and receive social supports that enable them to do so, this legislation set the stage for further progressions in facilitating the quality of life of individuals with such conditions. These protections were further strengthened by the 2009 Discrimination Act, which further strengthened legal protections for individuals with disabilities and instituted mechanisms for individuals who have faced discrimination on the basis of their disability to obtain compensation. The law is split into proactive and reactive portions, respectively legislating the public duty to take action for protecting individuals with severe disability, and prohibiting discrimination on the basis of disability or other immutable characteristics in education, work, and other areas of society (Government of Sweden, 2025).

Additionally, programs have been implemented on the national level to provide specific support for individuals with SMI and mental illness more broadly. In 2015, Sweden instituted a new National Mental Health Policy, which created a complete loop of mental health care that integrated directly into national primary care systems, with services including prevention, early intervention, and care coordination with primary care providers. Crucially, this model emphasizes community-based care over institutionalization, maintaining individuals' right to live independently while also making quality, coordinated mental health care highly accessible (Fjellfeldt, 2021). In line with this, the Swedish healthcare system ensures mental health services are accessible to all Swedish residents, objectives which are well-integrated with community-focused efforts like campaigns reducing stigma and promoting mental well-being in school- and community-based programs.

Sweden's strong social benefits and support systems also provide key protections for individuals with SMI and other disabilities. Individuals with a reduced capacity for working due to such conditions are entitled to disability benefits, ensuring financial support and a guarantee a baseline standard of living (Nordic Health & Welfare Statistics, 2024). Other social determinants of health are also provided for, such as housing and transportation. At the national level, the Swedish government provides grants for home purchasing and modifications, and public transit systems are continuously improved to accommodate for diverse disability needs (Government of Sweden, 2025).

Key in the Swedish approach to supporting individuals with SMI and other disabilities is also implementing oversight mechanisms to continuously evaluate disability policy and evaluate whether individuals of different disabilities, like SMI, are being adequately served. This is conducted by the Swedish Agency for Participation (Myndigheten för Delaktighet) (Government of Sweden, 2025).

Brazil

Being in the Global South and with a more similar demographic and socioeconomic profile to India, Brazil's success in legislating effective support systems for individuals with SMI, covered under national disability policy, can also be highly informative to the work of The Banyan and Indian national policy towards this as well.

The comprehensive legislative framework for individuals with disabilities, including for individuals with SMI enshrines protections for these groups. The Brazilian Law on the Inclusion of Persons with Disabilities (13,416/2015) protects on an equal basis the rights and freedoms by persons with disabilities, and emphasizes accessibility to equal opportunities and prohibits discrimination in education, health, employment, and social services. Doing so ensured that regardless of changes in governments or short-term political tides, protections for individuals with SMI and disabilities more broadly would be maintained (Federal Government of Brazil, 2016).

There is also a well-established system of mental health policies and services in Brazil that are accessible on the national scale. The Brazilian mental health care system transitioned from a hospital-centric model to a community-based care model, paralleling the shift employed by Sweden as well. Consistent with the aforementioned evidence supporting this care delivery model, mental health services are becoming more integrated into primary care, achieving improved prevention of SMI and providing more accessible and comprehensive support for individuals experiencing SMI (Mateus, et al., 2008). However, due to the geographic and demographic diversity of Brazil, there are challenges with access disparities, such as limitations in provider and service access in certain regions of Brazil (Araújo and Nunes de Torrenté, 2023).

Other social benefits and support systems also help support these groups. For example, the Benefício de Prestação Continuada (BPC) is a continuous cash benefit program that provides financial assistance to elderly individuals and persons with disabilities who have a family income below a certain threshold. This achieves similar objectives of providing social support, recognizing the unique financial challenges posed by experiencing SMI, while maintaining individuals' right to live as independently as desired (Wapling, et al., 2020). In addition, there are more non-traditional forms of care for individuals with SMI that have been instituted, including community-based programs. There are concerns with disparities in outcomes and accessibility of these programs, which highlights the importance of effective oversight and continuing to promote deinstitutionalization as done in the Swedish model (Human Rights Watch, 2018).

Regarding the implementation and oversight mechanisms currently in place, the Brazilian federal government does collaborate with state and municipal authorities to implement the aforementioned disability supports and services, but challenges lie with consistency across the diverse demographic and geographic profile of Brazil, which are concerns that parallel those of India as well.

Costa Rica

Costa Rica, while significantly smaller than India, also has some similarities in demographic profile that make its successes in supporting individuals with SMI and disabilities more broadly highly informative for India and the work of The Banyan.

Its legal frameworks for disability rights are extensive and long-established. The Equal Opportunities Law for People with Disabilities (No. 7600) was enacted in May 1996 and prohibits disability-based discrimination, also guaranteeing equal rights for education, employment, health, and accessibility. This aligns with international standards, including the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (Independent Living Institute, 2025). This legislation has also been amended and thus protections have expanded over time. In February 2014, Act No. 18283 amended Law No. 7600 to align disability and accessibility definitions with the CRPD (Government of Costa Rica).

National mental health policies and services have also been implemented to comprehensively serve the needs of individuals with SMI and other disabilities. Consistent with aforementioned trends, in 2006, Costa Rica revised its national mental health policy to emphasize the development of community-based services, integrating mental health into primary care, and protecting fundamental human rights for individuals with SMI (WHO, 2008). More recently, the Legislative Assembly passed a bill in 2022 to create a National Act on Mental Health. However, concerns have arisen about this bill potentially being aligned with an outdated biomedical model, potentially leading to regressions in rights for individuals with SMI and mental disabilities.

Like Brazil and Sweden, Costa Rica also has established social benefits and social protection for individuals with SMI and other disabilities. There is a decades-old social protection system with the aim of promoting access to universal human rights, particularly for marginalized populations like individuals with disabilities (Vega, 2012). In addition, in June 2022, the national government appointed a Commissioner for Social Inclusion, focused on addressing inequities surrounding disabilities and intersectionalities with disadvantaged racial groups such as Afrodescendants and indigenous individuals (U.S. Department of State, 2022).

Also similar to the aforementioned nations with successful support systems for individuals with mental disability, implementation of oversight measures is core to Costa Rica's policies in this area. The National Council for Persons with Disabilities (CONAPDIS) was established in 2015 to serve as the central body coordinating policies and programs related to disability, advocating for the rights and autonomy of persons with disabilities (UN Office of the High Commissioner for Human Rights, 2024). This progress and positive outcomes have been internationally recognized, particularly surrounding advancements in promoting personal autonomy for these individuals while developing support systems sufficient to meet their needs.

Caste and Mental Health: A Comparison between India and Nepal

Contributed by Reem Assi

Comparing the influences of caste on society in multiple contexts allows greater understanding of both. In both India and Nepal, caste plays a significant role in shaping the mental health experiences of marginalized groups, particularly women with severe mental illnesses. Discrimination tied to caste impacts both access to mental health care and the mental well-being of individuals. Women from lower castes, such as the Scheduled Castes (SCs) named "the untouchables" in India and the Dalits in Nepal, face compounded challenges due to caste-based stigma and exclusion. These intersections of caste and mental illness contribute to greater social isolation, discrimination, and disparities in mental health outcomes.

A study conducted by The Banyan explored homelessness among women with mental illnesses and found a notable association between caste and mental health. The survey revealed that over 90% of participants, both those who had experienced homelessness and those who had not, belonged to lower castes, including Scheduled Castes and Scheduled Tribes (Krishnadas et.al, 2021). 60% of Muslim respondents reported facing anxiety in the last month as opposed to 41% of higher caste Hindu respondents. This shows that Scheduled Castes and Muslims are more likely to suffer from mental health issues than higher caste Hindus because of the social and economic disadvantage that the caste system creates.

The situation in Nepal is strikingly similar, with Dalits, who make up about 20% of the population, facing significant mental health disparities due to caste-based discrimination (French, 2020). Studies in Nepal have shown that Dalits experience higher levels of depression and anxiety compared to higher caste groups (Kohrt et al., 2009). Discrimination and exclusion, particularly in terms of education, employment, and access to healthcare, have a lasting impact on the mental well-being of Dalit women as gender-based discrimination compounds challenges already presented by caste discrimination.

In Nepal, the national response to mental health issues has seen the development of policies aimed at improving access to care and addressing stigma. For example, the National Mental Health Policy of 2019, which emphasizes integrating mental health services into primary care, aims to make mental health support more accessible by “promoting the transfer of knowledge, service-oriented skills, and special training” (Khanal et al., 2023). However, the implementation of these policies has faced obstacles due to a lack of political will, resources, and effective local infrastructure. Moreover, cultural factors and caste-based stigma continue to limit the willingness of Dalit communities to seek care, further entrenching disparities.

To address these gaps, the Primary Health Care Revitalization Division (PHCRD) developed the Community Mental Health-Care Package (CMHCP) in consultation with key stakeholders (Khanal et al., 2023). The CMHCP is based on international standards such as the Mental Health Gap Action Programme (mhGAP) and the Inter-Agency Standing Committee (IASC), with the goal of improving accessibility to mental health care at the community level by primary health-care workers through a “task-shifting approach”. To meet these objectives, an STP (Service Treatment Package) was formulated for mental health services within the primary healthcare system, along with training modules for medical officers and health assistants to enhance mental health care capacity. This initiative provides primary care providers with the authority to prescribe psychotropic medications from an essential drug list, which includes chlorpromazine, amitriptyline, alprazolam, and more (Koirala, 2017).

Lastly, nongovernmental organizations (NGOs) have played a helpful role in developing health care within Nepal. NGOs have played an important role in Nepal for policy formulation, contributed to the expansion of mental health training services to paramedics and other primary health care practitioners, and delivery of a range of mental health services funded by the United Mission to Nepal (Khanal et al., 2023). Such services include the establishment of several rehabilitation centers for alcohol or substance abuse, the development of mental health programs in urban hospitals, and the founding of several centers for psychological care such as the Center for Victims of Torture (CVICT) and the Transcultural Psychosocial Organization (TPO).

In order to bridge the gap between caste and mental health care, policies aiming to make mental health care more accessible to vulnerable communities must be supported by institutional efforts of budget allocation, integration of both faith and traditional healing systems into care, recruitment of human resources, training of community members, and the expansion of partnerships with nongovernmental sectors for equity-based quality access to mental health care.

Conclusion

Indian women who are homeless with severe mental illness face significant barriers to equal participation in society. Social factors like stigma, insufficient medical support, risk of domestic violence, and lack of mental health awareness increase the likelihood that women with severe mental illness will be abandoned or experience homelessness. Political factors, such as gaps in legal protections for this population, allow these social factors to continue and put women in a vulnerable social position. Both politicians and organizations serving these women have work to do in improving the legal and social resources available in order to protect Indian women.

Recommendations for Non-Governmental Organizations such as The Banyan

Additional Research on Homelessness and Mental Illness in India

There is a lack of reliable data on the dynamics of homelessness and mental illness in India, which may limit the ability of policymakers to implement solutions. Part of this reality stems from an inconsistent definition of homelessness. Several studies and surveys analyzed for this paper utilized different definitions of homelessness and severe mental illness to assess their prevalence in India. Studies such as Busch-Geertsema et. al (2024) have sought to modify the European Typology on Homelessness and Housing Exclusion (ETHOS) to fit a global framework. Adopting a similar universal framework in government surveys and research studies could be a useful approach to contextualizing the issue.

Furthemore, it would be useful to conduct additional studies on how particular subgroups are impacted by homelessness and mental illness. While there is literature about caste and social stigma in India, there is a less conclusive understanding of the relationship between caste, mental illness, and homelessness. These findings could help policymakers tailor mental health policy regulations to these subgroups to ensure their needs are properly met.

Advocating for Patient-Centric Mental Health Care Policy

Numerous studies point to the importance of patient-centric mental health care. This includes keeping those who have experienced severe mental illness and homelessness at the center of program planning. Their feedback and suggestions should be seriously considered, and these individuals should be encouraged to participate in planning and implementing future programming for others experiencing similar circumstances. Providing platforms for women to share their experiences of SMI and homelessness can empower growth and challenge social stigma by making it more acceptable to talk about mental illness and homelessness. Sharing stories humanizes the experiences of people who are frequently overlooked, and it can urge policymakers to protect women's dignity with laws and funding that promote social services and protections. This can also support training empathetic medical and social workers if their training involves learning from the individuals they serve about their own experiences with medical care and how they could be better supported.

Communicating with Partner Organizations in Other Countries

The five countries referenced in this report have each taken significant steps to incorporate patient-centric mental health policy approaches. Some of these approaches are limited to each specific country, but others may be more applicable to India. The Banyan could study these approaches to see if there are particular policies that may be worth advocating for on the government level. For instance, countries such as South Africa have sought to bring their mental health policies in line with WHO guidance, while Costa Rica has shifted its approach to focus on community-based healthcare. It may be helpful for the Banyan to reach out to similar nonprofit organizations in these countries to assess points of convergence and effectively tailor its policy advocacy.

References

Background Research

The Evolution of the Banyan's Model Over Time

Narasimhan, Lakshmi, et al. "Responsive Mental Health Systems to Address the Poverty, Homelessness and Mental Illness Nexus: The Banyan Experience from India." *Journal of Mental Health Systems*, 2019.

Radhakrishnan, R.K., et al. "Developing Care Approaches to Address the Homelessness, Poverty and Severe Mental Illnesses Crisis." *Global Mental Health Journal*, 2021.

The Banyan, "The Timeline.", 2023, https://thebanyan.org/aboutus/

Indian Policy related to Homelessness and Severe Mental Illness

Arahanthabailu, P., Praharaj, S. K., Purohith, A. N., Yesodharan, R., Rege, S., & Appaji, R. (2024). Exploring barriers to seek mental health services among patients with severe mental illness and their caregivers in a modified assertive community treatment program: A qualitative thematic analysis. *Indian Journal of Psychiatry, 66*(7), 621-629. 10.4103/indianjpsychiatry.indianjpsychiatry_314_24

Kaur, A., Kallakuri, S., Mukherjee, A., Wahid, S. S., Kohrt, B. A., Thornicroft, G., & Maulik, P. K. (2023). Mental health related stigma, service provision and utilization in Northern India: Situational analysis. *International Journal of Mental Health Systems, 17*, 10. https://doi.org/10.1186/s13033-023-00577-8

Swaminath, G., Enara, A., Rao, R., Kumar, K. V. K., & Kumar, C. N. (2019). Mental Healthcare Act, 2017 and homeless persons with mental illness in India. *Indian Journal of Psychiatry, 61*(4), S768-S772. 10.4103/psychiatry.IndianJPsychiatry_117_19

Tripathi, A., Das, A., & Kar, S. K. (2021). Indian Perspectives on homelessness and mental health. In J. M. Castaldelli-Maia, A. Ventriglio, & D. Bhugra (Eds.), *Homelessness and Mental Health* (pp. 99-116). Oxford University Press.

Interaction of Homelessness and Serious Mental Illness

Aubry, Tim, Geoffrey Nelson, and Sam Tsemberis. 2015. “Housing First for People with Severe Mental Illness Who Are Homeless: A Review of the Research and Findings from the at Home—Chez Soi Demonstration Project.” *The Canadian Journal of Psychiatry* 60 (11): 467–74. https://doi.org/10.1177/070674371506001102.

Montgomery, Ann Elizabeth, Stephen Metraux, and Dennis Culhane. 2013. “Rethinking Homelessness Prevention among Persons with Serious Mental Illness.” *Social Issues and Policy Review* 7 (1): 58–82. https://doi.org/10.1111/j.1751-2409.2012.01043.x.

Padgett, Deborah. 2020. “Homelessness, Housing Instability and Mental Health: Making the Connections.” *BJPsych Bulletin* 44 (5): 197–201. https://doi.org/10.1192/bjb.2020.49.

Smartt, Caroline, Martin Prince, Souci Frissa, Julian Eaton, Abebaw Fekadu, and Charlotte Hanlon. 2019. “Homelessness and Severe Mental Illness in Low- and Middle-Income Countries: Scoping Review.” *BJPsych Open* 5 (4). https://doi.org/10.1192/bjo.2019.32.

Sullivan, Greer, Audrey Burnam, Paul Koegel, and Jan Hollenberg. 2000. “Quality of Life of Homeless Persons with Mental Illness: Results from the Course-of-Homelessness Study.” *Psychiatric Services, 51*(9): 1135–41. https://doi.org/10.1176/appi.ps.51.9.1135.

Dynamics, Causes, and Changes to Homelessness and Severe Mental Illnesses in India

Krishnadas, Preetha, et al. "Factors Associated with Homelessness among Women: A Cross-sectional Survey of Outpatient Mental Health Service Users at The Banyan, India." *Journal of Public Health*, vol. 43, no. Supplement_2, 2021, pp. ii17-ii25, https://doi.org/10.1093/pubmed/fdab219. Accessed 27 Nov. 2024.

Moorkath, Febna, et al. "Women with Mental Illness – An Overview of Sociocultural Factors Influencing Family Rejection and Subsequent Institutionalization in India." *Indian Journal of Psychological Medicine*, vol. 41, no. 4, 2019, p. 306, https://doi.org/10.4103/IJPSYM.IJPSYM_123_19. Accessed 27 Nov. 2024.

Singh, N., Koiri, P., & Shukla, S. K. (2018). Signposting invisibles: A study of the homeless population in India. Chinese Sociological Dialogue, 3(3), 179-196. https://doi.org/10.1177/2397200918763087

Trani, Jean-Francois, et al. “Mental Illness, Poverty and Stigma in India: A Case–Control Study.” *BMJ Open*, British Medical Journal Publishing Group, 1 Feb. 2015, bmjopen.bmj.com/content/5/2/e006355?cpetoc=.

Demographics of Homelessness and Severe Mental Illness in India

Banerjee, Debanjan, and Prama Bhattacharya. 2020. “The Hidden Vulnerability of Homelessness in the COVID-19 Pandemic: Perspectives from India.” *International Journal of Social Psychiatry* 67 (1): 002076402092289. https://doi.org/10.1177/0020764020922890.

Gopikumar, Vandana, Lakshmi Narasimhan, Kamala Easwaran, Joske Bunders, and S Parasuraman. 2015. “Persistent, Complex and Unresolved Issues: Indian Discourse on Mental Ill Health and Homelessness.” *Economic and Political Weekly* 50 (11): 42–51. https://doi.org/10.2307/24481495.

Kaur, Reetinder, and R K Pathak. 2016. “Homelessness and Mental Health in India.” *The Lancet* 3 (6). https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30050-5/fulltext.

Nambiar, Deviki. 2020. “Social Determinants of Health among Urban Homeless in Delhi, India.” *European Journal of Public Health* 30 (Supplement_5). https://doi.org/10.1093/eurpub/ckaa166.329.

Sagar, Rajesh, Rakhi Dandona, Gopalkrishna Gururaj, R S Dhaliwal, Aditya Singh, Alize Ferrari, Tarun Dua, et al. 2020. “The Burden of Mental Disorders across the States of India: The Global Burden of Disease Study 1990–2017.” *The Lancet Psychiatry* 7 (2): 148–61. https://doi.org/10.1016/s2215-0366(19)30475-4.

Wardhaugh J, Rural Homelessness in India. In: Susan J. Smith, Marja Elsinga, Lorna Fox O’Mahony, Ong Seow Eng, Susan Wachter, Suzanne Fitzpatrick, editors. International Encyclopedia of Housing and Home, Vol 6. Oxford: Elsevier; 2012. pp. 216–225.

Barriers to Accessing Existing Care

Arahanthabailu, P., Praharaj, S. K., Purohith, A. N., Yesodharan, R., Rege, S., & Appaji, R. (2024). Exploring barriers to seek mental health services among patients with severe mental illness and their caregivers in a modified assertive community treatment program: A qualitative thematic analysis. *Indian Journal of Psychiatry, 66*(7), 621-629. 10.4103/indianjpsychiatry.indianjpsychiatry_314_24

Bharadwaj, Y., & Koujalgi, S. R. (2024). Exploring the current status of the rehabilitation and welfare programs for women with severe mental illness. *Journal Transitional Universal Studies, 2*(3), 189-196. https://doi.org/10.58631/jtus.v2i3.88

Koul, P. (2022). Violence, homelessness and gender: A socio-legal issue in India. *Indian Journal of Integrated Research in Law, 2*(4). https://heinonline.org/HOL/LandingPage?handle=hein.journals/injloitd3&div=62&id=&page=

Radhakrishnan, R. K., Vallath, S., de Wit, E. E., Bunders, J. G. F., & Gopikumar, V. (2021). Developing care approaches to address the homelessness, poverty, and severe mental illness crisis. *World Journal of Psychiatry and Mental Health Research, 5*(1): 1027. https://www.researchgate.net/profile/Emma-Emily-De-Wit/publication/353331979_Developing_care_approaches_to_address_the_homelessness_poverty_and_severe_mental_illnesses_crisis/links/60f52c8a0859317dbdf1d63a/Developing-care-approaches-to-address-the-homelessness-poverty-and-severe-mental-illnesses-crisis.pdf

Roy, R., Kalyanasundaram, J. R., Elangovan, A. R., & Varambally, S. (2024). Factors contributing to unmet psychosocial needs of the homeless persons with mental illness in India: A narrative review. *Journal of Psychosocial Rehabilitation and Mental Health, 11,* 569-576. https://doi.org/10.1007/s40737-024-00413-3

Existing Models for Addressing Homelessness and Severe Mental Illness

Brousseau, R.T. (2009). Addressing Homelessness Among People With Mental Illnesses: A Model Of Long-Term Philanthropic Effectiveness. *HealthAffairs*, 28(3). https://doi.org/10.1377/hlthaff.28.3.907

Coldwell, C.M., & Bender, W.S. (2007). The Effectiveness of Assertive Community Treatment for Homeless Populations With Severe Mental Illness: A Meta-Analysis. *The American Journal of Psychiatry*, 164(3). https://doi.org/10.1176/ajp.2007.164.3.393

Fowler, P.J., Hovmand, P.S., Marcal, K.E., & Das S. (2019). Solving Homelessness from a Complex Systems Perspective: Insights for Prevention Responses. *Annual Review of Public Health*, 40, 465-486. https://doi.org/10.1146/annurev-publhealth-040617-013553

Henwood, B.F. (2011). Understanding program models to address homelessness and serious mental illness: A qualitative inquiry of service providers. *New York University School of Social Work*.

Kerman, N., & Stergiopoulos, V. (2024). Addressing health needs in people with mental illness experiencing homelessness. *Nature Mental Health*, 2, 354–366 (2024). https://doi.org/10.1038/s44220-024-00218-0

Financing of Care Models

Barczyk, A. N., & Lincove, J. A. (2010). Cash and Counseling: A Model for Self-Directed Care Programs to Empower Individuals With Serious Mental Illnesses. *Social Work in Mental Health*, 8(3), 209–224. https://doi.org/10.1080/15332980903405298

Cook, J.A., et al. (2019). Mental Health Self-Directed Care Financing: Efficacy in Improving Outcomes and Controlling Costs for Adults With Serious Mental Illness. *Psychiatric Services*, 70(3). https://doi.org/10.1176/appi.ps.201800337

Stephens, M., & Hodgkin, D. (1992). Financing Mental Health Services for the Homeless Mentally Ill in New England. *New England Journal of Public Policy*, 8(1).

Rosenheck, R., Kasprow, W., Frisman, L., Liu-Mares, W. (2003). Cost-effectiveness of Supported Housing for Homeless Persons With Mental Illness. *Arch Gen Psychiatry*, 60(9):940–951. doi:10.1001/archpsyc.60.9.940

Gilmer TP, Stefancic A, Ettner SL, Manning WG, Tsemberis S. Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness. *Arch Gen Psychiatry*. 2010;67(6):645–652. doi:10.1001/archgenpsychiatry.2010.56

Further Focus

Effect of Relational Disruptions for Women

Arahanthabailu, P., Praharaj, S.K., Purohith, A. N., Yesodharan, R., Rege, S., & Appaji, R. (2024). Exploring barriers to seek mental health services among patients with severe mental illness and their caregivers in a modified assertive community treatment program:

A qualitative thematic analysis. *Indian Journal of Psychiatry, 66*(7), 621-629. https://journals.lww.com/indianjpsychiatry/fulltext/2024/66070/exploring_barriers_to_seek_mental_health_services.5.aspx

Bharadwaj, Y., & Koujalgi, S. R. (2024). Exploring the current status of the rehabilitation and welfare programs for women with severe mental illness. *Journal Transitional Universal Studies, 2*(3), 189-196. https://doi.org/10.58631/jtus.v2i3.88

Koul, P. (2022). Violence, homelessness and gender: A socio-legal issue in India. *Indian Journal of Integrated Research in Law, 2*(4). https://heinonline.org/HOL/LandingPage?handle=hein.journals/injloitd3&div=62&id=&page=

Oram, S., Fisher, H. L., Minnis, H., Seedat, S., Walby, S., Hegarty, K., DClinPsy, K. R., Angénieu, C., Callard, F., Chandra, P. S., Fazel, S., Garcia-Moreno, C., Henderson, M., Howarth, E., MacMillan, H. L., Murray, L. K., Othman. S., Robotham, D., Rondon, M. B., Sweeney, A., DClinPsy, D. T., & Howard, L. M. (2022). The *Lancet Psychiatry* Commission on intimate partner violence and mental health: Advancing mental health services, research, and policy. *The Lancet Psychiatry, 9*(6). https://www.thelancet.com/article/S2215-0366(22)00008-6/fulltext

Raghaven, R., Brown, B., Horne, F., Kumar, S., Parameswaran, U., Ali, A. B., Raghu, A., Wilson, A., Svirydzenka, N., Venkateswaran, C., Kumar, M., Kamal, S. R., Barrett, A., Dasan, C., Varma, A., & Banu, A. (2022). Stigma and mental health problems in an Indian context. Perceptions of people with mental disorders in urban, rural, and tribal areas of Kerala. *International Journal of Social Psychiatry, 69*(2).

https://doi.org/10.1177/00207640221091187

Riley. A., Daruwalla, N., Kanougiya, S., Gupta, A., Wickenden, M., & Osrin, D. (2022). Intimate partner violence against women with disability and associated mental health concerns: A cross-sectional survey in Mumbai, India. *BMJ Open, 12.* https://bmjopen.bmj.com/content/12/4/e056475.abstract

How Mental Illness is Viewed as a Disability

Bramesfeld, Anke, Matthias Wismar, and Kai Mosebach. "Managing Mental Health Service Provision in the Decentralized, Multi-Layered Health and Social Care System of Germany." *The Journal of Mental Health Policy and Economics J Ment Health Policy Econ* 7 (2004): 3–14. http://www.icmpe.org/test1/journal/issues/v7pdf/7-003_text.pdf.

Development Pathways. (2020, February). Social protection and disability in Brazil. https://www.developmentpathways.co.uk/wp-content/uploads/2020/02/Social-Protection-and-Disability-in-Brazil-1.pdf

Disability:IN. (n.d.). Brazil. Retrieved from https://disabilityin.org/country/brazil/

Disability:IN. (n.d.). Costa Rica. Retrieved from https://disabilityin.org/country/costa-rica/

Dlamini, Nontobeko Nonkululeko. "Unbundling the Mental Health Act." *The South African Depression and Anxiety Group*, 2023.

Federal Anti-Discrimination Agency. "Disability and Chronic Disease." Antidiskriminierungsstelle, 2025. https://www.antidiskriminierungsstelle.de/EN/about-discrimination/grounds-for-discrimination/disability-and-chronic-disease/disability-and-chronic-disease-node.html.

Human Rights Watch. (2018, May 23). "They stay until they die": A lifetime of isolation and neglect in institutions for people with disabilities in Brazil. Retrieved from https://www.hrw.org/report/2018/05/23/they-stay-until-they-die/lifetime-isolation-and-neglect-institutions-people

Human Rights Watch. (2020, March 13). Expanding agency for people with disabilities in Brazil institutions. Retrieved from https://www.hrw.org/news/2020/03/13/expanding-agency-people-disabilities-brazil-institutions

Human Rights Watch. (2022, May 5). Costa Rica's mental health bill a step back for human rights. Retrieved from https://www.hrw.org/news/2022/05/05/costa-ricas-mental-health-bill-step-back-human-rights

Kleintjes, Sharon, Crick Lund, and Leslie Swartz. "Barriers to the Participation of People with Psychosocial Disability in Mental Health Policy Development in South Africa: A Qualitative Study of Perspectives of Policy Makers, Professionals, Religious Leaders and Academics." *BMC International Health and Human Rights* 13, no. 1 (March 11, 2013). https://doi.org/10.1186/1472-698x-13-17.

Morar, Tejil, Jozef Erasmus Breedt, Nokuthula Mdaka, Kagisho Maaroganye, and Lesley Robertson. "Is Mental Health in South Africa Moving Forward?" *BJPsych International* 21, no. 1 (October 6, 2023): 1–3. https://doi.org/10.1192/bji.2023.32.

SACAP. "The Shocking State of Mental Health in South Africa in 2019." SACAP, August 21, 2019. https://www.sacap.edu.za/blog/management-leadership/mental-health-south-africa/.

Salize, Hans Joachim, Wulf Rössler, and Thomas Becker. “Mental Health Care in Germany: Current State and Trends.” *European Archives of Psychiatry and Clinical Neuroscience* 257, no. 2 (March 1, 2007): 92–103. https://doi.org/10.1007/s00406-006-0696-9.

Silfverhielm, H., & Kamis-Gould, E. (2000). The Swedish mental health system: Past, present, and future. *International Journal of Law and Psychiatry*, 23(3-4), 293-307. https://doi.org/10.1016/s0160-2527(00)00039-x

Swedish Institute. (2022, November 15). Disability policy in Sweden: What does it mean? Retrieved from https://sweden.se/life/equality/disability-policy

Wootton, Olivia, Aisha King, Kayley Moy, Dan J Stein, and Ezra S Susser. “Disability Benefits Protect against Lost Income for South Africans Living with Schizophrenia.” *Social Psychiatry and Psychiatric Epidemiology*, October 17, 2023. https://doi.org/10.1007/s00127-023-02577-y.

World Health Organization. “Mental Health Care Law: Ten Basic Principles,” 1996. https://iris.who.int/bitstream/handle/10665/63624/WHO_MNH_MND_96.9.pdf?sequence=1&isAllowed=y.

Wecapable.com. (n.d.). Disability in Costa Rica: Definition, laws, employment and social status. Retrieved from https://wecapable.com/disability-in-costa-rica-definition-laws-employment-social-status/

Zielasek, Jürgen, and Wolfgang Gaebel. “Mental Health Law in Germany.” *BJPsych. International* 12, no. 01 (February 2015): 14–16. https://doi.org/10.1192/s2056474000000088.

Caste and Mental Health

Khanal, G., Selvamani, Y., & Sapkota, P. (2023). Insights on historical milestones of mental health in Nepal: Country profile. Indian journal of psychiatry, 65(11), 1122–1128. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_197_23

Kohrt, B. A., Speckman, R. A., Kunz, R. D., Baldwin, J. L., Upadhaya, N., Acharya, N. R., … Worthman, C. M. (2009). Culture in psychiatric epidemiology: Using ethnography and multiple mediator models to assess the relationship of caste with depression and anxiety in Nepal. Annals of Human Biology, 36(3), 261–280. https://doi.org/10.1080/03014460902839194

Koirala, Rishav. (2017). *Community Mental Health Package Nepal 2074*. https://www.researchgate.net/publication/348326290_Community_Mental_Health_Package_Nepal_2074

Krishnadas, P., Narasimhan, L., Joseph, T., Bunders, J., & Regeer, B. (2021). Factors associated with homelessness among women: A cross-sectional survey of outpatient mental health service users at The Banyan, India. *Journal of Public Health*, *43*(Supplement_2), ii17-ii25. https://doi.org/10.1093/pubmed/fdab219

Recommendations

Busch-Geertsema, Volker, et al. “Defining Homelessness.” *Research Handbook on Homelessness*, edited by Guy Johnson et al., Edward Elgar Publishing , 2024.