Recently, a High Court suggested that homeless persons with health conditions be branded with a permanent tattoo, when vaccinated against COVID-19, since tracking a ‘floating population’ may be cumbersome. Earlier judgments have also suggested ‘round ups’ of such persons to facilitate pathways into care. These are possibly well-intentioned directives, but what follows is that bewildered persons are huddled in a vehicle and admitted into shelters or mental hospitals that are usually crowded, yet lonely. What does this tell us about the way homelessness and mental illness are regarded in ‘polite’ society?

A responsive care system

Persons with mental health conditions need a responsive care system that inspires hope and participation without which their lives are empty. In many countries, persons with severe mental health conditions live in shackles in their homes, in overcrowded hospitals, and even in prison. On the other hand, many persons with mental health issues live and even die alone on the streets.

Three losses dominate the mental health systems narrative: dignity, agency and personhood. Far-sighted changes in policy and laws have often not taken root and many laws fail to meet international human rights standards. Many also do not account for cultural, social and political contexts resulting in moral rhetoric that doesn’t change the scenario of inadequate care. Society’s responses are often based on conditioning and perceptions, often verging on visceral forms of prejudice. This results in an “othering” of persons who seem different from dominant groups. Hence, even well-intentioned judgments could set off unintended negative, even grave, consequences. There is also the social legacy of the asylum, and of psychiatry and mental illness itself, that guides our imagination in how care is organised.

Historian Sarah Ann Pinto, in her account of the lunatic asylums in colonial Bombay, wrote that “doctors interpreted a patient’s refusal to wear clothing as a sign of morbidity, and clothing became a way of civilising the savage – the violent Indian man and the promiscuous Indian woman”. Individual preference and indigenous culture were substituted with what the coloniser thought was appropriate. Similarly, medieval London boasted of a hospital for the care of persons with mental illness, St. Mary of Bethlehem, which soon turned into a ‘bedlam’, a poorhouse and a site of shocking atrocities.

We must understand mental health conditions for what they are and for how they are associated with disadvantage. These situations are linked, but not always so. Therefore, not all distress can be medicalised. It is against this complex background of distress arising out of medical conditions and from inequitable social systems, of good intentions and calamitous consequences, that we welcome the Guidance on Community Mental Health Services recently launched by the World Health Organization. The Guidance, which includes three models from India, addresses the issue from ‘the same side’ as the mental health service user and focuses on the co-production of knowledge and on good practices built around the key themes of crisis services, peer support, supported living, community outreach, hospital-based services and comprehensive mental health service networks. Drawn from 22 countries, these models balance care and support with rights and participation.

Afiya House in the U.S. is driven by peers and offers respite to persons who have significant emotional or mental distress. People can stay for up to seven nights when they are connected to networks that support recovery. Services are non-coercive and persons can opt to stay or leave based on discussions with peer supporters. Tupu Ake, a New Zealand-based recovery house service, welcomes ‘guests’ from various ethnicities. Atmiyata in Gujarat employs a stepped-care approach using community-based volunteers who identify persons in distress, offer counselling support and enable access to social care benefits. Evaluation of the service indicates better general health, better quality of life and social functioning. Naya Daur in West Bengal is suitable for local networks and volunteers who support homeless persons through their outreach programme and enable access to food, clothing, counselling, shelter and housing. Home Again, a programme of The Banyan in Tamil Nadu, facilitates residence options in regular neighbourhoods while also offering graded levels of supportive services for persons with severe disabilities. It emphasises socio-cultural participation, ‘neurodiversity’ and normalisation of mental health conditions. Peer leaders provide wisdom from their lived experience to support others in distress.

The practice of open dialogue, a therapeutic practice that originated in Finland, runs through many programmes in the Guidance. This practice, conducted in homes or in service settings, combines individual and systemic family therapy with a focus on the centrality of relationships and promotion of connectedness through family and support networks. This approach trains the therapist in de-escalation of distress and breaks power differentials that allow for free expression.

A network of services

Recently, the Supreme Court and the Madras High Court have advised vaccinations for those in mental health care homes and for those homeless and living with a mental illness. While those in institutions should access this support at the earliest, for those homeless and who opt not to enter mental health establishments en masse from where exit pathways may be laborious, there are two paths. In the first, drives will be conducted and persons with mental illness will be housed in overcrowded institutions, with scant regard for agency or for social determinants of ill health. The other would aim to provide a network of services ranging from soup kitchens at vantage points to mobile mental health and social care clinics, non-intimidating guest houses at village panchayats with access to toilets and the comfort of a welcoming team, and well-being kiosks that offer a basic income and/or facilitate livelihoods. Small emergency care and recovery centres for those who need crisis support instead of larger hospitals, and long-term inclusive living options in an environment that values diversity and celebrates social mixing, will reframe the archaic narrative of how mental health care is to be provided.

With a strong health system, Tamil Nadu is well placed to demonstrate through pilots, and an exclusive policy for homeless persons with mental illness, that political intent, good governance and creative thinking can solve complex problems and cater to the needs of the ultra-vulnerable.

Meanwhile, a mental health service user whom we met interpreted her tattoo as ‘we are all one’. If we can learn to ‘be on the same side’ as the mental health service user, it seems possible that we can learn to respect human diversity.

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