Tamil Nadu State Policy to Address the Needs of Homeless Persons with Mental Health Issues

Guidelines and Protocols

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STAKEHOLDERS FOR STATEWIDE POLICY FOR HOMELESS PERSONS WITH MENTAL HEALTH ISSUES

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Abbreviations

Abbreviation	Description
HPWMI	Homeless Persons with Mental Illness
ECRC	Emergency Care and Recovery Centre

NULM	National Urban Livelihood Mission
NHM	National Health Mission
SDG	Sustainable Development Goals
FRT	First Responders Team
MHSCF	Mental Health and Social Care Facilitator
HDI	Human Development Index
GoTN	Government of Tamil Nadu
CSO	Civil Society Organisation
MHCA	Mental Health Care Act
RPDA	Rights of Persons with Disabilities Act
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
LMICs	Lower and Middle Income Countries
PHC	Primary Health Centre
DMHP	District Mental Health Programme
NMHP	National Mental Health Programme
IMH	The Institute of Mental Health
SCARF	Schizophrenia Research Foundation
SMHA	State Mental Health Authority
AD	Advance Directive
NR	Nominated Representative
PVT	Pudhu Vazhvu Thittam
MHRB	Mental Health Review Board
FGD	Focus Group Discussion
SPSS	Statistical Package for Social Sciences
STI	Sexually transmitted infections
PDS	Public Distribution System
MOSPI	Ministry of Statistics and Programme Implementation
EWS	Economically Weaker Section
LIG	Lower Income Group
ADA	Americans with Disabilities Act
M & E	Monitoring and Evaluation
SC	Scheduled Castes
ST	Scheduled Tribes
PPP	Public–private partnerships
SHG	Self Help Group
ICD	International Classification of Diseases
SMI	Severe Mental Illness
CWC	Child Welfare Committee
MHP	Mental Health Professional
MO	Medical Officer
TIC	Trauma Informed Care
LHS	Learning Healthcare Systems

Aims, Approach and Audience

Guidelines and Protocols outlined in this document are intended to inform the Government of Tamil Nadu's policy which **aims to establish a framework of perspectives and strategies to guide public investments and initiatives that preclude pathways into homelessness, offer culturally resonant care in hospitals and dignified exit options from institutionalised settings, where possible and needed.**

- The policy is positioned as a dynamic process with mechanisms for continuous reflection, improvement, restructuring of strategies and accountability for meaningful outcomes.
- The policy intends to stimulate progressive and decisive actions from state and non-state actors and articulate ethos, values and standards that must serve as the basis of these actions to address intersections of homelessness and mental health.
- The drafters of this policy are keenly aware that any articulations of the possible ways ahead need to be understood to be, by their very nature, both flexible and evolving. As such, it attempts to build into itself both a self-reflective, and a monitoring component. It is also understood that an endeavour of this nature will have to be in consonance with societal and individual variability, that will be neither formulaic nor rigid.
- They are aimed at a broad range of professionals and institutions, governmental and non-government sectors, concerned with the outreach, treatment and rehabilitation of homeless persons with mental health issues (HPWMI).
- This Policy will be of particular interest to those involved in similar issues across India and in other countries, and more generally to mental health professionals, social work practitioners, academic and policy researchers and others interested in advocating for rights-based approaches to addressing homelessness and mental ill health.

Highlights of the Policy

a. **An Ecosystem Approach to service Homeless Persons with Mental Illness (HPWMI):** To ensure comprehensive recovery approaches, embedded in values of dignity and participation, it is essential to build a support structure that addresses the multiplicity of needs of HPWMI. It is recommended that an ideal ecosystem includes a homeless shelter,' no strings attached' safe spaces with access to all basic amenities, community mental health and social care desks, outreach support, emergency care and recovery services and long-term care options that are inclusive.

b. **Policy In Consonance with Sustainable Development Goals (SDGs):** The social architecture of both the Emergency Care and Recovery Centres (ECRCs) and the National Urban Livelihoods Mission (NULM) shelter should ideally be located within a social justice framework that doesn't merely provide treatment and care options, but

builds social capital amongst disadvantaged individuals by addressing social determinants that impact mental health. These care paradigms will not just enhance mental health gains, but will also help reduce poverty, strengthen social ties and promote gender parity and inclusive communities, all integral to the advancement of the vision of the Sustainable Development Goals (SDGs).

c. **Emergency Care and Recovery Centre in every district in Tamil Nadu:** It is recommended that ECRC that offer person-centred mental health and social care for HPWMI are made available in all districts under the National Health Mission (NHM), in collaboration with the Department of Health and Family Welfare and local civil society organisations. These are small sized (bed capacity of 30-50) mental health units, that are typically integrated within General Hospitals; a few may operate as stand-alone mental health units, particularly in larger districts.
d. **National Urban Livelihoods Scheme (NULM) supported shelter in every district in Tamil Nadu:** It is also recommended that Special Shelters that service homeless persons with mental health issues are made available under the NULM scheme in every district (bed capacity of 20- 30).
e. **Safe spaces to be developed to ensure access to basic amenities and support circles:** While crisis and conflict resolution maybe provided at ECRCs and NULM shelters, many may not consent to be admitted into hospitals and may indeed be equipped with skills to care for themselves. While the First responders team and support circles facilitated by Mental Health Social Care Facilitators (MHSCFs) can help build trust to initiate care over a period of time, the need for non-coercive safe spaces that provide shelter, food, clothing, access to toilets and medical care may be piloted in a few districts. It is recommended that these units are run by peer advocates and homeless collectives and are open, not rigidly structured, safe and welcoming. Outcomes of the initiative may feed into the policy as it evolves.
f. **Every HPWMI should be able to access to basic amenities, as a constitutional right:** Access to basic amenities such as nutritious food and water, clothing, safe shelters and medical care are basic rights and non- negotiable. It is recommended that multiple service access points across ECRCs, NULM shelters, Police stations, Govt managed eateries such as Amma Kitchens, Kalaignar Unavagams, Ration shops, religious establishments, Self-Help Groups (SHGs), neighbourhood associations, youth clubs and Civil Society Organisations (CSOs) provide these essential commodities in panchayats, municipalities, towns and cities. It is also essential that information regarding the same be widely disseminated through peer advocates, mental health and social care teams, the Police, homeless collectives, community radio and public service advertising campaigns. This will also engage a diverse range of stakeholders in the mission of supporting HPWMI and help reframe the narrative around social mixing and exclusion in the context of minoritized communities. This is an essential step in the direction of building safer and more inclusive communities, aligned to the vision of the State and enshrined in the Indian Constitution. It is further suggested that this vision may be advanced under the theme- ***Kind People, Happy City/ Village,*** a campaign that may rejuvenate a sense of community in society to support the most distressed and help cultivate a feeling of hope and safety.
g. **Long term care provision for HPWMI to be inclusive and community based:** While a significant number of persons will return to communities and 'mainstream living', some persons with chronic problems may require ongoing care for longer periods of time. It is recommended that such persons be housed and cared for in culturally appropriate, community-based settings, rehabilitation homes or group homes with the possibility of transition from one service to the other based on choice.

h. **Effective Public Health Protocols to be followed in institutions:** As the world experiences some very trying times as a result of the Pandemic, it is recommended that public health protocols are judiciously integrated into care approaches. This mandates adoption of adequate human service professionals, sanitary provisions, healthy diets etc. It is strongly recommended that required resources be made available for the same.

i. **A Centralised Helpline to facilitate speedy grievance redressal and outreach:** In order to address the needs of HPWMI in crisis and in need of support or critical time intervention, a centralised helpline may be initiated and further linked to the missing persons data base and other helplines such as the Women's helpline, helpline for the Elderly, Childline etc. such that special concerns may be comprehensively recorded, needs assessed and addressed by competent stakeholders.

j. **A First Responders Team to support critical time interventions:** It is recommended that a First Responders Team (FRT) be trained in crisis support and mental health care. These teams may be located at ECRCs and NULM shelters and should be guided by protocols that determine the nature of care that a client should receive. Besides Mental Health Professionals (MHPs), the Police may be trained as First responders as may youth and women volunteers to make the process more accessible and less intimidating to a HPWMI.

k. **HPWMI may access medical care in the absence of a caregiver -** It is recommended that medical care without the presence of an attender should be made available for any homeless person referred to a government or private medical care facility as a basic right. Insurance schemes may be utilised for this purpose post-hoc, but all transactions should be cashless at the point of service. This is especially critical since many HPWMI are susceptible to road accidents and are immunocompromised and may require emergency care.

l. **Registration of crimes against HPWMI mandatory:** A human rights aberration that should be set right is the absence of atrocities against HPWMI being formally recorded or registered and therefore the lack of judicial recourse for the victim, however heinous the crime. It is recommended that any act of violence or provocation that affects a HPWMI is registered and corresponding action taken swiftly, setting the tone for the role of the State in ensuring the safety and protection of rights of the most vulnerable.

m. **Mental Health and Social Care Facilitators (MHSCF) a new cadre to service disadvantaged groups:** It is recommended that a new cadre of locally accessible and responsive MHSCFs are drawn from Panchayats, Women's Development Council (WDC), the Health Work Force, and teachers and trained to provide psychological first aid and social care. These MHSCFs will enable access to continued care through the District Mental Health Programme (DMHP) and to social care such as the Public Distribution Scheme (PDS), and other social entitlements based on needs and vulnerabilities through the Department of Disability and Department of Social Welfare.

n. **Social security to be provided to HPWMI and their caregivers:** Abject poverty has been evidenced to be a significant predicator of homelessness, especially in the context of mental illness. To prevent recurrence of homelessness and support needs of minoritised communities, it is suggested that Social Security allowances for HPWMI with no means of livelihoods be initiated.

o. **Housing Schemes to address needs of HPWMI:** Homelessness is closely linked with poor social capital and unstable housing, more so in the case of those with a mental health concern. A low cost, stable housing scheme for this vulnerable population is essential and strongly recommended.

p. **Livelihood facilitation mandatory to address social determinants of mental ill health:** Livelihood options and gainful employment are essential to valued social roles and participation. Skills hubs, facilitation of job cards, social cooperatives and incubation

of social enterprises will both reduce poverty and enhance social mobility. It is therefore recommended that an employment registry be created exclusively for this group affected by homelessness and psychosocial disability.

q. **A Mental Health and Social Care Commission to ensure oversight:** It is recommended that a Mental Health and Social Care Commission that supports the needs of HPWMI is constituted that translates recommendations into plans and monitors them effectively.
r. **Quality Audits to ensure effective monitoring systems:** It is recommended that Quality Audits and reviews led by this commission are periodically conducted across ECRCs, NULM shelters, safe spaces and rehabilitation centres to understand the effectiveness of these approaches and collaboratively bridge gaps where they exist.

Section A

Enabling access to appropriate and timely care for homeless persons with mental health issues

The Sustainable Development Goals (SDGs) commit all countries to ensure equitable living standards for all by 2030. This includes improving health, including mental health, and appropriate housing. Attempts to ensure that nobody suffers hunger, violence, segregation and multidimensional poverty – including housing poverty – have been disrupted with every health and social hazard that affects people worldwide, especially those who have been historically disadvantaged by barriers based on gender, class, caste, class and ethnicity. In view of the increasing number and intensity of natural calamities, growing concerns about climate change and conflict, and more recently the COVID-19 pandemic that has affected millions and plunged many more into abject poverty and distress, many nations and states – including Tamil Nadu – are developing policies to address the situation of vulnerable communities, especially those whose needs are often rendered invisible, such as individuals experiencing the double burden of homelessness and mental health issues. While SGD3 focuses on health and well-being for all, this will be achieved only if intersectoral collaboration is mandated by ‘governments and development actors’ to ‘reach out to people with mental disorders in the design of strategies and programmes that include those people in education, employment, health, social protection and poverty reduction policies’ (World Health Assembly 2012, 65.4).

While this policy is focused on health and well-being, its emphasis on inclusive development will help reduce hunger and poverty (SDGs 1 and 2), enhance gender parity and workforce participation (SDGs 5 and 8), in turn reducing disparities and inequalities and promoting ‘peaceful and inclusive societies for sustainable development, provide access to justice for all

and build effective, accountable and inclusive institutions at all levels' (SDG 16) and in doing so, foster partnerships (SDG 17).

A.1 Focus on intersectionality

Intersectional or multiple reinforcing factors, often transmitted over generations, affect people's quality of life, often resulting in deprivation and feelings of hopelessness. According to the Global Hunger Index 2021, as a combined result of COVID-19, conflict and unemployment and other issues, 47 countries experienced extremely alarming, alarming or serious levels of hunger (GHI, 2021). Moreover, 39% of the world's population still lacks improved sanitation and 751 million people 'share their sanitation facilities with other households or only use public facilities' (World Health Organization, 2009). Investments in health and mental health have been inadequate, and many health systems across the world have been overwhelmed by the pandemic. Health shocks, unstable housing and acute scarcity accompanied by mental ill health and disrupted care risk rendering many people homeless.

In 2021, 1.1 billion people lived in inadequate housing and more than 100 million were homeless. In the absence of support networks and adequate access to relief and respite from inclement weather conditions, income insecurity, insufficient nutrition, and abuse, such people already experience heightened vulnerability and are therefore more susceptible to stress and mental health concerns. It is estimated that nearly 1 billion people worldwide experience some kind of mental health issue, of whom 150 million are Indian citizens, and 32% have long-term needs (WHO, 2020). A downward spiral into homelessness as a result of psychosocial disability is often the result of persistent structural barriers. An estimated 1.77 million people in India are homeless and an estimated 30% experience a mental health issue.

A. 2 Focus on diverse lived experiences and on co-designing approaches to responsive care

The magnitude of the problem facing homeless persons with mental health issues (HPWMI) is both severe and often chronic, and represents an assault on their sense of self, personhood and dignity. Globally, pathways out of homelessness and ill health have focused largely on traditional options that many with lived experiences have criticised because of the poor attitudes associated with service provision and short-sighted care planning and policy development. While the landscape is complex and fraught with constraints and often intractable problems, and resources are limited, it is time 'to include in policy and strategy development the need to promote human rights, tackle stigma, empower service users, families and communities, address poverty and homelessness, tackle major modifiable risks, and as appropriate, promote public awareness, create opportunities for generating income, provide housing and education, provide healthcare services and community-based interventions, including de-institutionalized care'.

Despite the guidelines, progressive legislation and international declarations and conventions that many countries have ratified, including India, coercive practices, neglect and sub-standard mental health and social care continue to characterise mental health systems. In India, Public Interest Litigations have supported the transition from hierarchical to more nuanced models of care (Gaurav Kumar Bansal vs. State of Uttar Pradesh, 10 July 2017) and in some states

culturally specific approaches have enabled creation of community living options and inclusive ecosystems for persons with chronic mental health issues and severe disability. There has also been a rise in peer-led initiatives, collaborative care approaches, and a mindset that manages uncertain outcomes with critical and reflexive thinking, involving multiple stakeholders and exploratory approaches find to the most appropriate responses that address the needs of the 'whole person'.

In March 2020, alongside the cataclysmic effects of the pandemic, there were commitments to address the needs of disadvantaged populations and ultra-vulnerable groups, particularly the homeless sleeping rough or housed in shelters, to give priority to their well-being and safety. Taking into account the exposure to trauma and violence, along with clustered and congested housing and large, flailing and overcrowded public institutions, these people were clearly among the most vulnerable. While there was an emphasis on mental health care and the importance of housing, other important clauses adopted by the World Health Assembly such as the 'protection, promotion and respect for the rights of persons with mental disorders including the need to avoid stigmatization of persons with mental disorders; equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health-care system; access to educational and social services, including health care, schooling, housing, secure employment and participation in income-generation programmes; involvement of civil society organizations, persons with mental disorders, families and caregivers in voicing their opinions and contributing to decision-making processes; participation of people with mental disorders in family and community life and civic affairs; building upon the work already done and avoidance of duplication of action' were reinforced.

A. 3 Government of Tamil Nadu's policy to address concerns of persons with mental health issues from ultra-vulnerable backgrounds

In light of these guidelines, and committed to the philosophy of 'last mile delivery', the Government of Tamil Nadu (GoTN) set up a group of experts to develop a policy to address the needs of homeless persons with mental illness, and to ensure a dynamic and adaptive policy development process so that participatory research methods, service-user audits and feedback, and multi-stakeholder insights could inform framing, guidance and protocols. A diverse team under the chairmanship of the former Health Secretary, Government of India, Mr Keshav Desiraju, comprised development experts, social workers, public health experts, mental health professionals, advocates and leaders, persons with lived experience, human rights advocates, state and civil society representatives and researchers. A series of initial meetings with a core team and the Chair produced an outline that drew on brief surveys, focus group discussions (FGDs), key informant interviews, practice-based evidence, secondary literature and the 2012 Mental Health Policy. Emerging themes underlined the need to address deprivation and deficiencies through comprehensive responses that address profound concerns affecting the lives of homeless persons with mental health issues. There was an imperative need to continually monitor the real-world impact of the policy on individuals and measure incremental changes in their quality of life, experience of agency and participation, reduction of poverty and hunger, and improvements in health and mental health. The committee is now co-chaired by

Secretary, Health and Family Welfare, GoTN, and Director, National Health Mission, Dr Darez Ahamad.

The resulting **Tamil Nadu Policy for Homelessness** among persons with mental health issues aims to establish a framework of perspectives and strategies to guide public investment and initiatives that preclude pathways into homelessness and offer culturally appropriate, dignified exit options from institutionalised settings, where possible and necessary. The strategies and direction present the dimensions of providing health for this particular population group from a social justice perspective. The policy is positioned as a dynamic process with mechanisms for continuous reflection, improvement, restructuring of strategies and accountability for meaningful outcomes. The policy aims to stimulate progressive and decisive actions from state and non-state actors and articulate the underpinning ethos, values and standards to address the intersection of homelessness and mental health.

The specific objectives of the Tamil Nadu Policy for Homelessness are as follows:

1. Articulate considerations, values and ethos to guide culturally resonant service designs and delivery systems that acknowledge and prioritise dignity and agency of service users.
2. Establish mechanisms to recognise, enumerate and understand the experiences of homeless people with mental health conditions in the state of Tamil Nadu, in order to inform co-designing knowledge and developing sustainable solutions to prevent homelessness, address health concerns, segregation and neglect, and nurture a climate of inquiry and innovations, with lived experience experts.
3. Articulate the contemporary context of policy and law at the Centre and the federal position, aspirations and possibilities/ responsibilities for the state of Tamil Nadu.
4. Map services that address the intersection of homelessness and mental health issues and examine the efficacy of approaches in order that programme-level strengthening may be attempted collaboratively at a multi-stakeholder level. Stakeholders may range from Government Departments of Health and Family Welfare, Department for the Welfare of Differently Abled Persons and Social Welfare Departments to Housing and Rural Development Departments as well as panchayats, faith-based institutions and civil society organisations (CSOs), including those that use indigenous healing methods.
5. State strategies for action across interrelated domains and a roadmap to address homelessness and mental health issues in the state of Tamil Nadu.
6. Formulate a mechanism for dynamic monitoring, continual learning and accountability for outcomes so the policy and associated strategies may evolve and change based on expressed needs.
7. Ensure that person-centred, responsive systems of care are stressed that balance safety and the pursuit of capabilities with human rights of the users of mental health services, in a manner that lend themselves to personal recovery, life satisfaction and participation.
8. Focus on reducing crime and other atrocities experienced by homeless persons with mental health issues (HPWMI) experience by ensuring that legal and ‘law and order’ systems are in place to respond to abuse, assault, neglect and related crises.

9. In the process of addressing objectives 1–9, focus on poverty reduction, gender parity, stable housing and health and well-being for all, essential aspects of the SDGs.

Section B

Homelessness and mental ill health – global and local context

About 150 million people in India are estimated to live with a diagnosable mental health condition, but less than 10% of those with common (or less severe) mental health issues and only 40–50% of those with serious mental health conditions are receiving any form of care. The prevalence of mental health issues is higher in Tamil Nadu than the national average. According to the Census of India 2011 there are 1.78 million homeless individuals in India, and an estimated 50,000 in Tamil Nadu, 70% of whom are living in families. These figures are likely to be a significant underestimate, however, given the limited definition of homeless populations as 'those who live in the open or roadside, on pavements, in hume pipes, under flyovers and staircases, or in places of worship, *mandaps*, railway platforms, etc.' There are no precise numbers of people who simultaneously experience both homelessness and mental ill-health in India or in Tamil Nadu – though based on global estimates 25% of homeless people may be living with a diagnosable mental health condition. **Diverse groups occupy the intersection – spanning from people with serious mental health conditions, communities and families in insecure housing with psychosocial issues, to those in chronic homelessness due to substance abuse, pathways from childhood to youth and adult homelessness to people with developmental conditions.**

Scanty clothing, malnutrition, fear and alienation characterise the daily lives of homeless persons with mental illness. As with other marginalised groups who face social abandonment, they experience diverse and inconsistent responses from civil society, with a common thread of inadequate protection from state and legal entities that has remained largely unchanged for decades, with a dated and unidimensional approach. Support is not sustained, and HPWMI become easy targets for abuse and neglect, incarceration, coercive and long-term institutionalisation and, in the worst cases, nefarious acts of experimentation and organ theft.

There are HPWMI in rural and urban areas, although in the latter they may be more clustered, seeking resources in heavily populated localities such as eateries and places of worship. Bus stops and train stations are also preferred locations for HPWMI from other cities and towns, as these are relatively safe because they are busy, well-lit and patrolled by law-enforcement officers, which reduce the chances of being abused or exploited.

B. 1 Homelessness, deprivation and victimisation

Studies conducted by Fischer et al. (1992) on the victimisation of homeless persons concluded that psychiatric illness is one of the highest risk factors for individual victimisation. A study by Lam and Rosenheck (1998) to determine the prevalence and correlation of criminal victimisation

and clinical outcomes for people with mental health problems found that 44% of the respondents were victims of robbery, theft, threat with a weapon, physical violence or sexual assault. Women with mental health issues were at a much higher risk of physical and sexual assault. Another study found that homeless men with a psychotic illness were at a significantly higher risk of being beaten, robbed, threatened with a weapon or injured (Padgett et al., 1992). A study of the incidence of rape among women with schizophrenia reported that 22% had been raped, two-thirds of them multiple times (Darves-Bornoz et al., 1995). A study conducted by The Banyan, India, found that 57% persons had been exposed to heinous crimes and grave injuries, 22% experienced sexual abuse, 35% had been physically injured, and 57% had several co-morbidities including anaemia and wide range of metabolic syndromes.

Homeless persons with mental health problems are also at higher risk of incarceration, primarily due to lack of access to hospitals or community-based mental health and social care options. They are also vulnerable to a host of physical health problems and have markedly increased mortality rates owing to factors such as poor diet, cardiovascular disease, HIV/AIDS, pneumonia, smoking-related fatal disease and liver disease (Babidge et al., 2001; Brown et al., 2013).

B. 2 Social drift and social causation

Homelessness and mental health conditions are linked in a two-way relationship although the precise parameters of cause and effect are unknown and indeterminate. Contemporary evidence highlights both social drift and social causes that reproduce the simultaneous experiences of homelessness and mental health issues. Higher rates of mental ill health are reported among homeless people, particularly schizophrenia, bipolar disorder or harmful substance use – also associated with the greater risk of slipping into homelessness.

The routes into homelessness are usually explained by a breakdown in support networks precipitated by poverty, disadvantaged caste and ethnic identities, and the related lack of access to livelihoods; childhood adversity, disruptions in family and relationships; conflict and violence; and natural calamities, especially against the backdrop of historical and systemic disadvantage and insecure housing.

Of particular importance are findings in Indian and international contexts that suggest that rather than a lack of access to treatment, inequities and injustices experienced due to structural community-level factors heighten the risk of becoming homeless. Conversely, people with untreated mental health conditions, particularly psychoses, who are unable to gain sustained access to health and social care, suffer a greater risk of homelessness. While the incidence of homelessness among people with mental health conditions attributed to inadequate or lack of treatment may mask the more complex underlying factors that maintain the relationship between mental health and homelessness, both demand equal attention, including mental health and social care, gaps in care plans, and persistent structural barriers.

While structural violence precipitates trajectories of homelessness and mental ill-health, being diagnosed with a mental health condition and being homeless leads to widespread social

exclusion and the denial of basic entitlements. People with serious mental health conditions have an average life expectancy of 15–25 years less than the general population, remain out of work, encounter more abuse and crime, are at greater risk of suicide, and experience pervasive exclusion and human rights violations across the social, economic, cultural and political spheres. One study found high prevalence of suicidal thoughts and suicide among homeless persons with a mental illness, especially those with alcohol and drug dependence (Prigerson et al., 2003).

B. 3 Oppression and alienation

The mental health effects on the intersections between systemic violence and oppression based on gender and caste permeate the Indian context. The legacy of the criminalisation of homelessness through legislation and social stigma has led to cultural alienation, loss of rights over resources, forced evictions, harassment by justice systems and mass enforcement of institutional services. In general, the services provided under anti-beggary and mental health legislation leaves people navigating circular pathways between the streets and institutions or carceral systems, which in turn shapes social perceptions and perpetuates a culture of segregation or trans-institutionalisation.

Furthermore, approaches to addressing the concerns of HPWMI are not always appropriate, responsive or person-centred, resulting in resistance or sub-optimal use. A culture of dialogue, longer-term engagement and deeper understanding of the social context and emotional distress, including fear, withdrawal, hopelessness and rage – a natural response to the many intractable issues an individual might face – need care teams to be aware of these social vulnerabilities, unbearable social and psychological suffering and sense of social defeat. Mature governance structures, appropriate and responsive care systems, and dynamic clinical and social care planning are essential to reframing these narratives.

B. 4 Colonial legacies – punitive legislation and the lack of legal recourse for homeless persons with mental health issues

While the Mental Health Care Act (MHCA) 2017, the Rights of Persons with Disabilities Act (RPDA), 2016 and related legislation have gained prominence and supported significant reforms, many colonial and outdated laws are still on the books. The law and order and justice departments seldom step in and, in the case of HPWMI in conflict with law, commonly identify them as ‘disruptive’, rather than living in situations that expose them to harm and abuse. ‘Clean ups’ and ‘drives’, while often intended to promote access to shelter and care, are also historically embedded in a system that segregates and ‘others’ anyone who is ‘different’. This has its genesis in the criminalisation of homelessness and mental Illness or other disabilities under the Beggary Prevention Laws that penalise persons with mental illness and who are homeless. Beggary and vagrancy laws are in effect in 22 states (including some Union Territories) in India.

Some clauses in this antiquated legislation equate homeless persons with 'beggars', to whom punishment is meted out. Under the Prevention of Beggary Act,1960 beggars may be removed from the streets and placed in beggars' homes for up to a year – and recidivists for up to ten years. Homeless persons with mental illness are charged with committing an offence, i.e., begging, with details about their mental state often not mentioned in the charge sheet, making it virtually impossible to know how many persons arrested under these laws have severe mental health issues; only records from beggars' homes (if at all) may be of use. Any further inappropriate behaviour is treated as a criminal offence and escalated charges are pressed against the person, who now is fighting draconian legislation and punitive action alone, homeless and unwell, with no essential legal support or effective means of redress. Incarceration also leads to denial of any necessary treatment, leading to more years lived with a disability and poor quality of life. In the absence of relatives who will care for them, such a person could potentially remain in custody for an extended period, or even a lifetime if there is no way out.

Moreover, when a person develops a mental illness, their family may abandon them, or even seek to usurp their rightful property. This is in contravention of the United Nations Convention on Rights of Persons with Disabilities (UNCRPD), Rights of Persons with Disabilities Act (RPDA) and the Mental Health Care Act (MHCA), which decree legal and property rights to all people with disabilities, including those with mental health issues; but contradictory legislation in the Indian Penal Code, including the Indian Contract Act and 450 other statutes, do not permit persons of 'unsound mind' to enter into social contracts – which nullifies the advantages of rights-based, progressive legislation. In addition, lack of awareness of their legal rights among PWMI leads to widespread exploitation, often resulting in housing and financial instability and subsequently to homelessness.

In some countries, notably the US, HPWMI may end up in prison owing to laws that insist on 'grave danger' as a primary criterion for admission to a mental facility; some family members or friends who are caring for them may then opt to let person commit a crime just so they can receive help. As a result, US prisons are the largest service provider for HPWMI; for instance, Cook County Jail in Chicago houses over 6,000 individuals with mental health issues.

From Starbucks, Mike had run into a residential area, entered the backyard of a house, climbed on to his wooden deck and hurled a patio chair through the plate glass door, setting off the alarm. Ignoring the piercing sound of the alarm, he entered the house, turned on the stereo and began rummaging through the kitchen cabinets. He then made his way upstairs, going from bathroom to bathroom, turning on the taps. After checking the bedrooms and discovering no one was around, Mike stripped down and took a bubble bath. I knew from past experience that the police wouldn't commit him unless he proved to be a threat to me or himself, so I was forced to lie to them that I thought my son was going to kill me. He was finally taken to Mount Vernon Centre. The current mental health laws mandated for him to take psychiatric medicines for 5 days in the hospital after which, unless Mike chose to commit himself voluntarily, he will not be detained in the hospital, nor be forced to take medicines no matter how unwell he was. Despite repeated appeals to the hospital and the insurance companies to keep him in the facility for longer depending on when he would agree to take medicines voluntarily, they refused. Shortly after he was discharged, two felony charges for

Breaking and Entering, and for property damages greater than $100 was slapped on him, attracting a $10,000 penalty and one year in prison. We later found out that he would be arrested, but not sentenced to prison since it was his first arrest, and sent for probation and ordered to continue getting psychiatric treatment [the author later talks about a broken system that provides for emergency mental health care, but only after arresting someone]. That was it, but two felony arrests would go on his permanent record, which will impede his chances for employment in any profession, including the one he worked 4 years for in college.

Source: Early, P. (2007) *Crazy: A Father's Search Through America's Mental Health Madness*, Berkley Publishing Group.

In India, homeless persons with mental illness typically are usually admitted at a mental hospital or a beggars' home, with fewer ending up in jail, although a 2019 Prison Statistics of India report found that 15% of the inmates have a diagnosable mental health issue and may not be able to access mental health care.

B.5 Normalisation of crimes against persons with mental health issues

Worse still, crimes ranging from assault to being pelted with stones, abuse and rape are not registered as issues of law and order. The lack of formal records and virtually no attempt by some treating doctors, nurses and mental health teams to bring charges against the perpetrators have resulted in an acceptance of a culture of passivity and related aberrations. Rape often results in unwanted pregnancies that are usually carried to term, usually without appropriate care, informed or supported decision-making, and discussions regarding choice and agency about whether to continue with the pregnancy.

Case Study

The case of Ms Z illustrates the loss of reproductive rights and eventually the right to life of a homeless person with mental health issues. Ms Z was admitted to Shanti Kutir Rehabilitation home for Destitute Women in Patna where she was found to be pregnant after having been raped on the streets. She clearly and cogently expressed her wish to terminate the pregnancy. However, in view of her mental health condition, the case was politicised and passed between women's groups, state and district legal aid authorities and finally the High Court, which appointed a medical board to take a final decision. The board co-opted a psychiatrist who advised termination on health grounds and in consideration of Ms Z's choice, despite which the High Court did not authorise a medical termination. The case then went to the Supreme Court, which also appointed a medical board – by which time the permitted period for a termination had passed, so Ms Z was forced to carry the pregnancy to full term. She died shortly after childbirth of her child owing to excessive blood loss and other complications.

The final judgement is given in the textbox below:

'In the present case, the medical report does not suggest that the foetus is suffering from any abnormality. It further does not suggest that the foetus has already been infected with HIV+ve.

It only predicts that any definite opinion can be given only when the child attains the age of 18 months. The Medical report further does not suggest that if the victim is allowed to carry the pregnancy to its full course, then she will suffer any risk of life or grave injury to her physical or mental health. Explanation 1 of Sub-Section 2 of Section 3, provides that such pregnancy which is alleged to have been caused by rape shall be presumed to constitute grave injury to the mental health of the pregnant woman. In the present case, the victim has alleged that she had been ravished, but her conduct of not disclosing the incident of rape for more than 13 weeks and deciding not to get the pregnancy terminated for more than 20 weeks, as the writ application has been filed after 20 weeks of pregnancy i.e. on 07.04.2017, prima facie, does not suggest that such alleged conceivement has really caused grave injury to the mental health of the victim. Moreover, the termination, as contemplated under Section 3 of the Act, 1971, is only permissible up to 20 weeks of pregnancy. Definitely the effort for termination was made on behalf of the victim in the 17th week of pregnancy, but the present writ application has been filed before this Court after 20 weeks of her pregnancy.'

B. 6 Care approaches to homeless persons with mental illness

6.a Mental asylums

There are accounts, possibly apocryphal, from ancient Chinese, Indian, and Graeco-Roman civilisations describing institutional care for the mentally ill. By the end of the first millennium, the first formal asylums appeared in Baghdad and spread throughout northern Africa and southern Europe. The idea of care of the marginalised and ill became a principle of statecraft, conferring legitimacy on the rulers; while also emphasising the civic response to those who were unwell. Since rulers claimed legitimacy primarily on religious grounds, the care of the sick was a moral obligation. These ideas were later adopted in Europe, where there was a gradual increase in the number of asylums. These were initially supervised by the church, but as scientific and medical progress displaced religious notions of madness, the asylums were later supervised by professional 'asylum doctors' and psychiatrists.

The care of the mentally ill, to protect them from the vagaries and pressures of life, became a civic virtue, and communities vied to set up asylums, especially in Europe. In the colonies too, establishing asylums was seen as a legitimate expression of concern. During the colonial expansion, they were first established in the US (1773) and India (1788), and within a century were almost worldwide (California, 1855; Tezpur, 1876), including Japan and Africa. Their integration into 'local' society obviously differed, according to prevailing customs and mores, but they were heavily used and soon became overcrowded.

Most of these also served as custodial centres for those too ill to fend for themselves, but for the most part, patients came and went, after staying for a few weeks or months. However, given the nature of mental illness, some patients never improved, and some causes (syphilis, head injuries, dementia, epilepsy, intellectual deficiency, alcoholism, 'mania longa') made recovery unlikely. The number of people with a mental illness increased in line with massive population growth from 1 billion to 8 billion over the last 200 years. Overcrowding and lack of professional

oversight, as well as the lack of a scientific understanding of mental illness, gave rise to a lack of concern and indifference.

In south Asia, the first asylums were established by the East India Company. This coincided with the introduction of 'modern' health care, as dispensaries, taluk hospitals and medical colleges were set up. Their history, like all histories, is chequered. Though the asylums were initially intended for its soldiers (mainly Indian, but also some European), within a few years they were opened to the whole population, so that by 1790 asylums were opened for the poor in India. When the administration shifted to the Crown (after 1857) new, large, custom-built asylums (Lahore, Ranchi, Pune) were quickly added. Native kingdoms proved quite reluctant to invest in these, with only a few exceptions (Mysore, Travancore, Berhampur, Hyderabad). Medical education, research, and policy-making were tightly controlled by the colonial government. The asymmetry of knowledge, and power within Indian society itself, and with respect to the colonial rulers, did not allow for medical services to be integrated into civic life. In addition, traditionalist and revivalist opinions viewed the entire project of 'western' medicine with suspicion.

6.b The de-institutionalisation movement

From the 1930s, models of the causes (and outcomes) of mental illness veered back into social and cultural explanations. In addition, unmodified electric shock treatment, surgical 'solutions', and forced sterilisation of people with mental illness, particularly of women (done without their knowledge or consent, especially among indigenous women, women living in poverty or with a history of mental illness) etc. gave way to an era of reforms that led to popularising ' the moral treatment'. These ideas gained acceptance at the same time as the first psychiatric drug treatments became available (from 1931 in India; from 1952 in France and the UK). It rapidly became obvious that these drugs improved the symptoms and quality of life for a great many people suffering mental illness. This brought into question the role of asylums and asylum doctors both from the pharmacological advances and from wider social concerns. Almost everywhere, the mental asylums were shut down and 'de-institutionalisation' became an orthodoxy.

The 1970s and 1980s witnessed mass de-institutionalisation from mental hospitals across many western countries, promoted by Thomas Szasz, Franco Basaglia and Ervin Goffman, among others. Following the rights debate and numerous exposés of gross rights violations witnessed in mental hospitals, legislation and stringent laws were passed in order to reduce the absolute power enjoyed by mental health professionals on involuntary admissions into psychiatric hospitals and asylums. This movement also gained momentum with the advent of new psychotropic drugs such as Chlorpromazine. While this was a positive development for change in approaches to mental health, it also gave rise to unexpected negative consequences. Over 100,000 'mental patients' were discharged overnight in the United States without much forethought or a strategy regarding their future course of treatment. This, in addition to rising housing costs, led to a dramatic increase in the homeless population, especially in the UK and the US. Persons with mental health problems in need of acute care were refused admission on

the grounds that they were not of ‘immediate danger to themselves or others’. Some of these individuals were subsequently arrested. Many deinstitutionalised people also ended up on the streets or in unstable housing projects in suburban ghettos (trans-institutionalisation), further away from treatment facilities, at greater risk of victimisation, and/or incarceration, leading to a sharp decline in their physical, mental, emotional and social well-being. A concern about the increasing costs, and the financial burden of dealing with the mentally ill, became a preoccupation for several European economies.

6.c The advent of bio-medical care

The promise of drug therapies proved short-lived. They had side-effects; a full recovery was not always achievable; and social responses to those with mental illness were less accommodating than had been hoped. Since the initial discoveries between 1930 and 1960, here has been relatively little progress in better understanding and ‘new’ treatments of mental illness. This has led to a kind of stagnation in responses to those experiencing mental illness, although it was clear that patients need a complex network of care services to recover fully, the absence of which leads a pattern of recurrent ill health, or disappearance into jails or morgues. As there were fewer hospital facilities for the mentally ill, so the number of persons with mental illness in jails, beggars’ homes, or night-shelters (where they exist) rose dramatically, and it is estimated that the number of those in ‘institutional’ care is now about the same as it was decades ago.

B.7 Transition of care to community-based models

The care of the mentally ill has now shifted into the community, with most wealthier countries investing in a range of services, from subsistence payments, to protected housing and livelihoods. This has not been straightforward since in real terms the cost of living has risen more than wages, and those who cannot ‘work’ are seen as shirkers or a burden in many parts of the world. In post-colonial countries (also referred to as low- and middle-income countries, or LMICs) that had not developed the physical or intellectual infrastructure for health care, this period has been particularly damaging for those with mental illness. As communities come under the strain of rapid economic change, the lack of institutions of governance (and thus of care) is acutely felt. But this is nevertheless the only way forward, with call to increase budgets to support change of the sort envisaged and address core concerns rather than superficial solutions.

The de-institutionalisation movement that began in the 1950a in North America and most of Western Europe, and sought to reduce and often close down large psychiatric facilities, was accompanied in some parts of the world with a rethinking of community-based mental health services. In India, community mental health care emerged in the 1960s independently of de-institutionalisation, with a few rural extension centres of the psychiatric departments of major hospitals. With relatively scarce mental health services, whether institutional or community-

based, these efforts sought to make care for mental health more broadly accessible. By the 1970s, primary health centres (PHCs) gained importance internationally.

In India, there were two state-commissioned evaluations of the functioning and impact of the District Mental Health Programme (DMHP). The National Institute of Mental Health and Neurosciences (NIMHANS) conducted an initial evaluation to ensure the Health for All and the Alma Ata Declaration was adopted in 1978. At the same time there was a push to integrate mental health services at the primary level. Two experiments in the 1970s, in Raipur Rani and Sakalwada, established mental health clinics at PHCs alongside domiciliary follow-up services and training of medical officers, nurses and multi-purpose workers. These initial experiments contributed to the National Mental Health Programme that was established in 1982 with the objective of ensuring availability and accessibility of minimum mental health care for the population. Between 1985 and 1990, NIMHANS conducted a pilot community mental health programme in Bellary (Karnataka) that included community screening, awareness, out-patient and a 10-bed in-patient service with follow-up services with trained PHC staff. The success of the Bellary model provided the impetus for the launch of the DMHP in 1996, which sought to extend community-based mental health by training PHC personnel to offer services at the primary level and establish referral pathways to district-level mental health units. The DMHP has since expanded to cover 692 districts in India. In 2003 the GoTN integrated 27 districts under the DMHP, which helped mitigate some of the problems facing oppressed social sectors.

Realising that an effective way to achieve equity is to advocate for these districts in 20 states, the Indian Council for Market Research conducted the second evaluation in 2008, covering 20 districts. In 2011, NIMHANS evaluated the DMHP with a focus on 27 districts in the Southern states. In the same year, The Mental Health Policy Group examined the DMHP's functioning based on multiple data sources and field visits and recommended improvements. While there are vast differences in how the provisions of the programme are translated into practice, there are now more available out-patient mental health services provided through mental health teams at district hospitals or camps at nearer taluk-level community health centres. However, several challenges in the DMHP stem from attempting to integrate a programme into a public health system which was from the outset beset with infrastructural and staff deficits. Evaluations of the DMHP have highlighted the following:

1. Curative, bio-medical archetype with a focus on medication as the primary line of treatment. Critics argue that the DMHP is unable to offer culturally appropriate services or take account of the social determinants of mental health conditions in terms of both prevalence and prognosis.

2. Administrative challenges due to lack of clear ownership and responsibilities, and a lack of collaboration within and across ministries and departments at the national, state and district levels. These result in a fragmented experience for service users, with health departments ending their responsibility at care provision, and rehabilitation perceived as that of the social justice department.

3. Financial issues with the disbursement and use of funds acting as a significant barrier to even the availability of basic medication at the district level. The central government's annual budget highlights the predominant financing (~98%) of tertiary institutional facilities under the Centres of Excellence scheme of the National Mental Health Programme (NMHP).

4. The lack of staff with the perspectives and skills to provide appropriate community-based care for marginalised populations. Many evaluations have found that nearly half of the positions in the DMHP, particularly non-medical professional posts, are not filled. This is in part due to the lack of trained mental health professionals in India. The more persistent challenge has been to bridge the gap in perspectives of professionals to a person-centred, bio-psychosocial, non-pathologising perspective, and relevant skills to engage in reducing the burden for patients and carers, increasing their participation and promoting social inclusion.

India currently has 43 mental hospitals and 718 districts, of which 742 are covered by the DMHP, the community-based mental health option.

B.8 Long-term care options

For those with long-term needs or who live with chronic mental health issues and severe disability, there have been very few options besides long-term stay in hospitals, shelters or rehabilitation homes. It is estimated that close to a third of those with long-term needs continue to live in mental hospitals and institutions run by CSOs in the absence of other services or home-based care providers. Many governments have therefore established innovative and sustainable housing options for persons with mental health issues. While cross-pollination of ideas and models may be a desirable way to innovate and attempt to work around growing concerns about long-term care and dignified living, in India the lack of inclusive living options for persons with mental health issues remains a concern. There have been a few innovations such as 'Home Again' (Patel et al., 2018) piloted by The Banyan in 2015. Inadequate housing is often cited as one of the primary causes of homelessness among the chronically mentally ill; there are indications that homelessness in the US rose well after the de-institutionalisation movement, around the time there was loss of inexpensive housing (O'Flaherty, 1996). While it has proved to be difficult to establish the causal direction between homelessness and mental illness, compelling empirical evidence states that lack of suitable housing is equally a cause for major distress among the homeless mentally ill.

B.9 Persistent and complex challenges – paucity of solutions and innovations

Institutions need to be complemented by care in the community. However, with limited detailed understanding of the mind and its processes or the impact of social factors on behaviour, the approach has to be one of trial and error, seeking to reconcile the many struggles that the users of mental health services experience at the individual, family and social levels. Developments in neuroscience have been less significant than might have been hoped in exploring whether mental illnesses may be caused by brain disorders. Population-level mental and social health outcomes have not been fully assessed or systematically understood across diverse

geographies and communities or social groups (Susser et al., 2006). Consequently, there are only marginal improvements in the form of progressive legislation (with limited translation on the ground), and global-level attention and commitment to building effective solutions that work in the real world. In the meantime, hospital-based care for HPWMI as needed, and for reintegration into the 'community' when desired (which may not always be receptive or welcoming) remain among the principal approaches to care and social inclusion. While neither is a panacea, and each brings its own challenges, a binary approach to addressing long-term needs, focused on either the 'hospital' or the 'community', not taking account of individual and expressed needs, will only result in ideologically based 'solutions'.

Section C

Government of Tamil Nadu's Response to the Needs of Disadvantaged Persons and Vulnerable Groups

The far-reaching, sector-specific, and vulnerability-sensitive policies adopted by successive Tamil Nadu governments, from before independence, has mitigated of some of the problems facing oppressed social sectors.

Realising that an effective way to achieve equity is to advocate for and integrate principles of affirmative action in education and jobs, the South Indian Liberal Federation, popularly known as the Justice Party, was instrumental in passing the Communal Government Order of 1928, to increase representation of the disadvantaged and under-served communities in government. Since then, many progressive governments have tinkered with reservations for the lower socioeconomic and oppressed classes to enhance gains. For instance, after K. Kamaraj became Chief Minister of Madras State in 1954, reservation of 25% for the 'backward classes' (BCs) and 16% for the 'scheduled castes' (SCs) and 'tribes' (STs) in education and jobs was implemented. In 1969, Chief Minister M. Karunanidhi set up the first commission for the 'backward classes', the Sattanathan Commission. It recommended raising the level of reservation for SCs from 25% to 31% and for STs from 16% to 18%. This was implemented. In his first term, Chief Minister M. G. Ramachandran further increased reservation for BCs to 50%, maintaining the SC/ST reservation at 18%. In his last term (2006–2011), he carved out 3.5% from the BC reservation for Muslims and 3% from Arundhatiyars from the SC quota. The reservation in Tamil Nadu is protected by a Constitutional Amendment. (In contrast, the reservation for BCs in India was implemented only in 1991 (27%), after massive agitation demanded implementation of the recommendations of the Mandal Commission report.)

Some equally important steps taken by the GoTN include the reservation of 30% of jobs in government and public service (increased to 40% in 2021), and 33% of seats in local bodies for women, the creation of *samathuvapurams* (habitats of equity) to eradicate caste discrimination, issuing free house-site *pattas* for the poor and vulnerable families, and free mid-day school meals – all aimed at addressing barriers related to unstable housing, poor nutrition, low literacy rates and poor school enrolment. This scheme, implemented by Kamaraj, was universalised by

Ramachandran. The 1970 amendment to the Tamil Nadu Religious and Charitable Endowments Act, 1959 to appoint *Archakas* (non-Brahmin priests allowed to officiate in temples) from all castes was one of the earliest promises of the Dravida Progressive Federation (DMK) government, which came to fruition only in August 2021. Policy changes made by successive governments include legalising self-respect marriages, without the need for priests and rituals, by amending the Hindu Marriage Act, setting up first state-level planning commission to cater to Tamil Nadu's specific needs, setting up a Slum Development Board with the aim of providing houses to the urban poor, banning hand-pulled rickshaws and providing rickshaw workers with alternative employment, implementation of land reform and fixing fair wages for farm labourers, providing free electricity to farmers, opening direct procurement centres for paddy, and later, farmers' markets to free them from the clutches of intermediaries, free education to all up to Class 12, nationalisation of bus services to promote 'last mile' connectivity, and expansion of the public distribution system to cover the whole state and provide the poor with subsidised rice, sugar, kerosene and wheat.

While there was a scheme for the urban poor to obtain housing via the Slum Clearance Board (renamed Urban Habitat Development Board in 2021), the rural poor had no access to better housing until 2006. A census of all rural poor (thatched roof, mud walls) found that 22 lakh houses were of this nature; only 0.3% were from 'forward' communities, reflecting the role of caste in perpetuating disadvantage. The GoTN decided to build better houses for these disadvantaged people, and in the first year, 2010–2011, built 4 lakh houses, since when the scheme has remained dormant.

Of all the schemes were designed to ameliorate the conditions of the disadvantaged classes, the villages of equity (*samathuvapuram*), named after E.V. Ramasamy – fondly called 'Periyar' in Tamil Nadu – was the most ambitious. The Samathuvapurams envisaged the creation of a casteless and classless society by bringing together people from diverse groups within a geographical area to live as one community and demonstrate social cohesion as a way to challenge structural barriers that inhibit progress and inclusive development. These villages were built across Tamil Nadu, each with 100 houses. The experiment failed, however, owing to continued inter-communal clashes and human frailties that allowed hierarchies and social systems to obstruct higher-order goals.

More recent attempts to address food insecurity include the Amma kitchens initiated by former Chief Minister Dr J. Jayalalitha. In 2021, Chief Minister Stalin launched three critical schemes, two of which are Illam thedi Maruthavam and Veedai Thedi Kalvi, which focus on health care and education, both essential to equitable standards of living. The third, not yet implemented, to set up Kalaignar Unavagam canteens across 500 locations to serve the most disadvantaged, including homeless persons, along the lines of the Amma kitchens, will help eradicate hunger, one of the main goals of the SDGs. In 2021, GoTN won the State Award for its impressive and sustained efforts in supporting the rights, needs and aspirations of persons with disabilities. (Award for Tamil Nadu for empowerment of persons with disabilities,The Hindu, 2021).

C. 1 Government of Tamil Nadu's responses to the needs of homeless persons with mental health issues

C. 1 a. State-led community and hospital-based support services

Tamil Nadu has 15 corporations, 121 municipalities and 528 town panchayats; 48.45% of the population live in urban areas (Census of India, 2011); and 12,525 villages spread across 37 districts. Every village has a panchayat responsible for grassroots-level governance. Corporations and municipalities are further divided into zones. The DMHP operates across all 37 districts and largely focuses on early identification of those in distress, facilitating referrals to the tertiary Psychiatric Care facility at the district headquarters. Block-wise psychiatric services are provided through satellite clinics and mental health camps; most WHO-listed essential drugs (WHO, 2000) are available in the tertiary facilities and in Departments of Psychiatry at Medical College Hospitals. The PHCs that serve persons with common mental disorders are fully operational, with most treatment and admissions restricted to district or block-level health facilities or when clinics are run as camps. For those seeking hospital admission, beds are available across 320 Psychiatric Departmental Units at the district level. The Institute of Mental Health (IMH), founded in 1871 and now has 1,800 beds, is the state nodal agency for mental health in Tamil Nadu. It reaches 800 homeless people with mental illness each year, and runs an out-patient service for 300 patients a day. Until 2018, beds for homeless persons were available only at the IMH, since admissions at the district level required the presence of attendants and there are no beds for persons with mental health issues at the block or primary care levels.

C. 1b An era of reforms

There have been several reforms initiated alongside the Rights of Persons with Disabilities Act (RPDA) and the Mental Health Care Act (MHCA) 2017 as Institute of Mental Health (IMH), Chennai transitioned from operating as an asylum to a mental hospital. The IMH made many improvements in terms of staffing, training, infrastructure, sanitation and nutrition. It plays a major role in rehabilitation and reintegration as a nodal centre for DMHP.

Further, focus on livelihoods and social mixing was adopted as integral to its care systems, with the introduction of ‘Rvive café run by its service users; this also operates as the nodal centre of rehabilitation alongside other skill and vocational training options. Collaboration with diverse civil society partners to ensure adequate after-care support has also advanced the vision of the Institute. In addition, provision of UDID Cards and issual of Disability Certificates have also been facilitated. Attempts to initiate independent housing for clients with long term needs has also been piloted since 2018.

C.1c Dedicated services for Homeless Persons with Mental Health Issues

In what may well be a first in India, HPWMI were admitted into district hospitals through the creation of Emergency Care and Recovery Centres (ECRCs), an initiative of the National Health Mission (NHM) and the Department of Health and Family Welfare. This facilitated the integration of care options for homeless persons into general hospitals rather than dedicated mental health facilities. In rural areas, people affected by severe mental health issues have benefited significantly from this initiative. The DMHP now runs the ECRCs in13 districts, in collaboration

with the IMH, The Banyan and several non-profit organisations, serving approximately 1,000 people each year.

In 2013, the Shelter for Urban Homeless (SUH) Scheme was launched under the National Urban Livelihood Mission (NULM), later renamed as the Deendayal Antyodaya Yojana (DAY). It provides shelter and other essential services to the poorest urban population, including the homeless. These shelters are also intended to create linkages with other departments such as housing, health, education and social welfare, to foster inter-departmental convergence, and to provide of various essential entitlements help improve the quality of life of individuals, families and communities to break the legacy of historical and intergenerational marginalisation. The GoTN has sanctioned 242 shelters across the state, of which 176 are currently active and house 11,747 persons, including an estimated 35% who experience psychosocial distress. Though intended to serve mainly as night shelters, in view of the multidimensional needs of homeless persons, special shelters were created that allowed for the provision of psychiatric care. These services may be offered until a transition may be made to longer-term care and/ or more stable forms of housing and living. Greater Chennai corporation runs 53 shelters, of which five are exclusively for homeless persons with mental illness and can accommodate approximately 250 people.

Rehabilitation homes –There are 53 long-term rehabilitation homes with a total of 2,750 beds run by the Department of Welfare of Differently Abled for Persons with Mental Health Issues. These offer medical and psychiatric support, but only limited options for livelihoods or community-based rehabilitation or community living.

Civil society responses and partnerships with government – There are 82 registered mental health institutions in Tamil Nadu, although only a few work with people who are homeless or from disadvantaged backgrounds. As stated above, CSOs such as The Banyan run ECRCs for around 500–800 homeless persons with mental illness every year; The Banyan also provides outreach services, patient care and 'Home Again', an inclusive living option that supports persons with long-term mental health needs. These services are managed by mental health care teams, community mobilisers, social-care coordinators and peer leaders and managers. The Banyan also provides out-patient services for 2,500 persons from disadvantaged backgrounds, with antecedents of homelessness.

Schizophrenia Research Foundation (SCARF) is another CSO in Tamil Nadu, which has undertaken pioneering research and offers services to persons from low-middle- and middle-income groups. SCARF and The Banyan also run tele-counselling services. SNEHA Suicide Prevention Centre offers a 24/7 suicide helpline, and the TT Ranganathan Clinical and Research Foundation offers de-addiction services for those with problems of substance abuse. Udavum Karangal and The Missionaries of Charity have been supporting the needs of HPMHI since the early 1980s and assist thousands of ultra-vulnerable people with mental health concerns annually.

Among those who partnered with the government's scaling up of the ECRCs are Chellamuthu Trust (Madurai), Brothers of Charity (Sivagangai), R-SOYA (Tirunelveli), Atchayam Welfare

Trust (Erode), Nilgiris Adivasi Welfare Association (Nilgiris) Anbalayam Society (Tanjore) and Arulmigu Prasanna Venkatachalapathy Temple Trust (Gunaseelam, Trichy), Anbagam and Udavum Ullangal . Chellamuthu Trust is a leader in Madurai District and provides mental health care for disadvantaged groups through shelters, emergency care centres, out-patient clinics, as well as in research and teaching activities, and contributing to human resource development. Similarly, SCARF and The Banyan Academy, in partnership with local and international collaborators, offer certificate and diploma programmes to enhance skills in the mental health sector.

After-care services to prevent recurrence of mental ill health and homelessness – There has been greater convergence between health and social-care sectors over the past decade with access to citizenship rights, social entitlements and financial inclusion being integrated into care packages offered by the GoTN as a collaborative effort between the Departments of Health and Family Welfare, Disability, Social Welfare, Social Justice and Empowerment, and supported by CSOs. These address the social determinants of mental ill health and ensure access to food through the Public Distribution Scheme (PDS); access to optimal financial support through the disability allowance and access to the DMHP to enable uninterrupted access to psychiatric care. Recurrent ill health among those with histories of homelessness is fairly common, so these protective factors such help individuals attain some stability. Similarly, access to citizenship rights enables HPMHI to participate in the socio-cultural and political spheres. Table 1 summarises the departments and schemes available for HPWMI.

Table 1. Intersectoral coordination between departments to serve HPWMI

	Department of Health & Family Welfare	Welfare of Differently Abled Department	
		Budget	Services
	District Mental Health Programme Institute of Mental Health De-addiction Centres Chief Minister's Comprehensive Health Insurance Scheme Ambulance Services (102)	30778.44 (Lakhs) 48 lakhs 381.36 (Lakhs) 5 Lakhs 50 Lakhs 2045.11 (Lakhs)	● Allowances for differently abled persons (severely affected) ● Personal Assistance allowances to differently abled persons with high support needs ● Self-employment, micro-enterprises and bunk stalls ● Prime Minister's employment-generation programme ● Assistance for establishment of Aavin parlour by differently abled persons. ● Unemployment allowance to all categories of differently abled persons who have registered at employment exchanges.

		97.14 (Lakhs) 475.94 (Lakhs) 7.50 lakhs 59.50 (Lakhs)	● Assistance for differently abled persons to marry ● Home for the mentally ill persons ● Scheme for rescuing and admitting mentally ill persons in psychiatric hospitals/Rehabilitation homes ● State resource-cum-training centre for differently abled persons
National Health Mission		Department of Social Welfare	
Budget	Services	Budget	Services
	Emergency Dare and Recovery Centres	135 (Lakhs) 625.89 (Lakhs) 188.13 (Lakhs) 62.47 (Lakhs)	Sathyavani Muthu Ammaiyar Ninaivu Free Supply of Sewing Machine Scheme Government Service Home Government Working Women Hostels Indira Gandhi National Disability Pension Scheme Differently Abled Pension Scheme
Corporation of Chennai			Department of Housing
Budget	Services	Budget	Services
	Shelter for homeless mentally ill		Housing reservations for people with disability
Rural Development & Panchayat Raj			
Budget	Services	Budget	Services
	MNREGA – Socioeconomic development programme Indira Awaas Yojana – 3% reservation for PWDs **Indira Awaas Yojana**		

Professionals in the mental health sector – While services for homeless persons with mental illness are located across various departments (shown in Table 1), along with City Corporations and District Collectorates, better structured and clearly outlined intersectoral coordination would improve outcomes for the service users. Shortcomings in coordination may be due to lack of staff and different levels of departmental engagement. In relation to mental health, India has 0.3 psychiatrists, 0.07 psychologists, 0.07 clinical social workers, and 0.12 psychiatric nurses per 1 lakh population (Mental Health Atlas, 2017). Meanwhile, the DMHP in Tamil Nadu has significant number of vacancies, mainly, social workers and psychologists, meaning that care remains largely bio-medical, with limited focus on social health; this staff shortage is especially critical if the problem is viewed through a social or psychological prism. The national treatment gap in India is estimated at 83%. To bridge this gap, there needs to be a shift from addressing gaps in treatment to shortfalls in care, based on each person's needs. This will call for broader and more diverse conceptualisations of care teams and responsive frameworks, which in turn depend on multi-stakeholder dialogue, participation and collaboration.

In this regard, Tamil Nadu has established a State Mental Health Authority (SMHA) with representation from diverse stakeholders such as psychiatrists, peer advocates, psychologists, caregivers, social workers and CSOs, etc. The SMHA is responsible for care audits, registration of mental health facilities, review of mental health professionals' compliance with the ACT, management of Advance Directives (AD), assigning nominated representatives (NR) as necessary, and grievance redressal. Similarly, 13 district Mental Health Review Boards (MHRBs) have been established; 281 mental health facilities are registered with the SMHA, although only a few engage with homeless persons with mental health issues.

Focus on livelihoods – Tamil Nadu has also fostered a culture that places the needs of persons with disabilities at the centre of its development agenda. People with psychosocial disabilities have been served by various schemes including the Pudhu Vazhvu Thittam (PVP), funded by the World Bank. Following a unique approach, between 2012 and 2016, the PVP scheme focused on care in the community, social inclusion, access to livelihoods and formation of support groups. Unfortunately, this came to an end with the termination of World Bank funding. Similarly, Tamil Nadu was the first state in the country to create and implement employment schemes for persons with mental health issues through the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGA). Through a Time and Motion Study conducted in 2012, the GoTN made the case for engaging them in MNREGA work, with reasonable accommodation, in keeping with the core tenets of the UNCRPD. The Tamil Nadu model was recognised by the Central Government and replicated in other states. Currently 71,099, people with disabilities, formerly HPWMI, access the MNREGA. Greater focus on livelihoods is imperative to address the social determinants of mental ill health by focusing on social roles and participation.

Section D

Situational Analysis of Homelessness and Mental Health in Tamil Nadu

There have been very few studies on the situation of homeless people with mental health issues in India, although most on India and elsewhere underline the role of social disadvantage in perpetuating conditions where homelessness intersects with mental ill health. While most focus on causal pathways, or models that address complex needs or prevent recurrence of homelessness, only a handful go into detailed data and information on the nature of structural barriers and distress.

The Tamil Nadu Policy for Homelessness and Mental Ill Health needs to be informed by local narratives and experiences of street populations living with mental health issues so that recommendations and services address unique and diverse realities in the real world. For this reason, a mixed-methods study was undertaken, from which this section presents some illustrative vignettes.

D.1 Description of the study: methods and approach

A mixed-methods, rapid appraisal of homelessness and mental health in Tamil Nadu was undertaken in October 2021, focused on Chennai, Chengalpet, Tiruvallur, Sivagangai, Trichy, Tanjore, Erode and Coimbatore. The objectives were:

1. To understand the presence of mental ill health among homeless people

2. To examine living conditions and access to basic amenities

3. To explore pathways into homelessness among those with mental health conditions or those experiencing psychosocial distress

4. To explore expressed needs among homeless people

5. To inform policy on services and initiatives that may better address those trapped at the intersection of mental ill health and homelessness

The study aimed to interview homeless people, in particular those with multiple mental health needs. For the purposes of the study, the homeless population was defined as:

> Persons who do not have a roof over their head, live in temporary structures either self-owned or rented, but instead live and sleep at pavements, parks, railway stations, bus stations, places of worship, outside shops, under bridges and other places under the open sky or places unfit for human habitation.

Among homeless people, there are many degrees of vulnerability and disability. For instance, there are single women with children, persons with severe mental health issues, or in psychosocial distress, those with a physical disability and elderly people suffering from debilitating conditions. The diverse population was broadly categorised as those with a clinical mental health issue and those in psychosocial distress. Table 2 shows the categories of homeless people considered in this study.

Table 2 Categories of homeless people

	High / Low	Mental Illness (Present / Absent)
Homeless population with mental illness	High mental health ramifications	Present
Homeless population in psychosocial distress	High social with psychological ramifications	Absent

Purposive sampling was used with data collectors using their judgement to recruit appropriate participants, and 240 participants were interviewed. Table 3 shows the districts and number of participants in each district.

Table 3 Interview sample by District

District	N
Chengalpattu	34
Chennai	67
Coimbatore	26
Erode	16
Sivagangai	31

Thanjavur	7
Thiruvallur	29
Trichy	30
Total	**240**

In compliance with research ethics involving human subjects, the study proposal was approved by The Banyan Academy's Research Review Board (RRB). Participants were informed about the purpose of research and of their right to confidentiality and to decline to respond to any or all questionnaire items. Informed consent was obtained from all participants prior to the interview – either written or verbal – and personally identifiable names or details were removed prior to analysis

Trained data collectors conducted interviews were over a period of five days, most of them teams at the ECRCs with either with a Master's in Social Work, or trainees, plus an intern at the School of Social Work, Kumaraguru College of Liberal Arts and Science (KCLAS). A semi-structured interview schedule was used, along with a checklist to record qualitative observations. Data were entered on paper and uploaded via cloud-based software. Qualitative summaries of the interviews were prepared along with detailed observations for selected participants. The daily debriefing informed the selection of participants for whom qualitative case vignettes were prepared.

A focus group discussion (FGD) with seven participants was conducted after the interviews to elicit nuances related to the observed experiences of homelessness and mental health, and to confirm the criteria for categorising homeless people on the basis of their diverse psychosocial needs.

D.2 Data analysis

Data were divided into the two categories of homeless people described above. All participants meeting mental health criteria were first assigned to Category 1 (homeless population with mental illness) and those meeting specific psychosocial criteria classified under Category 2 (homeless population in psychosocial distress) (see Table 4).

Table 4 Criteria for categorising sample

	Criteria	Mental Illness (Present / Absent)
Homeless population with mental illness	Mental Illness – including substance use	Present
Homeless population in psychosocial distress	Homelessness due to death of the primary family member, Hansen's disease, physical illness, lack of family support	Absent

A senior researcher categorised the open-ended questions with free-text data. Quantitative data were examined using SPSS, with frequency and percentage for categorical variables and mean/median with standard deviation/range for continuous variables in order to understand the socio-demographic profile of the sample. Two senior researchers used content analysis to identify relevant themes and to prepare case vignettes.

D.3 Findings

D. 3a Socio-demographic profile of participants (n=240)

The majority of the sample (43%) were aged between 41 and 50 years, followed by 61–80 years. More men (56.7%) were surveyed than women (43.3%). None of the respondents expressed genderqueer identities, and no trans people were interviewed. Caste data were not available for 47.5% of the respondents, with 15% choosing not to disclose their caste, fearing discriminatory repercussions of such disclosure. Educational attainment was low with 65% never receiving formal education and 56.7% were not in employment.

While most (75.4%) noted their religious affiliation as Hindu, this was found to be fluid among the respondents. Religious practice was of particular interest to a number of homeless individuals in this sample, and religious place of accommodation were said to be non-judgemental, gave them a sense of identity, safety, and provided their basic needs such as food. Some respondents viewed religion and spirituality as distinct domains, so although they had been born and raised in a particular religion, homeless persons in this sample embraced

other religions whose institutions had offered them shelter. This experience was more pronounced in certain districts such as Chengalpet, Trichy and Sivagangai, where there are faith-based responses and sources of support for homeless people.

Overall, 37.5% respondents had disabilities. Disability associated with Hansen's disease features prominently in the Coimbatore sample, where people from various parts of Tamil Nadu with the condition congregate at Maruthamalai, a religious destination.

Of 240 people in the sample, 59 (24.5%) were reported to be living with a mental health condition, broadly categorised as psychosis (31), substance use (19), depression (5) and adjustment-related conditions (4). No systematic screening tools were used, but clinical social workers on the team assessed possible mental health conditions. Qualitative data of symptoms elicited were recorded and senior clinicians verified the categories of mental health conditions.

There were significant differences in the type of homelessness between those with mental health conditions and those in general psychosocial distress among respondents. While most reported being chronically homeless (49.6%), episodic homelessness was reported more by those living with a mental health issue (33.9%), and transitional homelessness was experienced more by those in psychosocial distress (29.8%).

D. 3b Access to basic amenities

People relied on religious institutions and non-profit organisations, which intermittently distributed cooked food; 54.2% of respondents reported serious food insecurity. Access to toilet facilities was limited, with 47.6% being unable to afford paid facilities on a regular basis.

Of those with serious mental health conditions, 98% have not sought any form of treatment, indicating persistent care gaps for homeless people despite the availability of services. Some of the qualitative aspects that emerged in the interviews to explain the gaps in access to health care, notwithstanding the widespread the public health system in Tamil Nadu, included pregnancy and physical health conditions – including associated disabilities, such as Hansen's disease. Reasons cited include out-of-pocket expenditure, delayed availability of treatment, caste-based discrimination at health services, disenfranchised status especially among intergenerationally homeless people, lack of immediate and favourable outcomes, and becoming a non-earning family member due to illness. Among those with disabilities, less than 5% had disability cards and associated benefits.

D.3c Pathways to homelessness

The qualitative data show that respondents highlighted multiple factors leading to homelessness. Prominent themes explaining homelessness reveal that while there were immediate precipitating reasons – such as mental health issues or family conflict – these occurred against a background of preceding critical life events and social disadvantage, particularly experiences of caste- and gender-based oppression.

Caste featured significantly in the narratives of homelessness. While generational difficulties sustained poverty, continuing discrimination and oppression excluded them from obtaining better life opportunities (see Case Study 1: Nanthiya). Caste-tied occupations, instability and the informality of such labour also led rural people to migrate in the hope of better, more dignified livelihood prospects only to encounter similar stereotypical jobs and more complex barriers associated with urban poverty (see Case Study 2: Sengeni).

Case Study 1: Nanthiya

Nanthiya and her family are among about 50 households from the Narikuravar indigenous people who live under Anna Nagar bridge. The conversation takes place under a tarpaulin precariously held together by makeshift poles while Nanthiya cooks. Her four-year-old son is the interpreter for the day, expertly translating important words from their language into Tamil.

The entire family, including the child, is engaged in collecting and selling scrap iron. 'We earn and live by the day. We make Rs 20-100 each day', she says. The family cannot pursue other forms of employment, rent housing, or even obtain basic health care, because of caste-based discrimination.

Caste oppression pervades every aspect of their life. Criminalised during colonial rule, although the Narikuravars were denotified in 1952, the legacy of stigma and oppression of their community still persists. Their traditional occupation of hunting jackals, rodents, and other small game, ostracised by caste Hindu society, has been replaced with bead-making, sanitation, or other forms of work related to waste. Like most in her community, Nanthiya spent her childhood without a home and had no access to formal schooling. Bureaucratic classification of their indigenous community under Most Backward Classes (MBC) has distanced them from several affirmative action and social policies accorded to Scheduled Tribes, which could have altered life trajectories. She tells us that caste determines hierarchy and access to resources even among the homeless. Unspoken rules enforce boundaries between highly valued pavements and the low-ranked ones where Nanthiya and her people are permitted to live.

Nanthiya says she faces additional barriers as a woman. She emphasises the indignity she encounters daily when navigating the few facilities available for essential privacy. She avoids using paid toilet facilities that charge about Rs 30 more than once a day. Managing menstruation is particularly hard, and Nanthiya has to use the same pad for two days. She recalls receiving support from the Anganwadi worker during her first pregnancy, but her children have not been vaccinated and have never been to school, continuing with the same intergenerational narrative of inherited vulnerabilities.

Nanthiya seeks nothing more than a house that she can call her own, 'enooda veedu', because a roof over one's head is also an identity that could bring stability to the family and their lives.

Case Study 2: Sengeni

Sengeni says repeatedly that she would never lie, while asserting that she travels every day from Pollachi to hang out for free food packets. She says she takes these home for her two orphaned grandchildren and her ailing husband, who was left without work and incapacitated after a bout of tuberculosis. She is as old as the buildings along Ukkadam bus terminus. When the foundations of those buildings were laid, her parents brought her to Coimbatore from Pollachi. Her father was a sanitation worker for the municipal corporation, mainly working along the goldsmith's road near the town hall, while her mother sieved waste and dust from drains to separate gold dust.

When she was married at the age of 12, Sengeni eventually left for Mumbai, and ran a tea stall near VT for 20 years. She says they decided to return to Pollachi as they were exhausted with constant fights with the sister-in-law. For some years, she worked as a rag picker, as many from the Arunthathiyar caste do, before her husband's illness made it difficult to engage in any sort of employment. There is no dearth of food in her current place of choice, by a platform behind the general hospital. It is very close to safe sleeping spots, which she says are very important for homeless women, who face sexual assault irrespective of age. She carries around a large stick for safety. In this stretch between Ukkadam, the town hall, and the government general hospital, plentiful food is available, and there are paid toilet facilities that may be used sparingly. Several people distribute clothes, some stop to have a chat, school-children give small change, while people who alight at the nearby bus stop give her some notes, which are enough for her to get by. She describes a recent incident where two women, a mother and daughter perhaps, waved at her from the car and sat down to have a conversation. Sengeni appears to have some form of neuropathy and complains of burning sensations in her feet and her arms – she uses a piece of cloth for compression on one of her feet on the doctor's advice.

Sengeni is curious about the purpose of the conversation and seeks to ascertain our intentions. She hopes we are not among the many people who repeatedly come to take her to a shelter. She points out a couple of other places where we could speak to homeless women – one of them she says has a mental health issue. She shows her Aadhar card, and we learn her name is Papathi, not Sengeni. The Aadhar card is offered to anyone who comes to take her to a shelter as proof that she has an address. We then learn that there is probably no home, husband or grandchildren to return to, but treating the past as the present serves to protect her freedom. Sengeni insists the only thing people like her need is a ‘no-questions-asked’ space where they can put their bedding and belongings to sleep for the night.

D. 3d Health conditions compounding poverty and the drift into homelessness

Developing chronic or stigmatised health conditions that require significant out-of-pocket expenses on travel and follow-up featured strongly among the precipitating factors for homelessness. The family’s reluctance to provide care was a dominant narrative in the background of poverty, especially when a person became unemployed as a result of the health condition (see Case Study 3: Ramasamy). When someone re-married for companionship and

social support, typically among men, the spouse also became homeless as families rejected them (see Case study 4: Anbuchelvan and Mathukai).

Case Study 3: Ramasamy

Ramasamy is among the many who occupy footpaths around the general hospital. In his early 70s, he was a gold jewellery craftsman who migrated from Thanjavur to Coimbatore as a child, along with his family. Their community and practice traces back to the Chola era and he quotes several temples that have jewellery crafted by his ancestors.

About 20 years ago, with the advent of mechanised jewellery and what Ramasamy describes vaguely as a series of poor choices in addition to gold price fluctuations, he incurred serious losses and moved into the security sector, working in several industries. Family strife accompanied this descent into economic distress. During one such placement, he came too close to some welding in progress and lost his sight as result of the injury. Despite treatment at Aravind Eye Hospital and subsequently the General Hospital, he never recovered his vision. This strained relationships with his family further and he was forced to move out about three years ago. He has several friends at the general hospital, contacts who help him get the basics. He receives financial support from the general public, church-goers from the adjoining church, a friend in the police, with which he meets some of his needs such as medication. Several individuals and NGOs are involved in distributing food packages and he manages at least two meals every day. Toilets and bathing facilities (available for a small fee) are inaccessible, at least 2 km away, and unreliable since they cater for large numbers of people. A couple of weeks ago, one of his bags with all his documents such as Aadhar, Voter ID, Ration Card, eye operation documents, bank passbook etc., along with all the money, was stolen.

His experiences during a 20-day stay at a shelter were not great, mostly because of excessive restrictions (no going out, not even one ‘beedi’ a day, restricted tea times, restricted food choices) limiting mobility and a range of choices. He asks why call it home for the elderly when it is actually jail. He believes the government should focus on creating spaces with safe sleeping arrangements and lockers without unreasonable restrictions on liberties.

Case Study 4: Anbuchelvan and Mathukai

Anbuchelvan and Mathukai are a couple in their 50s who have lived for the last six years at a bus stop, with some support from the shopkeepers in the vicinity. Anbuchelvan developed Hansen’s disease as a young adult, which caused a progressive deterioration of his vision and led to the loss of three fingers on one hand. Mathukai is his second wife. Anbuchelvan converted to Christianity so that he could marry her in a church as she desired. It is indicated that his adult sons never accepted the partnership, leading to constant conflict with the couple. At some point, the relationship appears to have disintegrated, and the couple was abandoned. They are reluctant to elaborate more, perhaps not wanting to relive the trauma and pain.

The couple are devoted to each other, and Mathukai spends most of her day caring for Anbuchelvan with the scarce resources they have. Collecting bottles, clothes, and other scraps that may be traded for money, they depend on the generosity of nearby shops and religious institutions for food. But navigating the environment with the constant need for support is challenging for the couple and exacerbates Anbuchelvan's disability. They seek stable accommodation and employment that can help them escape their predicament. The fear of being chased away by the police occupies their mind constantly. They recall a particularly harrowing encounter with the police, which ended only with the advocacy and support of people who run small businesses nearby. Anbuchelvan says, 'We constantly dread our lives when the cops patrol at night. We are threatened with the long lathi and asked to leave the bus stop, the only home now. There is no other place for us to stay'. Religious values and affiliation have been a positive and protective factor in this homeless population who have lost most support systems and in the process of rebuilding these from existing resources.

D. 3e Disruptions and erosion of social support due to family conflicts or the death of significant family members

The death of significant family members was prominent among homeless people with serious mental health conditions (see Case Study 5: Mugai). Among those who were using harmful substances, narratives centred around family conflicts, repeated encounters with the police and affiliations with groups of substance users and their sub-cultures. In some instances, substance use and the associated conflicts resulted in the family becoming homeless, with serious consequences for women whose partner was the substance user (see Case Study 7: Kaliyamma). Domestic conflicts were a recurring theme among reasons contributing to homelessness from childhood to adulthood (see Case Study 6: Karikaalan), with respondents reporting being abandoned or running away from home with friends in order to escape unrelenting domestic discord, which often ended in serious physical abuse.

Case study 5: Mugai

In 2021, the Kumbakonam police found Mugai, lying in a pool of blood with a new-born baby beside her. She was rushed to the General Hospital, where she received treatment in the Intensive Care Unit (ICU) and was referred to the ECRC for her mental health needs. The initial days were difficult for Mugai, with her mind clouded yet fresh with memories of the traumatic experience of giving birth on the streets. With time and healing, as she began to reconnect with the world around her, Mugai revealed details of a childhood of adversity. Her narrative, pieced together with several disconnected details, starts with her mother's death when she was barely 10 years old. Left with a neglectful father with harmful substance use, who prioritised his needs over Mugai's safety, she experienced overwhelming grief and loneliness that cascaded into a mental health condition at a very young age. While her father attempted treatment at various places, Mugai's life was punctuated with several episodes of wandering away from home in search of a supportive environment. She recalls going away with strangers in the hope of friendships to fill the emptiness she had been feeling since the loss of her mother. One such

episode of wandering away from home during the pandemic left her homeless for over a year, during which she was repeatedly sexually assaulted.

Mugai wants to see her baby but does not wish to raise the child. She finds it difficult to reconcile the experience of giving birth in public and the sexual violence that precipitated this absolute violation of her being. She sometimes ponders on what life may have been had her mother lived, 'If my amma had been alive, I would not have landed up on the streets or fallen into hands of scavengers who prey on women like me who do have any support'.

Case Study 6: Karikaalan

Karikaalan has been homeless for over 50 years, but in a departure from the dominant narrative of poverty to homelessness, he had an affluent childhood as the only son of a wealthy industrialist with over 40 weaving units. After the death of his parents following a prolonged illness when he was only 15 years old, the other family members conspired to usurp all property and threw Karikaalan out of the house. Still an adolescent, Karikaalan did not know where or how to seek support and ended up taking shelter in a Shiva temple. This proved to be a definitive turning point, and Karikaalan has devoted his entire life to the worship of Shiva. His quest for Shiva and his ardent devotion have taken him to several places in India. Travelling mostly by foot, sometimes by bullock carts, from Thirunallar to Kedarnath to Badrinath to Kashi, there is no Shiva temple that Karikaalan has not explored. The visit he most treasures is to Badrinath and being in the presence of the River Ganga.

For the past 15 years, he has taken refuge in the Shiva temple at Chennai. He relies on the generosity of the temple, the general public who visit for blessings, and hotels nearby. Karikaalan wonders about the point of a life that is spent simply on working and earning money. Emphasising his choice of frugality, and contentment despite no material possessions or comforts, he says, 'Over these years, I have learnt how to not to feel hungry, so I can go without food for days. So how much is too much when you are homeless?'

Case Study 7: Kaliyamma

Kaliyamma and her husband are among the many devotees who throng the Goddess Mariamman's temple in Thanjavur in search of abundance and prosperity. Such is the famed prowess of the Amman that people travel hundreds of kilometres to seek her blessings and favour, to be rid of difficult life circumstances and diseases, for the land to be gifted with rain, humans with fertility, and to usher in new beginnings.

Like many women of her social circumstances, as a child Kaliyamma believed her eventual marriage would be to her maternal uncle. She says she fell in love with him and recollects the days they spent together as friends when they were growing up. Convinced that they were

meant to be together, Kaliyamma persuaded her parents, and soon she was married to her *mama*. Unfortunately, her husband's alcohol abuse led to several conflicts and disruptions in the relationship with her parents. She recalls the day they were kicked out following a brawl between her mother and husband over his drunken behaviour. Kaliyamma suffered a stillbirth soon after, an event that followed severe financial difficulty, trauma, and stress of loss and homelessness.

Bereft of hope and left with limited options, the family sought refuge on the pavement opposite the temple, hoping that the Goddess would support them through all adversities. In the two years since they arrived, Kaliyamma has one child and is currently seven months into her second pregnancy. The family relies on the temple's Anna Daanam for food and other facilities, which are available intermittently. Kaliyamma's husband continues to spend the little of what he earns, through unstable daily wage employment, on alcohol. She is malnourished and weak, with little or no information or support for her health needs or those of her toddler. She often stops to catch her breath or to seek the right words, too weak to sustain a conversation. Despite the huge distress and hardship, Kaliyamma's faith has not wavered, 'My children, mama and I will be safe in the hands of Mariamma Aatha. Even though we struggle with basic needs, this temple and Aatha will provide for us.

D.3e Gender-based oppression and intersections with poverty and caste contribute to homelessness

Women sought to escape cycles of violence, especially committed by their intimate partner, by leaving home for the streets. Narratives highlight their preference for autonomy rather than living in a controlled environment with their family or in an institution (see Case Study 8: Vaini). Women from disadvantaged castes living in poverty or intergenerational homelessness faced sustained institutional discrimination and systematic exclusion from access to entitlements including health care (see Case Study 9: Avini).

Case Study 8: Vaini

Vaini recalls when she worked at a chocolate factory, where she spent every minute immersed in the aroma of fresh cocoa, and luscious chocolate poured and moulded in various shapes. These are distant memories of a somewhat happier life, filled with a measure of independence and agency. In her current life, Vaini is no longer employed or housed. She spends most of her days sitting in front of a dargah at a coastal town in Tamil Nadu, finding solace in prayer and friendships with others like her who live there.

Vaini detested formal schooling and dropped out in favour of working for the family from an early age. Brought up in a social environment that emphasised marriage as the ultimate life goal for a woman, she often dreamed of a perfect partnership that would allow her to finally escape difficult life circumstances. These hopes fell apart within minutes of her marriage at the age of 18 to a man who relentlessly abused and violated her.

After her marriage, she was coerced to relinquish all agency and independence. She could not work, think for herself or even communicate with anyone besides her spouse and in-laws. Every aspect of her life was monitored and controlled; every day was filled with verbal and physical violence. She dreaded each day and sought several ways to end the violence, including suicide. The thought of her children – two sons and two daughters – kept her tied to the marriage for several years despite the trauma. Her body stands witness to this daily abuse she suffered for years with cigarette burns and bruises.

It is unclear how or when Vaini left home for life on the streets. Possibly the effects of the unrelenting violence on her mental health are indicated in the way she presents herself. Perhaps overdressed for the context, Vaini speaks rapidly as if ideas and words are rushing through her brain. Did she ever consider treatment at a mental health facility? The question is met with an immediate, resounding rejection of any such prospect as it resonates with the authority and control, she experienced in her marriage. In her current life, albeit homeless, she has found freedom from physical and mental suffering, safety and support from a close-knit group of friends with similar histories, and most importantly, solace. Vaini believes that it is 'better to be homeless than to get thrashed by my husband every day. Do publish my story in a local magazine or newspaper so that women like me don't fall into such traps'.

Case Study 9: Avini

Avini, barely 23 years old, cares for five children along with her husband and brother. Born homeless, her parents died when she was nine and she was brought up by her maternal grandmother. She recalls with fondness the moments she spent on her grandmother's lap, listening to stories of perseverance and the big world of opportunities. Avini and her then four-year-old brother travelled to several places with their grandmother, leading a largely nomadic life before settling as adults in their current location, a piece of land opposite a temple. She married a homeless man soon after, they have five young children.

Living in a tent precariously held together by odds and ends, Avini laments the lack of privacy she has faced throughout her life. This has become particularly difficult in relation to intimacy and the couple's sexual life. Avini and her family lack access to state entitlements or health care, barely meeting day-to-day needs as rag pickers. She gave birth to four of their children on the street; none has been vaccinated or received any early childhood education or schooling. Despite the insurmountable odds, Avini nurtures hope for a better future for her children, 'As a woman, I have delivered four children on the streets. Only I know the pain and struggle I went through during those times. Our existence is viewed as invalid because we are poor and homeless. But I'm hopeful that someday, my children will be educated, find better jobs and earn well. This is my desire'.

D. 4 Focus Group Discussion with homeless and formerly homeless persons with mental health issues

D. 4a Proneness to abuse, lack of access to basic amenities and safe spaces

Focus group discussions (FGDs) with formerly homeless individuals with mental health issues were conducted to draw on lived experiences and identify any additional themes besides those arising from the interviews. A range of questions elicited deep insights into the constraints and challenges posed by the experience of homelessness. Women with mental health issues are particularly vulnerable to assault and sexual violence. A US study on the incidence of rape among women with schizophrenia reported that 22% had been raped, two-thirds of them on multiple occasions (Darves-Bornoz et al., 1995). Women therefore are a much more vulnerable group requiring urgent attention and immediate access to safe spaces. Most women emphasised safety concerns and exposure to violence and abuse and the related feelings of fear and anxiety. Further, being unable to access public toilets or other basic amenities seemed to make their situation more precarious. Lack of food, hygiene products and clothing, especially during menstruation, presented particular problems. Even so, some women preferred living on the streets than in shelters since they feared being trapped in custodial institutions, and losing their ‘freedom’ and ‘sense of autonomy’.

D. 4b Need for dialogue and trauma-informed support against a backdrop of discrimination, prejudice and feelings of alienation

According to service users, psychological and social losses that affect self-esteem, as a result of shame, labelling and related ostracism, made the experience of re-entry into communities a somewhat Herculean task. Based on interviews and FGDs, measures to reduce stigma through awareness campaigns, testimonials and engagement of and with experts in lived experience, as well as professional public campaigns that help reframe the narrative on mental ill health, seemed inadequate. A culture of discrimination seemed the norm, often resulting in feelings of alienation and related trauma. The need for therapeutic approaches to counter these experiences seemed lacking in most in-patient hospital, shelter and rehabilitation-based services, thwarting people’s willingness to pursue their life goals, engage in a rewarding livelihood or cultivate feelings of hope. Care plans centred on services rather than on those needing them sometimes seemed to frustrate users’ hopes and pursuit of their capabilities and aspirations. Equally, many felt that access to a mental health professional, a peer advocate or a supportive service at times of urgent need and deep distress boosted their morale and reaffirmed their sense of trust in the government, society and supportive systems that were meant to empower individuals who had experienced disadvantage.

D. 4c Focus on social care, rebuilding identities and deeper community ties

FGD participants also believed that while drug treatment made a difference and was indeed imperative for effective care and recovery, equally social interventions helped end the perpetuating and impeding factors that prevented justice-oriented well-being frameworks. It was suggested that the enhancement of social capital required as much emphasis in mental health care as the reduction of symptoms. Participants believed that this would catalyse the rebuilding of ‘spoiled identities and stronger social ties within communities, essential to participation (Ding

et al., 2015). While access to livelihoods and welfare schemes that helped support basic needs were deemed essential to a healthy standard of living, notions of valued social roles and social capital were not restricted to work and financial security, and included healthy social ties and attitudes and enjoying a sense of agency and control. Most participants unanimously reinforced the need for lived experience experts to co-design interventions, a strong and much-needed foundation to promote and align with core tenets supporting local recovery movements.

Protective factors such as spirituality, the ability to engage in activities that helped offer the individual a sense of meaning, information symmetry, and enabling and nurturing support networks and groups seemed to inspire a sense of community and hope.

Table 5 Key findings from Focus Group Discussions

	Prompt / Probe	**Key Responses**	**Recommendations**
1.	Challenges living on the streets	**Safety** Fear of sexual violence Fear of physical belongings being confiscated and assault **Prejudice and shame** Fear of taunts and ostracism Labelling **Lack of access to basic amenities** Food Clothing Housing	**Creation of safe spaces** Government support system for HPWMI, especially women, who may become homeless due to interpersonal conflicts **Co-designing interventions** User-survivors can offer help to HPWMI on the streets **Social ties and sensitisation** Create awareness on mental health so that HPWMI are better supported; Government should take firm action on families who abandon or harm members suffering from mental ill health
2.	Overcoming challenges – what helps?	**Holistic approaches to advance personal recovery** Religious beliefs Spirituality	**Role of lived experience experts and support groups** Mental health service users

		Finding employment Acquaintances who offered support and inspired hope Building support circles and trusting relationships Faith that people are supportive by nature Music motivated 'me' and 'calmed me' Parents' love and decisions that supported them (thinking of it offered solace) Medicines, counselling and social care Access to employment Disability allowance or income support / enhancement Access to problem-solving support networks and referral services	sharing experiences and journeys of healing and recovery will help many in situations of similar distress
3.	What does mental illness mean to you?	**Compromised identity** Ill health that is precipitated by negative attitude of family members Being 'ridiculed' and taunted 'No safety in my own house' – where do I go? Being referred to as mentally ill even after recovery (hurts a lot) – 'spoiled identity' – should this be the case? Society and family do not see you as the same person any more after one episode on mental illness – prejudice	**Promotion of mental health** Effective sensitisation campaigns and testimonials, normalising mental illness, adequate depiction in mass media, disseminating success stories, engaging peer advocates in research and co- designing interventions and programmes, focus on neurodiversity and social mixing
4.	What does recovery mean to you?	**recovery perspectives** Freedom of speech 'Not being labelled' 'Beyond an illness perspective' Livelihood options based on skills and talent, as in every other case **Mental Ill health not an impeding factor in all domains of life**	**Sustainable and inclusive recovery options** To challenge views that exclude, segregate and continue to remain 'conformist' To challenge limiting factors

		Feelings of not being judged Mental illness not being attributed as key to every 'atypical', 'non-conformist', decision Independence and self-reliance Being like 'others' – need to form affinity groups and not feel segregated Physical and social mobility Ability to share and partake in each other's lives and form nurturing relationships Find a sense of purpose and meaning	in developing supportive interventions To look beyond short-sighted 'quick fix' solutions

Section E

Operational Challenges, Service Gaps and Recommendations

This section outlines some of the major general challenges and specific gaps in the services that are currently available to homeless persons with mental health issues in Tamil Nadu, and makes recommendations on how to address these.

E.1 Bio-medical versus holistic approaches to care

Too often, psychiatric practice focuses on short-term, quantifiable interventions, such as reducing symptoms and whether hospitalisation was reduced through drug therapy, without capturing 'culturally relevant social outcomes of recovery' (Kirmayer & Gomez-Carillo, 2018) to those who are affected. Kirmayer and Gomez-Carillo suggest that 'psychiatric research has tended to reduce illness experience to symptom reports, ignoring the bodily, narrative, and social embedding of illnesses. Symptom-oriented classifications, however, risk overlooking the complex causes, and the social, political, and economic forces that determine differentiated health outcomes, and predict the incidence and severity of mental illness. Social determinants are a leading cause of stress and the related exacerbation of ill health. Focusing on addressing the 'social' remains a challenge in India and globally. The culture of consistently pathologising distress and therefore resorting to medication as a first and perhaps most available remedy, results in short-sighted recovery plans that largely fail to address problems arising from diverse domains of a person's social and cultural life (Jain & Jadhav, 2008).Social care, counselling, 'talking therapies', problem-solving support, conflict-resolution, strengthening of relationships, social cohesion, cultivating hopefulness, addressing trauma, and so on – all shown to be integral to person-centred care – are seldom effectively integrated into plans for recovery, mental health or social inclusion.

The pernicious cycle of vulnerability and illness cannot be captured through a catalogue of symptoms, but requires a holistic intervention. Taking a holistic or 'whole person' approach in medical and social work practice contributes to the 'structural humility' of these professionals, enhances empathy, and uses the affected individual's and perhaps their community's 'own expertise and resourcefulness in resisting the structural violence that affects them' (Stonington, Holmes, Hansen et al., 2018: 1960). Understanding the existing sources of resilience within individuals and communities is therefore as important as diagnosing the symptoms, as it is through personal and collective resilience that medicine is made meaningful and congruent with the beliefs and values that define well-being and allow for a capacity to aspire and have hope.

In order to operationalise this approach, the DMHP and other mental health and social care services would have to structure their mental health teams differently and also collaborate actively with development-sector professionals, local stakeholders, and peer advocates in addition to mental health professionals – who would need to be drawn from a range of disciplines with equal status and roles in order to view mental health and community inclusion holistically.

E.2 Address intersectionality and the phenomenon of homelessness and mental illness

The urgent need to better tackle structural barriers and intersectionality (mutually reinforcing aspects of disadvantage and oppression), and thus to influence related policies and sectors such as education, social welfare, rural development, urban development, disability and housing, is particularly important addressing the nexus between homelessness and mental illness. Many studies have shown that adverse life events, abuse, domestic violence, poor social capital and a breakdown in support networks influence a descent into homelessness; as has a positive correlation between homelessness and trauma. Not all distress or systemic and structural barriers can be pathologized or viewed as static conditions; inequities and injustices also have their own dynamics in creating and sustaining disparities, under-privilege and disadvantage. It is essential to be aware of these dual realities.

E.3 Focus on psychiatric pluralism

The multiplicity of narratives, diverse conceptualisations and causes of mental illness, and a range of responses and models – from social realist to bio-medical, psychological to spiritual and social constructionist – it is important to emphasise pluralism in psychiatry and mental health care in care planning and policy development. Community-based care should incorporate flexible and context-sensitive practices that promote individual and social well-being, based on understanding how the individual and the social are critically interlinked (Kirmayer & Gomez-Carillo, 2018; Kleinman, 1988). It should also develop responses for a range of mental health concerns including for those who experience severe disabilities and refractory mental disorders.

E.4 The need for early identification, treatment and care

Childhood experiences have an impact on the incidence and severity of mental health issues among young adults. Epidemiological studies suggest that the onset of mental illness typically occurs at around 14 years of age. Despite evidence that the early identification and treatment of mental disorders influence a better prognosis, very few mental health programmes in India support children and adolescents. Pervasive stigma towards mental health and lack of accessible and appropriate services results in children and young adults experiencing distress and / or mental health challenges. This means that neither they, nor their caregivers, are receiving the support that they need. The period between the ages of 15 and 35 years, is often spent in and out of homelessness, forced incarceration and often in a drug-induced stupor that could have been prevented with counselling and other mental health support services in schools and colleges. This points to a vital need for psychological first aid and social support for those who experience bullying, caste-based discrimination, violence and scarcity. Social causation in mental ill health needs to be recognised and better understood, in order to set up support school and community circles, led by local self-governing structures, teachers, parents and youth/ students. Youth leaders who are informed and aware of mental health issues are as important as formal early identification strategies.

E.5 Issues of demand and supply

Demand currently exceeds supply in mental health care. Access to nearby and round-the-clock mental health care in an emergency, which thus avoids travel and the opportunity cost of having to take time off work, is not always available. The DMHP still operates primarily in a camp or satellite clinic mode, and initial consultations or follow-up care are usually limited to tertiary-level hospitals or special psychiatric clinics; mental health programmes at the block or village panchayat level are a rarity. Essential psychiatric drugs and long-acting medication that are known to have better outcomes are seldom available in PHCs. Without an effective transition of care to PHCs, with appropriate referrals as necessary, accessible care and treatment will remain a concern. Recurrence of homelessness and trans-institutionalisation are common among people who homeless and living with severe mental health issues, exposing them to further emotional distress and instability. To break this cycle calls for systemic changes.

E.6 Limited outreach options and crisis support

Outreach facilities are limited for homeless persons with mental health issues. Food and water are offered in some clusters three times a day in certain districts through the involvement of NULM Shelter coordinators (where they exist), mental hospital staff, and ECRCs or NGOs. However, the current approach to care is located between a shelter and a hospital. Conversely, outreach is an expansive concept, and needs to go beyond distributing hand-outs to include more interactions among various community members. For the state and society to collaborate in supporting the needs of this group depends on diverse and comprehensive responses. The absence of safe spaces and short stays, respite care, soup kitchens, well-being kiosks, skilling and placement centres, hostels, unemployment benefits, medical care etc. are current gaps in care plans with the potential to address the multidimensional needs of minority groups. This heterogeneity may also pave the way for greater civil society engagement and more opportunities for social mixing.

E.7 Crime and ineffective redressal mechanisms

Repeated instances (on which there are limited data in the public domain) of deaths/severe injury of homeless persons with mental health issues are seldom acknowledged or addressed with the commitment and urgency they deserve. Even when these people have been abused physically and sexually, and exposed to various atrocities and grave harm including theft, loss of valuables, assault, and even kidnapping of their children, their complaints are rarely addressed or the perpetrators brought to justice. Pregnancy and sexually transmitted infections (STIs) are common occurrences as people who are distressed or unwell are further exploited, with no access to legal recourse.

E.8 Poor observation of protocols when persons are admitted without their explicit consent

Although there are benefits to early access to mental health care, health care and social care, and HPWMI are victims of exploitation on the streets, the balance between safety and rights has always been delicate and complex from the perspective of service users. When a person's ability to use their agency and self-determination in relation to their well-being is compromised for brief periods of time, it is critical to maintain a focus on dignity and building trust. Offering care without the person's explicit consent does not necessarily translate into a negative or traumatic experience if this consistently addresses their needs and distress, even if honest communication is difficult. To see someone, die, wounds ridden with maggots, perhaps sexually abused, malnourished and exposed to harsh weather conditions is tantamount to neglect. There is much evidence of the potential gains of accessing care in order to enhance one's capabilities and freedoms, agency and self-determination. However, ad hoc coercive practices including 'drives' and 'rescue missions' are likely to have a negative impact on longer-term mental health outcomes and to generate fear, distrust, anger and trauma.

Conversely, sustained engagement with an individual in poor social health may influence better health-seeking behaviour over a period of time. This depends on establishing trust and confidence and strengthening facilities where the person obtains care, along with responsive practices and processes that are just, humane and open to uncertainties and complexity. While there is no perfect, a priority grid may help to distinguish between those who may need immediate care and those who experience a reasonable quality of life with community support and access to care in a form that they deem fit.

Sadly, as things stand, HPWMI fall in the 'no man's land' between health and social welfare, as a result of which they see outreach only as a function of benevolence or 'punishment', and the latter may result in neglecting individual dignity during the admission process, often accompanied by stark photographs of individuals in highly distressing circumstances, either naked and/or with severe injuries and infections. While there is a need to record a patient's status on admission in order to track their progress, sic photographs perpetuate stereotypes of HPWMI, encourage state and civil society alike to deny their basic right to consent, and build an environment of unchecked and unjust power structures that take away trust, openness, and foster learned helplessness. Taking photographs of homeless individuals who are mentally ill is just one example of the oppressive approaches that are prevalent in the 'rescue process'. This calls for developing care pathways collaboratively with (formerly) homeless persons and peer advocates, so that lived experience informs diverse approaches to care – and would also help address barriers and impediments to procedural justice.

E.9 Inadequate approaches to institutional care

Standards of care are often inadequate and sometimes appalling as a result of poor adherence to public health protocols by both state and CSO providers, which remain relevant and broadly applicable even in the context of health emergencies such as COVID-19. Overcrowding as a result of shortages in staffing and resources that frequently affect persons needing mental health care and those providing it. This results in burnout and feelings of apathy among care providers, even at leadership levels. Overcrowding is often the result of demand outstripping supply, limited resources, and lack of exit options for HPWMI – as indicated in the Report of the Technical Committee on Mental Health. HPWMI account for 40% of long-term patients in state mental hospitals. There is as yet no comprehensive report on their situation in NGO- and state-run rehabilitation homes and homeless shelters etc., but anecdotal evidence suggests similar trends.

The immediate impact of this reality is that state and non-state actors are unable to assist persons with acute needs because of the lack of beds. This presents a particularly formidable challenge that seems almost intractable. Inequitable care that persons receive based on their social and economic status is undoubtedly a reality and an affront to the concept of universal health care and principles of social justice. There is an urgent need to overhaul institutional care, particularly for disadvantaged patients. Smaller units, integrated within general health systems where possible, rather than huge structures, may better support both patients and care providers. It is essential that larger institutions that support patients with mental ill health have the necessary human and financial resources, backed up with quality audits to ensure the well-being of this population.

E.10 Lack of convergence between health and social sectors

An emphasis on patients' agency by facilitating employment, housing, and semi-independent living, leads to a much better long-term prognosis (e.g. Luhrmann & Marrow, 2016; Patel et al., 2018; Nakamura, 2013). Intersectoral collaboration is therefore of profound, wide-ranging and far-reaching importance. A focus on social health will help improve behavioural health. Social health will also open new prospects of life-long care, even taking account of the social determinants that affect a person's quality of life. Taking a comprehensive approach to the issues of homelessness and mental health will depend on collaboration among departments of disability, social welfare, housing, rural and urban development, housing, and health, along with city corporations, panchayats, district collectorates, the National Health Mission, and with other stakeholders such as the Education Department, the Child Welfare Committee, the Police, among other bodies.

E. 11 Lack of access to basic amenities and social care needs – nutrition, health, insurance, livelihoods, allowances and housing

Access to the Public Distribution System (PDS), health cards and insurance to cover nutritional and health needs are essential to improving the psychological and social health of disadvantaged groups, particularly those who are homeless. It is also imperative that the lack of housing and therefore of a permanent or temporary address, or the lack of a family – which perpetuate a cycle of exclusion, unemployment, segregation and hopelessness and even mortality – do not prevent anyone from obtaining the basic rights that may help extricate the most vulnerable from abject poverty and cycles of disadvantage and exclusion.

Many homeless individuals, whether or not living with mental illness, are not in the formal or informal workforce and usually the first to be affected when there is an economic slowdown, a health shock or a natural calamity. Unemployment, and the lack of a basic income in the case of those with mental health concerns, especially those with moderate to severe disability, is particularly a cause of concern as the combination of limited financial resources, poor support networks and poor social capital could generate a destabilising spiral that affects the individual and their family in multiple ways. This becomes much more complex in the case of child, adolescent and elderly caregivers, resulting in intergenerational distress, dropping out of school, and crippling helplessness.

E.12 High support needs and related challenges

While 80% recover from episodes of ill health, including psychoses (Lieberman et al., 1993; Lieberman et al., 2003), 10–20% (Bertolote et al., 2005; Thompson et al., 2003) continue to experience persistent symptoms and severe disability and may require life-long care. Inclusive living options, and facilities that foster participation and social mobility, are as essential as medical care. Options of self-discharge, revolving-door arrangements, customised care plans that allow for collaborative, non-risk-averse arrangements may help open up the system, help build trust among service users, and influence them to adopt positive help-seeking behaviours.

E.13 Lack of stable housing

The 2001 Census reported that 1.78 million people were living on the streets, and that almost 15 million are in need of separate dwellings. Considering that nearly half of the homeless are single migrants and half have an average household size of three, a Technical Group set up by the Ministry of Statistics and Programme Implementation (MOSPI) calculated a total housing requirement for 0.53 million; 0.99 million people live in non-serviceable kutcha houses and 2.27 million in poor housing built less than 40 years ago, and any house built over 80 years ago. Three-quarters of the shortage is in the Economically Weaker Section (EWS) income category, i.e. up to Rs 5000 per month, and 25% in the Lower Income Group. (LIG) income category of between Rs 5001 and Rs 10,000 per month. There is a correlation between overcrowding and mental ill health. Similarly, it is suggested that scarcity and the lack of a sense of stability affect cognition (Mullainathan & Shafir, 2013; Padgett, 2007). There is a need for city and town planning to focus on providing inclusive and equitable housing, especially for those who live near or below the poverty line.

E.14 Negligible representation of peer advocates in service development

The role of peer advocates can be critical in helping recovery. Their role and responsibilities in the mental health system is negligible and located within the SMHA. Globally, recovery movements (Kilbourne, 2018) seek out the wisdom of those with lived experience in service and policy development as well as in research to assess impact and audit quality in mental health establishments and care plans. This needs to be more than just a symbol of compliance with human rights conventions to be a function of formulating locally relevant, robust and meaningful responses and policies. The is a need to build the capability of peer advocates so that they participate in diverse spheres of care management and policy influence. This is particularly relevant in the case of HPWMI, since lived experience of homelessness and mental ill health should inform policy development and care approaches.

E.15 Absence of Public Service Campaigns – focus on stigma reduction

Public service campaigns and media representations of the phenomenon of homelessness and mental ill health require a rethink. Showcasing the diversity in ill health as well as in personal goals, social backgrounds, norms and mores and in individual care and recovery trajectories will influence social perceptions and attitudes.

E.16 Focus on research, monitoring and evaluation (M&E), and feedback loops

Longitudinal tracking of outcomes at individual, familial and society levels in combination with quality audits will facilitate the development of adaptive and dynamic care plans and policies. There is also a need for case-study methodologies that explore the social and cultural terrain in which an individual experiences forms of structural violence, be it abuse, discrimination, stigma, and poverty, in order to better understand how extreme vulnerability is contributing to conditions of homelessness and mental illness. Results from research and trends should feed into programmes and support mid-course corrections when required and adaptive designs.

Section F

Policy for Homeless Persons with Mental Health Issues – Theoretical and Practical Considerations

State responses, legislative amendments and global policies have a critical and long-lasting impact on the life of persons with mental health issues. Individuals have suffered immense distress as a result of reduced budgets for mental health care or unimaginative funding allocations, lack of affordable housing, disenfranchisement, top-down policies and archaic laws that disregard the rights of persons with mental health issues and their role in society.

Over the last 20 years, there have been significant changes and additions to state responses and global policies, including the UNCRPD (2007), National Mental Health Policy 2014 (India), Americans with Disabilities Act (ADA), 1990, among a great many others. Any legislation, however, will have a positive and lasting impact only if it takes account of multiple views and provides opportunity for dialogue and dissent. Mental health is non-linear, complex and nuanced, with many ethical grey areas; these need to be accepted for what they are, rather than law-makers forcing a ‘one-size-fits-all’ approach on the provision of mental health services.

Most importantly, all levels of government, law-making bodies, funding organisations and service providers should focus on inclusion and social participation. Erving Goffman states that society attributes a particular identity to an individual based on certain expectations and demands (Goffman, 2009). When those attributes contravene society’s expectations, the individual is viewed as less desirable, dangerous or weak. This is most relevant in the case of mental illness, which for centuries has been viewed as an individual weakness and/or moral failing, justifying ostracization, abuse and exploitation.

Stigma, discrimination and social exclusion have negative consequences at the socio-political,

economic, familial and individual levels, leading to escalating costs of care, unemployment, opportunity costs, abuse, human rights violations and homelessness. One of the most effective and sustainable ways to mitigate stigma is through increased contact, backed up by awareness and public education (Lauber et al., 2004).

F.1 Guidance from the First Indian Mental Health Policy (2014)

India's first policy for persons with mental health issues drew significantly on the UNCRPD, which has 55 articles; of particular relevance are the rights to education, employment, housing, community participation, citizenship, health and access to justice. The UNCRPD embodies the universality and inherent dignity to which all human beings are entitled, irrespective of nationality, caste, creed, religion, sexuality and disability. Disability is approached as a function of society that creates environmental and attitudinal barriers for individuals with certain impairments, impeding their full participation and attainment of personal goals (United Nations General Assembly, 2006).

The primary vision of the policy was to promote health, prevent mental illness, enable recovery from mental illness, promote desegregation, and ensure the socioeconomic inclusion of persons affected by mental illness by providing accessible, affordable, and good-quality health and social care to all persons through their lifespan within a rights-based framework. It created a roadmap for mental health care in the country in keeping with values of equity, justice, participation, intersectoral collaboration, focus on quality, effective governance, evidence-based approaches and M & E. In keeping with the goal of making mental health care accessible to all, it placed specific emphasis on vulnerable communities, including HPMHI. Recognising that the breakdown of support networks results in a descent into homelessness, the policy advises on efforts to promote localised access to emergency services and long-term housing and ancillary support. It also addresses the need for open and safe communities, by creating more liveable conditions on the streets (for individuals not needing emergency care, and receiving sufficient support) through micro-nutrition interventions, drinking water, well-being kiosks, and exclusive services for women and children who are particularly vulnerable. Shelter services run through public–private partnerships (PPPs) and panchayats, and self-help groups (SHGs) were also advocated, in keeping with building a layered cadre of professionals available to care for homeless persons with mental health issues.

A consistent finding of research on the nature of the nexus of mental ill-health, poverty and experiences of homelessness relates to the complexity and persistence of the problem. This complexity plays out across multiple levels of problem analysis and problem-solving in a way that aligns with literature on social problems variously termed 'complex,' 'persistent' or 'wicked' (Gopikumar et al., 2015).

The relevance of multi-factorial socially disadvantageous situations in the phenomenon of homelessness and mental health issues calls for a reimagination of health and social care and the expansive formulation of treatment, social care and public health interventions that acknowledges and addresses, through collaboration and/or integration with other services, the structural violence that precipitates trajectories of homelessness. Achieving this will depend on

seeking out the commitment of multi-stakeholder collaborations that transcend disciplines, departments and affiliations. Service provision, care formulation and measures of success need to include – but also move beyond – nearby access and numbers enrolled in services, to focus on the experience of dignity, responsiveness and appropriate redressal of social distress and grievances.

F.2 Guidance from the Indian Mental Health Care Act

The Mental Healthcare Act, 2017 (MHCA) was enacted in compliance with India's obligations under the UNCRPD with the objective 'to provide mental healthcare and services for persons with mental illness and to protect, promote and fulfil rights of such persons during delivery of mental health and services and for matters connected therewith and incidental to…'. As rights-based legislation for providing mental health care and treatment, the MHCA is based on universally accepted principles embodied in the UNCRPD. These include the following non-negotiable principles:

- All individuals are entitled to basic human rights, including the right to equality, liberty and dignity;
- Every person must be given the autonomy to make the choices they consider the best for themselves and this extends to decisions about their mental health care and treatment;
- Everyone has the right to full participation and inclusion in society;
- No person can be discriminated against on grounds such as caste, class, ethnicity, sex, gender, sexual orientation, religion, disability, social, political or cultural beliefs;
- Receiving appropriate and varying levels of support (supported decision-making) is integral to exercise one's right to make their own decisions.

The MHCA recognises the rights of all persons with mental illness to access and receive care and treatment without discrimination. It also establishes procedures and safeguards to ensure that persons with mental health problems are protected when required and supported and not subject to discrimination. The MHCA makes it mandatory for all mental health professionals in India to make changes to their clinical practice in order to comply with the law. Mental Health Professionals (MHPs)s are granted powers, for instance, pertaining to admission under Section 89, which allows them to make recommendations alongside a psychiatrist for admissions (Harbishettar et al.,2019). Other MHPs would also be able to plan for discharging patients. The MHCA is the first to bring MHPs in its ambit, ensuring their accountability (the previous Acts did not encompass MHPs). The MHCA also has a dedicated section that is relevant to addressing needs of HPWMI (outlined in Sections 18(c) and 19) (Swaminath et al., 2019).

F.3 Guidance from Human Rights Declaration and Core Tenets

International bodies, including the World Health Organization (WHO) and United Nations, have developed various frameworks and policy documents focused on articulating and protecting the rights of persons with disabilities (Martinuzzi et al., 2010; Stucki et al., 2007; United Nations,

2006). These important rights-based frameworks foreground the fundamental ethical and moral responsibilities of governments as well as non-governmental entities and society in protecting basic rights to community participation (work, school, parenting), to health (health care, treatment) and to maximum self-determination in the context of legal systems and policy.

F.4 Mental health and inclusive development – guidelines for planning care

F.4.a social dimensions of mental illness, care and rehabilitation

A series published in the *New England Journal of Medicine* has argued for the need for a return to the social medical practice in order to avoid the symptom-oriented emphasis on 'evidence-based medicine'. Stonington et al (2018) launched this series, stating that, 'Much of what [clinicians] read in clinical journals appears to corroborate the assumption that in clinical medicine, the biologic and behavioural world of the patient's body is more important than that of the social world outside it'.Yet there is increasing evidence on the role of 'social forces in determining health, disease, treatment, and recovery'(ibid, 1958) While this holds for all clinical practice, it especially important in psychiatry, psychology, social work and other relevant humanities, and therefore in the treatment of mental health. With a focus on the social in community-based care, Tamil Nadu is a leading force in the Global Mental Health movement, which will enable it to engage in a necessary rethinking of the 'evidence-based psychiatry' that dominates the classification of diseases in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V), produced by the APA and used in the US; and the International Classification of Diseases, 11th edition (ICD 11), produced by WHO. Few psychiatrists do not use either of these. Critical Psychiatrists Network (UK) has abolished their use altogether.

The risk of bio-medical reductionism, and its failure to take social determinants into account, is persistent and real, particularly given the global pharmaceutical interests that may drive research and treatment in psychiatry (Rose, 2018; Kirmayer & Gomez-Carillo, 2018). Solely focusing on reducing symptoms in the short term will be result in failing to understand the social determinants and culturally embodied experience of illness. It is also important to reflect on the cultural, social, and economic determinants of bio-medical practice. 'Evidence-Based Psychiatry', as Kirmayer and Gomez-Carillo (2018) assert, 'is also cultural', bound by conventions, values, and social forces. With this in mind, care providers can approach the intersectional lives of people who are vulnerable and marginalised with respect for the medical pluralism that might more meaningfully offer hope and dignity, as well as symptomatic relief.

F.4.b Addressing social suffering and social defeat

A 2003 *WHO Bulletin* written by leading mental health specialists and psychiatrists at Harvard University, Vikram Patel and Arthur Kleinman, presented findings and analysis from three large global mental health reports and 11 community studies published since 1990. This survey confirmed the strong correlation between poverty and common mental disorders, particularly those related to depression and anxiety. The authors defined poverty as 'low socioeconomic status (measured by social or income class), unemployment and low levels of education' (Patel & Kleinman, 2003) but were careful to state that causal relations are not necessarily confirmed by correlations, although they did suggest several factors associated with socioeconomic

deprivation that appear to have a strong epidemiological impact on emotional and mental distress. Patel and Kleinman found that income alone is not determinant, whereas when it was associated with poor education and housing problems, the relationship with mental illness became stronger. In particular, anxiety about income, such as when a person suffers 'an acute income drop in the previous six months' Patel & Kleinman found this increased the risk of mental disorders, noting, for example, farmer suicides in India as falling into this category. Unsurprisingly, they found a strong correlation between hopelessness as a 'core experience' that contributed to depression and suicide. **Within these core experiences of hopelessness, shame, stigma, homelessness, and the humiliations associated with poverty were seen as more important than poverty itself.** In urban contexts, where social change associated with migration led to isolation, **loneliness** was another key factor leading to common mental disorders, as Emile Durkheim had long ago theorised. Trauma caused by violence, physical or structural, coupled with a lack of social support, played an 'important role in the etiology of common mental disorders' (Patel & Kleinman, 2003). Gender, the authors also found, was another factor to consider, as women 'bear the brunt of the adversities associated with poverty: less access to school, physical abuse from husbands, forced marriages…fewer job opportunities…' (ibid., p. 612). Malnutrition, lack of access to clean water and living in toxic environments, inadequate housing, and other factors associated with poor health, were co-morbid with mental health disorders. Moreover, these health and mental health problems both increased costs and worsened poverty, contributing to a vicious cycle of psychosocial stress and poverty.

Equally important is the need to understand their independence of each other. Not all distress or poverty can be 'psychiatrised' (Mills, 2015) or pathologised. While there may be mental health implications, these may be more relevant in the context of the descent into homelessness or the rapid destabilisation and related social losses as a result of abject poverty, domestic and structural violence (Farmer, 1999).

F.4.c Housing and income instability

A more recent survey of the epidemiological literature and ethnographic study by Luhrmann and Marrow (2016) found that the trajectory of schizophrenia, the most refractory of mental illnesses, was also influenced by experiences of 'social defeat', or the repeated humiliations associated with the structural violence of stigma, racism, poverty, homelessness, and interactions with a health care industry and legal bureaucracy that was oft dehumanising. There were better prognoses when housing and work were available, and 'diagnostic neutrality' meant that when there was less emotional stress in the patient's household and wider community concerning this medical diagnosis, hope was better maintained. This study also pointed to the greater efficacy of community-based care than of long-term hospitalisation, as it was more culturally nuanced and placed less emphasis on bio-medical care than on psychosocial interventions. Furthermore, outcomes from the 'Housing First' (Padgett et al., 2016) and 'Home Again' models (Patel et al., 2016) have shown the role of stable housing in enabling a process of personal recovery, community re-entry, participation and a sense of agency and community. Existential instability and mental ill health intersect at multiple points, exacerbating distress and precipitating a

downward slide into homelessness and, worse still, hopelessness resulting in withdrawal from participation in society and life (Padgett et al., 2007).

F.5 Transdisciplinary lens in addressing persistent and complex problems

A key strategy to fostering successful interaction is transdisciplinary policy development, the structure and implications of which are discussed below. Though it is applied mainly in research settings, recent work has established its potential in knowledge translation and social change, in reference to its capacity to build intersectoral policy literacy, communication skills, advocacy and coalition forming. Through its structuring of equal stakeholder collaboration both by recognising individual knowledge cultures and by identifying and sustaining common goals, transdisciplinarity has great potential for addressing the links between multidimensional poverty and mental ill health.

Given the complexity outlined above, it is fairly straightforward to consider how typical reforms of the health system or policies relating to financial or human resource investment may be inadequate to tackle the root problems (Narasimhan et al.,2019). Furthermore, the need to consider local responses and experiences would mean incorporating a wider range of actors in the process than might typically be assumed, given the need to apply bodies of knowledge to the social realities in which problems exist (Narasimhan et al., 2019, Misra et al., 2011). Indeed, this is likely to go beyond grassroots organisations, whereby current understandings of effective health systems extend beyond their component parts to consider their responsiveness to service users (Narasimhan et al., 2019). Working with affected individuals in setting priorities in research and practice has been shown to increase stakeholder support for outcomes and enhance legitimacy (Broerse et al., 2010).

This suggest the first policy-related area of complexity relating to the wide range of actors who would need to be involved in the process, including affected individuals, grassroots organisations, NGOs, Ministry of Health, hospitals, psychiatric institutions, law enforcement, psychiatrists, nurses, social workers, psychologists, community workers and more. Collaboration of this nature is necessarily problematic, since the different groups operate from within their own schools of thought, priorities, and assumptions, and so are likely to diverge in how they understand the problem and favour different solutions (Benard et al., 2014). This may be exacerbated by divided lobbies, lack of internal consensus and competing goals, as well as differing degrees of effectiveness depending on the readiness and capacity for collaboration (Gopikumar et al, 2021, Misra et al., 2011). The complex collaboration required to tackle the problem itself further requires a level of accommodation and compromise in a structured approach. This is where the transdisciplinary method, which scholars have found is a promising approach for investigating complex health problems (Murphy et al.,2017) has many advantages, for instance in terms of its structuring of interaction and aligning of expectations and goals, which reduces the time lost in the early phases of collaboration (Misra et al., 2011).

Building on the complexities discussed, the common issue of stakeholder buy-in will require clear, value-driven goals to create a common framework for development (Gopikumar et al.,2021). With regard to the complexity of the issue itself, it is important to establish a line of questioning that moves beyond the oversimplification that has at times characterised this field. Finally, structuring stakeholder collaboration requires explicit consideration of matters such as the coordination of leadership that accommodates complexity (Bunders et al., 2010) , managing expectations and creating an environment for mutual learning (Kirst et al., 2011)

F.6 Recovery-based approaches to care

The origins of the so-called modern 'recovery' movement are often traced to research questioning earlier assumptions about the longer-term prognosis of serious psychiatric disorders, including schizophrenia (e.g., Harrison et al., 2001; Hopper et al., 2007), as well as advocacy efforts by service users, families and progressive providers (Davidson et al., 2011; Deegan, 2003). Basically, recovery-oriented practice describes services that emphasise the human rights of people with psychosocial disabilities and that work to promote their full participation and integration in society, even in the absence of the remission of symptoms.

Like many originally emancipatory movements, the concept of recovery has sometimes been misused or misappropriated in policy and practice (Slade et al., 2014) and – particularly in India and other L&MICs – there are concerns about the potential for uncritical adoption of a framework based on Eurocentric thinking and framing (Bayetti et al., 2017; Gamieldien et al., 2021). For example, some critics have warned against invoking the discourse of recovery to justify closing high-quality residential facilities and eliminating hospital beds, which rather than benefiting patients have instead often relegated them to streets and jails (Braslow, 2013; Braslow,2013). Preferences and rights that are centred around hope have inspired alternatives, such as the pursuit of capabilities and life goals, culturally appropriate living and healing styles; and the values of dignity, participation and such like assume critical importance in developing solutions that address the social context, trauma, distress, mental illness and well-being of persons affected.

Recovery approaches in L&MICs

In some L&MIC contexts, recent and emerging efforts to develop participation-focused services might best be understood as a reflexive, syncretic integration of global human rights frameworks (such as the United Nations Committee on the Rights of Persons with Disabilities, or the World Health Organization Quality Rights Initiative), stemming from progressive international development work (e.g. Amartya Sen), exemplary service models from different parts of the world, and regionally and culturally specific considerations regarding local meanings of family, community and valued social roles (Radhakrishnan et al., 2021; Ravi et al., 2021; Venkatapuram, 2014). This approach to person- and community-centred services includes careful attention to the intersections of psychosocial disability, recovery and participation with gender, caste, religious identity and non-medical explanatory frameworks.

Holistic, cost-effective, and sustainable models of mental health care emphasise agency, rights, and understanding over and above short-term outcomes in reducing symptoms. International research and practice concerning severe mental illnesses (SMIs) and their intersections with homelessness, poverty and other forms of 'minoritisation' have stressed the importance of engaging in ways that minimise coercion and centre the experiences and values of the individual in the cultures and communities with which they identify. Arthur Kleinman (2012) suggests that the focus in global mental health needs to shift from a diagnostic model focusing on pathology vs non-pathology, towards one that addresses 'social suffering' in all its multidimensional aspects – linking poverty and health in a cluster of co-morbidities, in addition to understanding the psychological experience of suffering in its local and culturally shaped dimensions (2012). He focuses on the sometimes dehumanising aspects of medical care, and how it can contribute to social and moral defeat, despite the best intentions. There is a need to pay attention to the dehumanising treatment of the mentally ill, he argues, rather than simply expanding access to pharmacological treatments. Kleinman points out that in many L&MICs, however, that there is often a lack of basic access to mental health care and counselling, asking, 'what happens when we see the state not primarily as the source of powerful control over the mentally ill and through them society at large, but rather as fragile, constrained, and almost powerless to provide the most basic care for its most impaired and vulnerable members?'. In such a context, over-medicalisation is less critical than alleviating the socioeconomic disparities that contribute to co-morbid health and mental health issues. Section H lists key value frameworks mental health professionals should espouse, which ultimately shape a sustainable and holistic mental health and social care system.

Section G

Guidelines to Support Recovery and Community Inclusion of Homeless Persons with Mental Health Issues: Service Maps and Intersectoral Coalitions

This core section recommends guidelines for services at three levels – preventive, supportive and restorative – to ensure that all approaches to care are person-centred, embedded in well-being, and address the bio-medical, social and psychological factors of mental ill health or psychosocial disability. Doing this depends on having a range of services at every stage of the care continuum, taking account of predisposing, precipitating, perpetuating and protective factors in a life-cycle approach. This may result in greater access to an array of services that address diverse needs.

We believe that the recurrence of distress and homelessness arising from mental health issues may be reduced or arrested provided that a range of services are available at various administrative levels ranging from village panchayats to block-level PHCs and tertiary hospitals or public and private care centres (managed by CSOs etc.) and health and social care systems. These recommendations need to take into account the context of the village, town, municipality and city where these services or interventions are located.

Table 6 Preventive, supportive and restorative services for Homeless Persons with Mental Health Issues

Preventive	**Supportive**	**Restorative**
Child and Adolescent Wellness Programmes for those in difficult circumstances	Collaborative First Responder Teams from village to district level (in collaboration with CSOs, volunteers, panchayats and youth leaders)	Supported Housing: rented, owned or hostel-type with needs-based personal assistance for long-term or transitional care (Padmakar et al., 2020)
Continuity of Care Programme for those recently discharged from in-patient care and episodes of wandering/homelessness	Crisis Intervention Services (CIS)	User-led social enterprises
Support for Vulnerable Carers	Critical Time Interventions (CITs)	Employment facilitation (based on aptitude and skills) and enhancement of social capital (income, social networks)
Community-based harm-reduction and referral systems for substance use	ECRCs: 30–50 beds per 3 lakh population managed as integrated care centres within government secondary	Legal Aid Services

	and tertiary care hospitals by NHM, Department of Health and Family Welfare, IMH and CSOs	
Intersectoral collaboration to systematically cover legislated rights (food, housing, employment, pensions) for high-risk populations living with mental health conditions	Open Shelter Services: 100 beds per 1 lakh population for homeless persons in psychosocial distress (per the NULM scheme) with one special centre for every three zones	Valued social roles and co-production of knowledge (peer advocates, researchers and managers to be engaged in care, audits and policy development)
Early Intervention in Psychosis Programme	Safe spaces and social care desks at panchayat, municipality and District levels	
Training for PHC and block-level mental health teams to proactively recognise and respond to gender- or caste-based violence and other forms of oppression occurring concurrently with mental health	Sensitisation of stakeholders in health system and allied sectors on person-centred, rights-based, least-restrictive outreach and care	
Sub-Centres / PHCs as wellness kiosks/ social care desks	Centralised Helpline Service	

G.1 Preventive support approaches

Holistic care serves as a pivot in the formulation of this policy and suggested planning and implementation. Medical and social care are equally important in facilitating person centered care. Lack of continuous medical care and disintegration of safety nets are important reasons for recurrence of homelessness amongst persons with SMIs. Strengthening of medical care is essential in the prevention and care of HPMI.

Medical care is available in the State of Tamil Nadu in the Institute of Mental Health, Departments of Psychiatry in Government Medical College Hospitals, District Head Quarters Hospitals, DMHP, in CSOs and ECRCs. Such facilities providing medical and social care should

be strengthened in infrastructure and human potential and essential drugs should be made consistently available are non-negotiable. For early intervention of psychosis, Child and Adolescent Psychiatry Units have to be developed in Departments of Psychiatry in all Medical Colleges and Hospitals.

G.1 a Child and adolescent social health care

Child and adolescent mental health is an important predictor of lifelong well-being, making it essential to establish support and networks of mental health and social in the education system. This should include collaboration with the Education Department and other stakeholders focused on providing care for children and adolescents, in order to identify early signs of ill health or social distress, and to prevent structural barriers and related disadvantages or difficult relationships from affecting their growth and development in their formative years. Having enough to eat, stable housing and income, and training in consistent parenting skills, plus Positive Youth Development strategies in schools, play a key role during this phase of child and adolescent development. Linkages with local self-governing systems, the Social Welfare Department, the Education Department, Departments of Housing and Health and Family Welfare are critical, as is their collaboration with local mental health facilitators or volunteers in order to assess the needs of the most vulnerable children and adolescents whose families are at risk of sliding into poverty and significant social losses. In such situations, 'last mile care' is imperative, provided through sustained and proactive engagement and social care support in a non-stigmatising and non-discriminatory manner.

Resilience-focused interventions for children in difficult circumstances

Self-esteem and resilience are important in contributing to recovery among people with mental illness and in reducing the risks of developing mental illness. A key focus for prevention and promotion in the mental health sector must therefore be on increasing protective factors and diminishing risk factors. The DMHP already has life-skills education in schools and colleges in its mandate. Translating this into a directed intervention programme of promotion and prevention will require:

- Systematically identifying children at risk of developing mental ill health (e.g., living with parental mental illness, experiencing social and economic discrimination, children in institutions, street children) by conducting surveys and community mapping without being intrusive or stigmatising.
- Standardised group-based modules in schools and other settings offered by grassroots mobilisers and mental health and social care teams to cultivate adolescents' mental well-being by fostering social support, adaptive coping, self-esteem and resilience.

G.1 b Early intervention in psychosis

Early intervention in psychotic disorders is likely to have a better prognosis, while delayed treatment is associated with chronicity and poor outcomes (Marshal et al., 2005; Perkins et al., 2005); conversely intervention at the critical early-onset phase predict social and vocational functioning (Craig et al.,

2004). Specialised early intervention services in liaison with primary care such as TIPS (Johannessen et al., 2000), RAISE (Rosenheck et al., 2016), OPUS (Peterson et al., 2005) and LEO (Craig et al., 2004) have demonstrated better functioning, reduced in-patient care and fostered independent living. We propose the initiation of Early Intervention in Psychosis (EIP) programme with active identification of untreated psychosis and intensive engagement by a specialist team with these individuals in community-care settings for a 2–5-year period followed by transfer to maintenance teams or appropriate referral if there is a decline in the person's condition.

G.1 c The DMHP's impact on reducing the recurrence of homelessness

We recommend that the DMHP extend into under-resourced rural and urban areas, which in turn depends on having mental health and social care structures in PHCs and Sub-Centres as well as in clustered and unstable urban housing areas, initially in camp mode and moving towards an integrated systemic service. This would help provide continued care for those experiencing severe mental illnesses, as well as ensuring early screening for mental health concerns and providing effective, timely and appropriate care. Besides access to medication, counselling and problem-solving support, the role of social care is particularly relevant in ensuring access to livelihoods and other social services in order to pre-empt triggers that precipitate distress or a descent into or recurrence of homelessness.

MHSCFs are an important cadre in the health and social care and disability sectors, and could catalyse swift responses, grievance-redressal mechanisms and convergence between sectors. This could be achieved in collaboration with members of local panchayats, SHGs, teachers, youth leaders, peer advocates, community-based rehabilitation workers etc., as well as CSO leaders, members of local city Corporation Councils such as health officers and NULM shelter coordinators and so on. Local support circles are equally important and may use principles of befriending, solution-focused brief therapy and Open Dialogue (in which they are trained) in order to build accessible and culturally acceptable caring communities – another element that may reduce the incidence and recurrence of homelessness as a result of severe mental illness.

G.2 Support services

This sub-section outlines recommended support structures for those who are homeless and with mental health issues; **these include outreach services, emergency services and rehabilitation services** that existing mental health and social care programmes could adopt. We recommend a **hub and spoke model** whereby someone who is connected to a MHCF at a centralised level is then linked up to a relevant regional or zonal team that would assist the individual through the continuum of care, from care and outreach services on the streets, as appropriate, to helping access to safe spaces and basic amenities, and to local mental health and social care teams responsible for assessing needs and assigning appropriate care approaches. Since the range of services includes access to hospital-based services,

rehabilitation services, long-term care services and social needs care, their provision should comply with broader human rights tenets and current legislation in addressing individual concerns.

G.2 a Centralised Helpline

We recommend setting up a toll-free centralised helpline to provide timely assistance to HPWMI, in accordance with the person's needs, and in compliance with human rights and current legislation. This helpline, while located in a district, would be linked to local helplines at intra-district and inter-district levels. We also recommend that a First Responders Team (FRT) should man these helplines, which should be linked to others such as the suicide helpline, helpline for elders, women's helpline and childline in situations calling for expert guidance. The helpline may refer the caller to a health or mental health care facility such as the ECRC, to a social care desk/ well-being kiosk or to a homeless shelter – or simply alert mental health and social care teams about a situation of abuse and neglect. The helpline provided by the local ECRC team (who double up as the FRT) will also ensure follow-up of care and address social care needs, in conjunction with various local collaborators including self-help groups, panchayats, multipurpose workers in the health system, the NULM-developed shelter network (where available), members or representatives of women's development councils, peer advocates, caregivers etc.

The helpline should be accessible to HPWMI, not only during a crisis, to seek access legal aid, health and mental health care, and to facilitate conflict-resolution and social care. The helpline should ideally also offer support to persons who are on the verge of mental ill health and of being more vulnerable to homelessness. It is recommended that all calls are recorded and that geo-tagging options are enabled. Requests for emergency care, peripatetic support or outreach services will be directed to the local FRT.

Information on the helpline may be disseminated through relevant community-based institutions such as community radios, workshops, popular mass dissemination methods, folk art etc.

G.2.b First Responders Team (FRT)

The FRT will comprise members from the ECRCs, NULM shelters, village and town panchayats, homeless collectives, women's groups and SHGs and will therefore have a multidisciplinary perspective on the concerned individual. The composition will include mental health professionals, social work practitioners, government representatives, peer advocates, volunteers, CSO representatives etc. The police will also be a part of the FRT when required; the Mental Health Care Act, 2017 stipulates that the police are responsible for offering protection and access to health and mental health facilities when required for HPWMI identified in their jurisdiction, for assessments and continued care. They may join the FRT for a Critical Time Intervention (CTI) or as necessary, refer people to the FRT for further support. The FRT will offer peripatetic support, emergency medical care, and ensure actions undertaken in supporting the concerned individual are compliant with the MHCA, 2017 and other human rights obligations set in these Guidelines and Protocols. Information on the purpose and goals of the intervention and the subsequent processes will be clearly communicated to the individual based

on an established script. The FRTs will ensure that health and mental health assessments are made by government-approved health institutions, enabling the individual to access immediate support. The FRTs should ideally be multilingual (given that many HPWMI may have come from other states and wandered into Chennai) culture-sensitive and ensure that initial support and continued access to basic amenities and mental health care are appropriate to the person's needs and socio-cultural background. The FRTs are also responsible for continued outreach services and engagement with the individual, if they do not consent to receiving care. They may also be nominated as the responsible authority for referrals to an **approved list of institutions** (see Annexure 2)) and will seek specialist services when required from intersectoral departments and multiple stakeholders, outlined above. The FRTs will take account of the urgency of the situation and act accordingly, balancing personal choice with access to appropriate and timely care, restricting the use of coercion except under extraordinary circumstances of serious neglect, exposure to health hazards including severe malnutrition, abuse and acute mental health care needs and in particular, if a minor is accompanying the individual. A priority grid may be created for this purpose as a reference point.

G.3 Priority grid to enable access pathways

Table 7 Priority grid

Category	Priority	Description	Services	Ensuring procedural justice in admissions	Duration of stay	Health and Social Care plans

Homeless persons with severe mental health issues	High (rescue between a day to a week of observation and deep engagement by a mental health and social care team that attempts to build trust and seek consent)	Severe symptoms of mental ill health, experience of an acute episode. Propensity to abuse owing to poor social capital and minimal support networks, greater vulnerabilities, presence of injuries and infections, pregnant women, women with children, individuals with limited or no access to basic amenities such as food and sanitary needs	Institute of Mental Health/ other government and private hospitals/ECRCs/ NULM shelters The Banyan ECRC	Matched gender of rescue team of mental health and social care facilitators / nurse. No physical restraints to be used and when admission without explicit consent is mandated, a trained team to engage in the CTI; explanation of reason for a CTI even if the individual is highly is symptomatic	3 months and reviews as per the MHCA 2017 (Sec 90, MHCA, 2017). If required, an extension may be sought. Attempts at reunification, or referrals to inclusive living options such as group homes, 'Home Again'type facilities, peer-run guest houses, hostels, rehabilitation homes and rest houses run by NHM, volunteer and CSOs, and faith-based organisations etc.	Access to health and social care facilitation including a) Citizenship documents b) PDS and access to food and nutrition c) Access to Social Care support such as out-of-work allowances or disability support / basic income-type support – focus on financial inclusion and

						banking support d) Li velihood s access through attainme nt of job cards, for MNREG S-type schemes and / or other skilling, social enterpris e-type arrange ments – to avail the 3% reservati on in the RPDA, 2016 e) C ontact with a local DMHP and / or NGO/ Health and social care service for periodic

						reviews, medication and counselling support f) Access to support groups through local networks such as panchayats, SHGs, client and caregiver groups, homeless collectives. g) Access to health cards and insurance

Persons with common and less severe mental health concerns	Medium Deep engagement for a fortnight and beyond if required	Presence of safety and support networks, nutritional and sanitary access to be made available; if client fairly self-reliant and agential, and yet exposed to multiple marginalities, discuss most suited care plans collaboratively	NULM Special shelters, peer run homes or guest houses. Please use this link for more information on services that may be developed for this group of persons	Understanding and documentation of needs, support from affinity groups and meal providers. Weekly outreach and check in and formation of support networks	In cases where required, 1–3 months If they choose to self-discharge, ensure continued weekly outreach and assign a care coordinator from the local community / their support circles (could be incentivised) to be available and ensure safety and well-being	Independent or co-housing options may be offered. Additional vocational options may be suggested including as peer workers, managers of shelters etc.
Homeless persons in psychosocial distress	Medium	Those who choose to stay on the streets, experience intergenerational homelessness, street vendors etc. Agential and self-reliant. clarity in goal-setting	NULM shelters, permanent housing under PM Awas yojana, access to soup kitchens and a social care desk that connects individuals with services to address	Monthly engagement with such individuals / families on the streets and in shelters.	1–3 months in shelter, if preferred option; refer to permanent housing//hostels. For those choosing to stay on the streets, monthly engagement to ensure safety and access to basic amenities.	Complete health and psychiatric work-up where needed. Individual care plans with social care and legal aid support, particularly from those in NULM

			diverse forms of distress			shelters experiencing psychosocial distress; Stable Housing planning, Access to employment support for those living with children; education and social psychological and social support for children

G.4 Supporting ultra-vulnerable persons

G.4.a Women with infants or children

If a HPWMI has a child, the Child Welfare Committee (CWC) should be notified immediately. It is important to stress the importance of the bond between a mother and her child(ren), irrespective of the severity of the illness, unless there are indications of homicidal ideation. Even if the child is moved to another shelter or care facility, the CWC and ECRC/NULM Teams need to ensure that they continue to meet/spend time with the mother (or father). Studies have repeatedly established the need for contact and fostering an environment (Winston & Chichot, 2016) for bonding to enhance the mental health of mothers and children (Young, 2013). The parent and child should be reunited and supported, whether the parent is discharged and returning to their chosen home or going to long-term care facilities such as 'Home Again'.

G.4.b Elderly persons with mental health issues

Tie-ups with the Elderly helpline and with geriatric care and support facilities should be initiated to address specific concerns of older people. Any long-term needs and long-term options also need to be discussed.

G.4. c Substance abuse and co-occurring conditions

It is estimated that 35% of homeless persons have a diagnosable mental health issue and/or co-morbid substance use, in addition to which many homeless persons consume alcohol and other substances to survive harsh conditions on the streets. Homeless men in particular often smoke cigarettes to suppress hunger, and use alcohol to help them to sleep. Rehabilitation efforts for HPWM need to include a detoxification component in existing inpatient services, and in state and non-state rehabilitation facilities. There is an emerging body of evidence in India for lay workers to deliver care packages to address harmful alcohol use. In the background of high prevalence of substance use, particularly of alcohol in Tamil Nadu, block-level mental health teams will require guidelines and capacity building to effectively screen for harmful use, offer primary-level pharmacotherapy and harm-reduction interventions and move up to in-patient care at district or state-level tertiary care centres.

G.4.d. Homeless persons with mental health issues and natural disasters

Tamil Nadu has witnessed devastating tsunamis, floods and cyclones, and homeless persons and those living in unstable housing are worst hit. Many individuals and families have repeatedly lost their home to successive natural disasters. Responses to date have been limited to moving people into shelters and community halls that get overcrowded, and seldom offer privacy and support services including trauma care and psychological first aid. In addition to incorporating ancillary support services as part of a disaster management plan, it is also recommended that governments and welfare systems co-opt newer stakeholders. Hotels, for instance, are seldom used; during the second wave of COVID-19, given the lack of hospital beds, hotels opened up as care facilities (*The Hindu*, 2021). It is recommended to use this approach in other situations, including natural disasters, extreme weather conditions and such like.

G.4.e Development of human service professionals

In order to provide customised care and introduce 'whole person approaches' (Eldal et al., 2019) to mental health that takes account of mental ill health, social health and mental health, it is essential to establish a transdisciplinary team that works at the intersections of health, disability, community inclusion, inclusive development and social justice across diverse facilities. Sustained change in the sector will depend on a skilled workforce. **Mental Health and Social Care leaders, mental health and social care facilitators (MHSCFs) and other 'change agents'** (Steckler et al., 2018) **are therefore critical to translation of the Policy to tangible gains.** Investment in human resource development, skills and structure is an essential part of transformative structural change. It is therefore is recommended that the GoTN **establishes state-wide staffing norms and roles for mental health teams across the continuum from tertiary to primary care, with particular focus on enhancing the availability and skill sets of cadres to provide psychosocial interventions.**

There is increasing global evidence that appropriately trained and supervised lay workers, who do not necessarily possess professional qualifications in mental health, can successfully provide a wide range of interventions. Further, for services to take into account the social determinants of mental health and **conscientiously** provide interventions to address these, the roles of various disciplines in the mental health and social care systems need to be invigorated, to move away from an often default physician assistant role to specialists who offer inputs based on their disciplines. It may be necessary to create cross-sectoral linkages with existing cadres from poverty-alleviation and disability programmes in order to be able to expand services. The addition of grassroots negotiator roles in institutional and community settings to help people navigate clinical and social care resources may help achieve gains in social justice. We propose an audit and analysis of existing staffing norms, their orientation and skills to support the vision of recovery-oriented services across the continuum of care and use this as a basis to prepare a Human Resource Plan that will increase availability of grassroots cadres in community settings; and improve the representation of peer advocates, grassroots mobilisers, social workers, psychologists, nurses, nursing assistants and occupational therapists across the spectrum.

Institute of Mental Health, Chennai, the 2nd largest Institute in India, persistent efforts has got permission from The Government of India to start a 1 year Certificate Course in Psychiatric Nursing Assistant with an annual intake of 20 seats from the academic year 2020-2021 (G.O.(Ms) No.78 Dated: 17.02.2021). The skilled paramedics trained in this course will serve as mental health stewards and promote the ideal of community mental health.

G.4.f Training

Guidelines for Mental Health and Social Care teams have been outlined in Section H. In order to engage a diverse range of professionals and workers, there is a need to develop training modules on the Policy, on value-based approaches to mental health care, on operationalising ECRCs and special shelters and related protocols associated with their functioning, on early

identification of persons in distress or living with mental health issues in conditions of social disadvantage etc. We recommend that training human resources, from diverse fields who will be recruited in attaining this policy, who include:

- Training modules from IMH and other Departments of Psychiatry, Psychology and Social Work in Government Medical Colleges, and other mental health establishments, Universities and CSOs, for District Mental Health and Social Care teams and Nodal Mental Health Officers
- Relevant police officers
- Staff at ECRC, NULM shelters and rehabilitation homes
- FRTs
- Collaborating partners and CSOs
- Members from Panchayats
- Members from SHGs
- Members from Women's Development Council
- City Zonal Health Officers (Corporation)
- Legal Aid teams
- Community Based Rehabilitation workers
- Village Health Nurses
- Psychiatric Nursing Assistants
- School teachers engaged in child and youth mental health programmes
- Tribal Welfare Committees

Among these, many social work practitioners, psychologists, peer advocates and nurses or grassroots mobilisers and psychiatrists may be trained as Mental Health and Social Care facilitators (MHSCFs). They will liaise with FRTs, Mental Health Review Boards, ECRCs, Special shelters, various rehabilitation homes and inclusive living options, the Police, CSOs, the individuals concerned, caregivers, and all the intersectoral departments involved in providing care for homeless persons with severe mental illness. This cadre will also manage continued care and basic outcome tracking-related data and management skills, based in the ECRCs, DMHP programmes and the NULM shelters and operate the Social Care Desks located at various administrative levels of Tamil Nadu.

G.5.Compliance with the Mental Health Care Act (MHCA)

The MHCA recognises that determination of mental illness and authorisation of admissions into mental health establishments is a clinical decision. This means that the admission of a person to a mental health facility can be authorised only by the designated mental health professional (MHP) or the medical officer (MO); and reception orders by judicial magistrates for authorising admissions and discharge are no longer permitted. There are two kinds of admission methods recognised for persons with mental illness – independent admission and supported admission.

Independent admission: In this case, a person voluntarily requests to be admitted to the mental health establishment for treatment. The MHP/MO reviews the application on the basis of the

legal criteria and makes the decision. The patient can ask to be discharged at any time, and must be informed of this right on admission.

Supported admissions: In this case, the nominated representative (NR) requests admission of the person with mental illness (whose consent is not required). Supported admissions are authorised in exceptional circumstances when the individual lacks the capacity to make treatment decisions and/or requires very high support and any one of the following situations are met: (i) recently threatened/attempted or is threatening/attempting to cause bodily self-harm; (ii) has behaved/is behaving in an aggressive manner towards another person or causing them to fear bodily harm; (iii) they are at personal risk owing to the inability to take care of themselves.

Two MHPs must examine the individual independently based on the criteria set out in the Act for and certify whether the person should be admitted. Supported admission is initially for 30 days and can be extended further to 90 days, 120 days and eventually 180 days by repeating the admission process at each stage. The patient's capacity has to be assessed at least once a week. On regaining capacity, the patient can seek to be discharged or continue admission as an independent patient.

When the police bring a homeless person with mental illness to a mental health establishment, the same admission and assessment criteria apply. The MHCA allows mental health establishments to refuse admission if these criteria are not met, but they are obliged to protect the rights of persons with mental illness and thus provide appropriate health care and treatment as required. (Please refer Annexure 1 for detailed guidance from the MHCA.)

All homeless and wandering persons with mental illness have the same rights mentioned in the MHCA as others enjoy, including (i) right to equality and non-discrimination; (ii) right to medical insurance; (iii) right to community living; (iv) right to protection from cruel, inhuman and degrading treatment; (v) right to information; (vi) right to confidentiality; (vii) right to access medical records; (viii) right to personal contacts and communication; (ix) right to legal aid; and (x) right to make complaints about deficiencies in services.

The Mental Health Review Board (MHRB) is a district-level quasi-judicial body, whose role is to protect the rights of persons with mental illness and ensure implementation of the MHCA. If any person's rights have been violated or they wish to challenge any decision of the mental health establishment or law-enforcement official, they can submit a complaint to the MHRB to seek redressal of their grievances. The MHRB then conducts a proceeding and passes a binding order. The MHRB is also authorised to register advance directives and appoint/revoke/modify the NR.

G6. Needs Assessments and care planning

The MHSCF or the FRT will assess needs in coordination with identified and approved health, mental health and social care institutions in accordance with an individual's expressed needs

and in accordance with the priority grid (see Table 7) and the MHCA. Needs assessments conducted by the FRT and the MHSC teams located in the ECRCs will be multidimensional and focus on health and social care, financial stability, mental health, housing etc., incorporating the 'whole person' approach from the outset. Care pathways could lead the individual to safe spaces in rural and urban areas (see below), NULM shelters for the homeless where they exist, ECRCs when required across districts and / or in contact with a volunteer who will attempt to engage with the individual in a sustained manner over a period of time. The care plans will evolve and address immediate needs as well as ongoing and longer-term mental health and social care needs such as enhanced incomes, access to livelihoods and stable housing. Causal pathways that led to homelessness will also be taken into consideration in formulating care plans, in order to prevent the recurrence of homelessness.

G.6.a Outreach services

Not all HPWMI require in-patient treatment or referrals to a shelter (Corin, 1990). Many thrive on the streets with the support of local networks. In many cases, well-being (Renes et al., 2018) can be seen both as a sense of agency and freedom and also accessing support networks and friendships. Often, owners and employees of small establishments such as local shops become family and sources of security for HPWMI. They also provide employment, a stable income and sustenance by giving them various jobs, such cleaning, security work, buying provisions etc., encouraging participation and respect for neurodiversity. The forcible removal of homeless persons and thus severing contact from these ties only worsens trust issues, social skills and motivation for community participation. Judicious use of the priority grid as a reference seems key to pursuing goals of person-centred care.

However, there has for centuries been harm in the community, which still continues (Reid Quiñones et al., 2011). From abuse to assault and even lynching – HPWMI have experienced it all. Therefore, these have to be informed decisions based on the pros and cons of community-based support structures and outreach services versus ECRC-based in-patient care. It is recommended that at least one ambulance is available for each village panchayat across districts and one per zone in cities for emergencies related to mental health, and to meet the needs of HPWMI. These may be coordinated by the MHSCFs.

Morse et al (1996) define mental health outreach as 'workers contacting homeless mentally ill individuals in non-traditional settings for the purpose of improving their mental or physical health, social functioning, or utilisation of human services and resources'. The cornerstones of outreach are building relationships, trust and sustained partnerships with the relevant community. In the case of HPWMI, the following are essential:

1. Establishing contact and credibility
2. Identifying people with mental illness
3. Engaging individuals, conducting assessments (focusing only on screening and referrals seldom leads to meaningful outcomes; outreach therefore needs to be consistent, personalised and intensive)
4. Treatment planning, and providing ongoing service.

Outreach takes place in areas where HPWMI may congregate, including, eateries, shelters, places of worship, bus and train stations, to name but a few. A significant majority of HPWMI with experience of hospitalisation or other forms of custodial care that may not have been supportive or suited their needs, may mistrust outreach workers and mental health professionals. Support networks therefore also play a role in alleviating barriers that impede trust and relationship-building. It is therefore recommended that outreach services include the following.

G.6.b Consistent supply of food and water – A Tamil Nadu where no homeless person sleeps hungry or thirsty

There should be soup kitchens, food carts, linkages with GoTN-led Amma Kitchens and Kalaignar Unavagams and food and nutritional supplements provided at Sub-Centres made available for this purpose. Coordination with CSOs across NULM homeless shelters, ECRCs, religious trusts should aim to ensure that no homeless person experiences hunger or thirst for lack of basic food and water. These services should also be made available across approved smaller eateries on the national highways and in religious organisations that many homeless persons access or frequent. If necessary, the GoTN could compensate these entities. There should also be wide dissemination of information about sources of food and water to ensure it reaches all homeless persons in need.

G.6.c Access to toilets and shower facilities

It is mandatory that all toilets are free for HPWMI, and we recommend that additional toilets be built with shower facilities at places where homeless people tend to congregate, such as toll gates, bus stations, train stations, religious organisations. Information about these services needs to be disseminated. NULM shelters and ECRCs could also be used for this purpose, even if the individual opts not to seek continued care in these facilities. All toilets should ideally be equipped to meet women's menstrual hygiene and other sanitary requirements. This may also help build trust and encourage the person to access mental health care over a period of time. Private CSOs and hotels may also be approached to offer their toilet facilities, as well as food and water to HPMHI as part of a larger campaign around the '**Kind People, Happy City/ Village**' initiative to foster a sense of community and care for the most vulnerable. In addition, to make villages, towns and cities friendlier to those who are homeless, stores selling clothes and sanitary products may be piloted at vantage points in an attempt to layer up services. While this would provide options for homeless persons to interact with MHSCFs who would manage these stores, dealing with such non-threatening environments may also foster trust. **These comprehensive outreach units combining food, clothing, water, access to toilet and hygiene products may be located in shelters, ECRCs, private establishments such as small eateries and hotels, CSOs, GoTN-run stores and canteens, religious establishments etc.**

G.6.d Access to medical care

All medical care should be provided free at the point of delivery in any hospital that a homeless person goes to, whether referred or as a voluntary patient seeking treatment for a specific concern. Attendance should not be mandatory for admission into a health facility.

G.6.e Access to a MHSCF and social care desks

MHSCFs should be available as required to address concerns at shelters, ECRCs, rehabilitation homes, rest houses, hospitals and as part of hospital and social care teams. They may assess needs, make referrals to appropriate facilities and identify options that may work best for the individual. All data should be centralised so that work and social care options may be tracked by multiple departments and governments involved until appropriate responses/ solutions are identified.

G.6.f Safe spaces, rest houses and **community buildings for short stay**

Short-stay access to non-restrictive, 'live on your own terms' rest and care/ housing provision may suit the needs of some individuals, until there is enough trust to seek longer-term care and / or support services. These may draw on the work and fellowship components of the 'clubhouse' model and facilitate closer support circles. It is recommended to initiate models ranging from those located within NULM shelters and ECRCs to charitable trusts or faith-based organisations. Any policy must comply with the values of community inclusion and civil society participation, incorporating the needs of HPWMI and other homeless persons in urban planning. This includes using existing community buildings and kitchens on a regular basis (with fixed times for access).

Safe spaces in and around religious and charitable organisations that may also wish to offer beds for the night or short stays, ideally also offering basic amenities. Details should be made available, and the establishments inspected and, if approved, listed by the GoTN. Such places could also serve as hubs that connect people to continued medical, mental health and social care services as required.

G.6. g Critical Time Interventions – Emergency Care and Recovery Centres

'As long as the harm is serious and its likelihood of occurring high, a case presents much of a basis of civil commitment as do others when there is a case of serious harm. He is exposing himself to more than the usual harms from being homeless, and he is doing so as a result of his mental illness', according to Elyn Saks.

This is the subject of many debates, and there are obviously grey areas and valid arguments on both sides. One of the most balanced views was expressed by Dr Elyn Saks, a mental health advocate and service user, stating that persons with mental health issues undergo several personality changes, which means that their voice of rejection may not be their own. When 'a lack of mental capacity' leads a mentally ill person to refuse hospitalisation or care that would help alleviate their suffering, provided it is offered in a supportive manner that is aware of their needs and distress, then their rejection of services must be considered carefully, since thriving or flourishing is one of the goals of mental health care and social health – which, ostensibly, a life on the streets may not offer. One way to minimise ethical and legal dilemmas in such

situations, according to Saks, is to record a person's future decisions on involuntary commitment after hospitalisation following their first psychotic episode. Processes of CTI, or 'rescues' as they are commonly referred to, need to respect the values of dignity and responsiveness and, as far as possible, choice. Supported decision-making involves working with the individual in their best interest, in accordance with the choices they would have made towards their well-being. The FRT, for instance, has to spend time understanding the person, their wishes and preferences, and set out in detail the nature of their care plan. Services offered at the institution also need to be explained to the person to build trust and credibility, without which procedural justice will be denied, with negative long-term consequences for the therapeutic relationship.

It is not recommended to engage in mass drives or admissions and 'rescues', which can burden the individual, break trust and place pressure on the health and social care system.

G.6.i Inclusive long-term care options

I. Rehabilitation Homes: It is recommended that rehabilitation homes run in collaboration with CSOs should be better staffed and resourced, and budgetary allocations increased significantly in order to ensure adequate staffing and infrastructure. Long-term care may entail support throughout a person's life, especially in the case of those with severe disabilities. The physical design of the space has therefore to be inclusive, allowing for physical mobility and opportunities for social mixing.

ii. Home Again, scheme of assistance for personal support and housing options: It is recommended that community-based housing systems be assigned for those opting not to return to families and requiring long-term care. An approach piloted by The Banyan and validated by the World Health Organization (WHO, 2021) suggests that persons with severe psychosocial disability requiring long-term care may be offered housing support across different sites or congregated, under the supervision of a mental health care team, approved by the Department of Welfare of Differently Abled or the SMHA. Similarly, hostels with financial assistance to buy in support from government -licensed user–carer collectives or CSOs are recommended for those who prefer hostel-type options. Atypical discharges such as self-discharge to independent living as a single employed person or communal living should be recognised and implemented. Hiring support need not be tied to structured programmes or housing facility-based arrangements. Adults with a psychosocial disability who have their own homes may instead choose to hire support of choice with the financial assistance package. Similarly, some may only require housing options that may be offered in diverse forms consistent with personal preferences. No-one may be coerced into choosing a specific living arrangement.

G.6.k Support for carers

Caregivers are a crucial informal workforce, who are often undervalued and face challenges in maintaining their caring role, well-being and health. Vulnerable or informal caregivers are often exposed to exploitation due to their lack of rights or unions to represent them. They are often underpaid, forced to work long hours and are exposed to trauma from caring for those with an illness. First, the identification of the vulnerable caregivers and the nature of their vulnerability can improve their well-being and health as well as their patient's. Furthermore, studies have demonstrated that failing to address the needs of vulnerable caregivers can create a stressful and potentially unsafe environment for both parties. It is therefore crucial to ensure reasonable working hours and adequate compensation, along with access to schemes and benefits, since many working in this sector are from lower socioeconomic strata.

G.6.l Legal Aid Services

The Indian Constitution promises the right to free and quality legal aid to the poor and weaker sections of society, including mentally ill (Article 39A and Article 21). Engagement with the Tamil Nadu State Legal Services Authority (TNSLSA) on the needs of mentally ill would improve the quality of legal assistance offered by legal aid lawyers. Measures to make access to legal aid for the mentally ill should remain at the core, by establishing a legal aid clinic at every mental health care institution across the state. Organising regular workshops and seminars may further improve dialogue on this issue – enabling lawyers to educate clients about their legal rights, and set out the limitations within the legal system and courts when these interact with the mentally ill.

G.6.m Focus on recovery: core tenets of a localised recovery approach include being integrated across long-term care centres including safe spaces

i The primary goal of community reintegration in the way that makes most sense to the individual in the context of family, community and culture – including options of family reunification, supported employment and/or residential community living.

ii. Services that centre 'functional' support over medical intervention, i.e. that enable access to normal daily activities (cooking, bathing), social flourishing, work or training, civic participation and religious involvement.

iii. Intentional support in navigating community and social obligations, hierarchies and identities as central to the healing process.

iv. Dialogic practice, including collaborative therapies, and the co-design, co-production and participatory evaluation of programmes and services, wherever feasible.

Design and social architecture*:* The design of any safe space, ECRC, a shelter or any long-term care option must be unintimidating, promote social mixing and foster a sense of hope and community. The staff should have skills that allow them to demonstrate dialogic practice and 'whole person' approaches embedded in a system that values dignity and individual uniqueness, encouraging free expression and allowing for uncertainty and flexible schedules and care planning. The spaces should ideally have open wards, separate rooms or spaces for individual therapy sessions and encourage movement and mobility, i.e. residents should be able to visit theatres, markets etc. while being treated and housed.

Mental health and inclusive development dialogues: Encouraging town hall discussions among building associations (in urban areas) or panchayats (in rural areas), local eateries, area councillors and homeless persons fosters an environment of trust and dialogue, and eventually leads to inclusive city, town and village planning.

G.7 Approaches to care

G.7.a The role of culturally resonant therapeutics

In the Indian context, it is essential to offer an eclectic mix and range of psycho-therapeutic and social services, in view of the diversity of culture, availability of resources and social context. Socially isolated communities such as the Irulas, dalits, and sexual minorities who continue to experience extreme forms of physical, social and economic exclusion call for a determined focus. Conventional Psychodynamic and behavioural approaches may not always yield results, given that social triggers are often located within local cultures, sub-cultures and social systems. It is therefore recommended to use experimental therapeutics to better understand and address the role of social and ecological factors in precipitating ill health and the role of psychosocial interventions in alleviating related distress. We propose sensitisation of panchayat/ block/ zonal mental health teams and building their capacities to engage with such excluded minorities, in order to understand their unique cultural narratives of mental health, adapt services accordingly.

G.7.b Focus on participation and self-reliance

It is recommended to pay significant attention to income enhancement and self-reliance in order to break stereotypical roles and demonstrate varied and valued social roles, matching skills with vocation and income. This may also reduce the recurrence of homelessness as a consequence of unemployment or abject poverty.

a. Incubate user-led social enterprises with active public interfaces, such as cafés, tourist trails, production and retail of indigenous arts and crafts, which engage with the public to challenge existing narratives of mental ill-health; develop a museum of the mind to develop the journey of mental health treatment over centuries in Tamil Nadu as a means to promote dialogue and discourse.

b. Build networks with employers, advocate for inclusive policies and offer supported employment translating into long-term placements in the service sector – catering, housekeeping, security, gardening, data management and determining placements based on aptitude and skills.

c. Recruit and skill a cadre of peer service providers (service users as health care coaches, care coordinators etc).

d. Psychosocial Disability is one of the disabilities mandated by the RPDA, which recommends a 3% reservation for those with mental health concerns. ‘Reasonable accommodation’, one of the core tenets of the UNCRPD (2007), may be suggested

for those living with a severe mental illness and seeking employment so that that workforce participation is inspired, matching interest, capability and health needs.

G.8 Enabling intersectoral linkage – facilitating access to citizenship, allowances, nutrition, employment, housing and catalysing social mobility

Convergence between health and social welfare mechanisms are essential to ensure comprehensive care that can mitigate clinical symptoms and socioeconomic issues. Schemes and interventions provided by different departments need to be coordinated to jointly serve users' diverse needs. We recommend establishing interagency/department agreements with the disability sector to reach a consensus for identifying disability in mental illness and to align the issue of a disability certificate and disability pension with the care process for people with mental illness. Similarly, government departments and agencies for urban and rural housing need to be engaged to allocate housing for those with long-term care needs enrolled in Home Again; and agencies/departments involved in urban and rural livelihood rejuvenation must be encouraged to allocate dedicated resources for increasing employment opportunities for people with mental illness.

Grassroots mobilisers who play negotiator roles – jointly delivering necessary health interventions, with assistance to access social care – will be mandated to work with a focus on the ultra-poor households who have a family member with mental illness and mitigate risks of descending into homelessness. We further propose cross-training of staff in the Department for the Welfare of Differently Abled Persons, mainly the District Disability Welfare Officers and key functionaries in their offices, to sensitise the recognition of disability in mental illness and clarify agency roles. To further strengthen integration, we propose State-level sensitisation and training of leaders in urban local bodies and panchayats and building capacities of block-level mental health teams to engage with and train local Village Poverty Reduction Committees (VPRCs), self-help groups and other such institutions.

G.9. Providing a continuum of care, using Sub-Centres and Urban Health Centres as first contact and follow-up hubs

We recommend developing Sub-Centres (and Urban Health Centres), which are currently used mainly to provide maternal and child health interventions, as hubs for social care assessments, joint delivery of health-linked welfare entitlements, e.g., disability allowance for people receiving therapy for mental health issues, follow-up and home-based services for those discharged from a higher level of care, lay counselling services and group-based therapies. They could also operate as follow-up centres for those discharged from a higher level of care and provide 'step-down' services. These centres would be staffed by grassroots mobilisers (assigned to the PHCs) recruited to work as part of the DMHP.

Continuity of care for people with complex needs – People discharged from tertiary care/in-patient settings, or who have antecedents of homelessness, or with unremitting symptoms or living in absolute

poverty require specific attention and consistent engagement to support their living in the community and reducing their recourse to in-patient care. We recommend establishing a rigorous 12–18-month home-based programme of continuity in care, which supports the development of independence in domains necessary for social functioning ranging from self-care to participation in work and civic life through a matched community volunteer or health worker.

G.10.Tech-enabled data information management systems

We suggest using a technology platform to record data across services to support key collaborative care and follow-up. These would include maintaining details from users' health records from first accessing a service to discharge and follow-up relevant to service delivery with mobile-based interface for staff and users to access their records; identifying and recording anonymised research-relevant data for the purposes of improving services and introducing innovations; collating information on outreach by FRTs and periodically checking against the centrally maintained missing persons database; a mobile application for staff different levels of service delivery with dashboard-based task review and assignment to enable them to easily access their daily assignments and collaborate with other staff and agencies involved.
It would also enable the collation of support resources, government schemes, local support networks and so on, with easy communication via the mobile application for referrals.

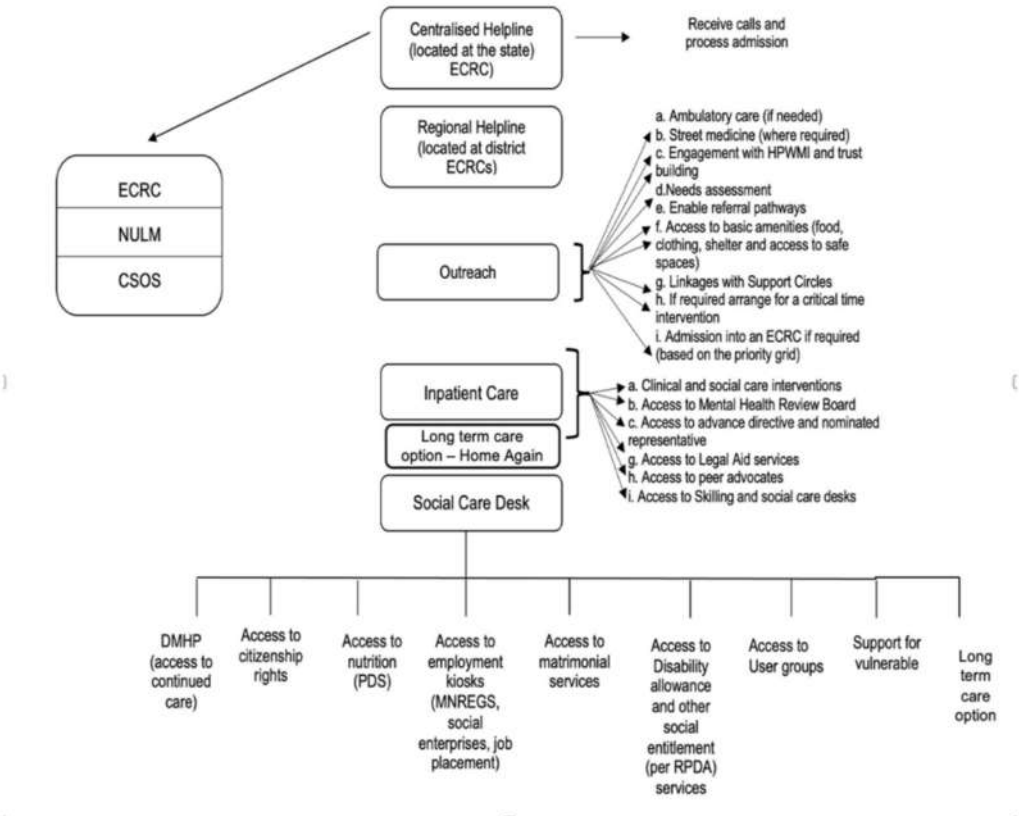
In designing these systems, the principle of 'privacy first' needs to be followed with stringent permissions protocols governing access to personal data, which remains the property of that individual. Personal data should be used only in order to achieve better service delivery and with the individual's explicit consent.

G.12 Collaborative quality audits

A Collaborative Quality Audit is the process of systematic monitoring and examination of a particular system to identify strengths and gaps, and provide ongoing evaluation. Given the inclusion of multiple stakeholders, and an emphasis on the collaborative involvement of various government bodies and NGOs or CSOs, and including those with lived experiences, it is imperative to develop a system of collaborative audit. This will allow for a periodic assessment of the stated policy goals and objectives, and facilitate any necessary adaptations and improvements. A collaborative audit will further inspire trust and assurance among the various stakeholders. This is further explained in Section I.

G.13 Directory of institutions

A directory of services available for homeless persons and persons with mental illness including State Hospitals, ECRCs, NULM Shelters and NGOs at the district level should be lodged at all police stations, hospitals, care homes and relevant departments. It is also recommended that all service providers have live dashboards showing the available beds at each facility.



Section H

Focus on Value-based Care, Sustaining Well-being, Flourishing and Recovery: Guidance for Mental Health Practitioners

H.1 Active empathy and dialogic practice: Inculcating a climate of trust

It is imperative to be empathetic in working with any human being, not only persons with mental health issues. This goes beyond ‘putting oneself in another’s’ shoes to truly understand the other person’s perspectives and circumstances, and suspending preconceptions and opinions during the therapeutic process. Aligning with the Housing First and Home Again type of

approach (Narasimhan et al., 2019), outreach workers and those involved in referral should understand fundamental principles of harm reduction, and non-judgmental provision of services even if an individual is engaged in forms of behaviour (e.g., sex work, illegal drug use, refusal of COVID-19 vaccinations) that the professional finds problematic.

In a therapeutic relationship with a person with mental health issues, it is critical to build a sense of trust, belief and faith in their narrative from the outset. This enables the person to share their experiences and feelings candidly, and establish trust. An area of progressive thinking in mental health stems from dialogic frameworks, which were largely developed in northern Europe, inspired in part by the work of the Russian philosopher and linguist Mikhail Bakhtin (Bakhtin, 1981, 1986), and elaborated in Anderson's reflecting therapy (Andersen et al.,1987, 1991) and Finnish Open Dialogue (Seikkula et al., 1995; Seikulla & Olson, 2003). Collectively, these approaches emphasise the collaborative construction of one's own experience and its meaning through conversation and dialogue with others. Applied to therapeutic interventions, dialogic approaches ward against imposing external explanatory frameworks, emphasising democratic and non-hierarchical participation (by families, clinicians and service users, as the case may be) in a process of dialogue and discussion. Many dialogic writings explicitly stress the importance of 'being with' rather than 'doing to' or 'for' (Andersen, 1997, 2007), even when a person might be appear confused or 'disordered': it is key to show patience, tolerance of uncertainty, and a commitment to allowing individuals to make decisions in their own time.

H.2 Trauma-informed approaches to care

People who end up without a fixed abode or on the streets have often experienced significant trauma, including mistreatment by family members, health workers (especially in confined hospital settings), and in many cases, sexual, physical or verbal victimisation (Gilmoor et al., 2020; Bhattacharya et al., 2021; Roy et al., 2014); these individuals may or may not agree with a conventional understanding of psychosocial disabilities as 'illnesses' or 'disorders. It is therefore imperative that community workers and providers who interact with such individuals and/or who play a role in their referral to supportive services are trained and prepared to engage in trauma-informed, culturally sensitive, non-coercive, collaborative care. Although there are simplified versions of 'trauma informed care' (TIC) that focus on screening for childhood adversity and/or trauma and awareness of its impact on mental and physical health, more robust TIC frameworks direct attention to the complex and layered ways in which cumulative experiences of disempowerment and/or force, including those arising from institutions such as hospitals, affect individual agency, self-worth, and trust in individuals and institutions. TIC approaches to outreach and engagement emphasise the maximisation of self-direction and careful avoidance of practices that repeat/replicate relational violence. In the context of gender, TIC approaches underscore the need to pay attention to the gender preferences of individuals who have experienced gender-based violence and the importance of creating a sense of physical and emotional safety.

H.3 Culture-specific healing processes

Creating the capacity for 'aspiration' and hope, as Appadurai (2013) notes, also requires understanding the models for living a good and worthwhile life that only culture provides. This makes it essential to have some understanding of locality and context. Culture is not only about tradition, heritage, and the past reservoir of ideas; rather, it is a template and matrix for understanding and projecting social actions into the future. Indeed, it is about the future, as a model of 'of' and 'for' reality, as Geertz famously argued (1974). Much medical anthropology, as Cohen (2012) observes, has either aligned itself with or against medicine in championing locality and culture over universal public health models of illness and disease. That is, some aspects of medical and psychological anthropology have overstated that illness is a cultural construct, or is 'culture-bound', as in the emphasis on 'culture-bound syndromes' in the literature. But Cohen, like Kleinman, has also pointed towards another reality: that the body, while cultural and local, is also produced at the crux between structural conditions *and* local beliefs. The local body is produced through experiences of poverty, malnutrition, and repeated social defeat, as much as it is shaped by beliefs and models for living. Simply put, structural and social violence is at the core of understanding any local context, in addition to how this body is experienced in symbolic or meaningful terms (Rajan, 2017).

The contribution of religious institutions in extending ontological security (i.e., a stable mental state) and a sense of hope among HPWMI is often understated. Places of worship across Tamil Nadu run soup kitchens, offer shelter, employment and mobilise other forms of support for HPWMI through their devotees and patrons. They also approach neurodiversity with equanimity and a sense of duty, which enables individuals to find peace, calm, acceptance and opportunities to be themselves and thrive. The work of anthropologists (e.g., Obeyesekere, 1985; Luhrmann & Marrow, 2016; Corin 2007; Gopikumar, et al., 2016) has indicated the critical role that faith and traditional healing practices continue to play in establishing a sense of well-being and fortitude in the wake of the structural violence that has affected material conditions within communities and individuals. Community resilience and aspirations towards a better future depend not only on external assistance, but are integrally linked to existing cultural and spiritual resources within the community. Therefore, any outside interventions and mobilisation of community empowerment are more effective when combined with meaningful forms of living already existing within communities, as aspiration and culture go hand in hand (Appadurai, 2013).

H.4 Sustained engagement and responsiveness

It is imperative that mental health professionals foster an environment in which it is accepted that an individual may experience distress, while still ensuring the individual has a safe space to move through their ups and downs, and regain stability. Owing to the nature of mental illness, individuals may swing between good and bad days, and the care team must ensure that they are supported and have a non-judgemental space in which they feel comfortable with experiencing their emotions. Similar forms of engagement and responsiveness are also seen in families when they do not 'let go of' their loved ones, but continue to engage even in the face of

strong insistence to give up. Persistence and resilience will hold mental health professionals in good stead, especially in working with HPWMI.

H.5 Building a culture of interdependence

Contrary to the idea that a health practitioner should maintain a professional distance from the patient, many practitioners believe that organic and symbiotic bonds (Mehry, 2018) between them result in more honest and authentic engagement, and greater change in the patient's mental, emotional and psychological well-being. It also makes the relationship easy and more equal, inspiring the health professional or social care facilitator to invest in the individual's well-being, who then builds reciprocal trust and cares for the relationship and practitioner. Conventional approaches to therapy may, however, not always be appropriate in low-resource settings or in addressing complex issues such as 'just therapy'.

H.6 Fostering choice and agency

Practitioners should seek to ensure that the individual can make their own everyday choices, such as about clothing, leisure, food, religion, spiritual practices, friendships, engagement and withdrawal, intimacy or even the expression of anger. It is important to show the individual empathy and respect.

In the last decade, 'recovery' approaches have been diversified or complicated by changes in other areas of international development and human rights. Amartya Sen's (2009) Capabilities Approach (CA), for example, has influenced and helped reframe thinking about community participation in mental health (see also Hopper, 2007; Wallcraft & Hopper, 2015; White et al., 2016). Highly influential in international development, CA focuses on the freedom to experience or find well-being, understood as a function of people's 'capabilities' and 'functionings'. Capabilities are the 'doings and ways of being that people can (or should be able to) *choose* to pursue – such as marriage, civic participation, and work. 'Functionings' are capabilities that have been chosen and realised. CA stresses the role of social, cultural and environmental factors in the context of capabilities. In other words, the social, political and physical environment in which people live should provide the opportunities to realise chosen functionings.

In the context of mental health policy, and aligning with other socio-ecological disability frameworks, the CA thus highlights the extent to which the well-being and community participation of people with psychosocial disabilities depends on the society in which they live, rather than arising solely from 'intrinsic' individual impairment. Practical interventions loosely connected to CA, seek to create additional enabling opportunities (e.g., capital to start a small business), in addition to support focused on individual manifestations of disability.

H.8 Building a culture of innovation, supported by feedback from users of mental health services

Mental health is a lifelong aspiration that is seldom linear. Care structures therefore need to work with an individual's ebbs and flows, and professionals encouraged to innovate on the basis of their core values. This could mean incorporating two coordinators for one individual, bringing in family members, friends who lived with them on the streets, going outside a hospital setting and engaging with the person in a place where they feel more comfortable, and so forth. This is an often under-explored catalyst in promoting well-being and personal recovery.

H.9 Representation/peer leadership

A further major development in mental health services, health interventions and support more widely is that of so-called 'lay,' 'community' and/or 'peer' support or intervention roles (see also Balaji et al., 2012; Javadi et al., 2017; Rathod et al., 2017). In the broadest sense, these roles may cover any area of service provision (transport, assistance with basic needs, befriending, group facilitation). In many countries, lay and/or peer workers can be found in a wide range of settings, including prison-based mental health services, hospitals, and residential facilities as well as non-medical community-based programmes (Myrick & DelVecchio, 2016; Repper & Carter, 2011; Sokol & Fisher, 2016). Specific to mental health services, peer roles are generally premised on shared experiences of these services and psychosocial disability, and common activities include outreach and engagement, direct support for the challenges associated with psychosocial disabilities, and the navigation of complex or difficult-to-access services (Chapman et al., 2018). It is also worth underscoring the value of 'peer workers', particularly in relation to outreach to unhoused individuals or groups; a large body of narrative and qualitative research illustrates the potential of individuals who have themselves navigated homelessness to effectively connect with those currently on the streets (Olivet et al., 2010; Vale, 2004).

Given the diversity of roles, peer workers' principles of practice vary, but most peer-support frameworks emphasise mutuality, reciprocity, shared sense of belonging, and the development and exchange of experientially grounded learning and strategies (Andersn et al., 2017; Mead et al 2001; Sweeney et al., 2016). In addition, individuals with similar experiences to those they are supporting (or trying to reach), often include insights other professionals may not have, including knowledge and understanding of 'street survival' strategies among homeless individuals (Fisk et al., 2000), 'real world' ways of accessing or qualifying particular services and benefits (Paskett et al., 2011; Valaitis et al., 2017) and techniques for dealing with disability-related challenges including distressing voices and paranoia (Corstens et al., 2014), and social stigma (Burke et al., 2019; Yu et al., 2018).

In addition, family-peer roles, in which families of individuals with significant psychosocial abilities are trained or employed to connect with and support other families in a similar situation, may be particularly valuable when they are able to bridge linguistic and cultural differences.

In building teams and creating support structures at emergency, outreach and long-term facilities, it is vital to ensure adequate representation of persons with lived experience of mental health issues/psychosocial distress in navigating complex problems. In addition to people with lived experience, local representation and an equal gender balance (with pay parity) adds

diversity to the stakeholders engaged in care and support for persons with mental health issues, and ensures crucial cultural, religious and gender representation and understanding about ill-health and recovery. In the context of social medicine, this planning becomes central.

H. 10 Balancing dignity, risk, care and rights

While the minimisation of coercion is an important principle of rights-based care, in reality serious psychosocial disabilities, particularly schizophrenia or intellectual disability, pose major ethical challenges with respect to balancing dignity and risk, rights and care. While high-level ethical principles may guide policy, in practice certain situations tend to be idiosyncratic, complex and require highly individualised decisions. Even in such situations, direct or indirect coercion, basically forcible treatment, must be kept to the absolute minimum, a principle that should form the basis of all staff training, backed up with ongoing supervision, potentially including peer supervision, to promote on-the-ground quality. While involuntary treatment or decisions should never be the default, they are sometimes unavoidable. For instance, infectious diseases (and related treatment decisions) carry risks not only for individual patients and carers, but also for others in places where people congregate or in large families/communities.

H.11 Diverse social and cultural frameworks for understanding mental illness and their clinical importance

Much has been written about the 'sociocentric' self in India and other parts of Asia, in which, as many analysts have suggested (Kakar, 1982; Obeyesekere , 1985; Nichter, 1982; Roland, 1988; Fabregas, 2009), the individual is healthy insofar as they are in harmony with the collective. To 'know thyself', as Kakar (1982 argued, is to shift one's internal state to harmonise with the social and, by extension, the universal, and to dissolve the individual ego, in conventional Hindu terms; whereas in the West, to 'know thyself' means to know the limits to one's own wisdom and understanding, which assumes a constant sense of identity as unique and bounded.

From a constructivist position, the experience of selfhood and normality is culturally defined, making universal claims about disease and illness impossible. Foucault (2006) took this argument further, claiming that madness is the thinking of power and the defining of normality based on power expressed in cultural discourse and social practice (Rose, 2018). Cultural determinists in anthropology, conversely, committed to the idea of greater plasticity as an adaptive capacity, adopted relativism in shaping the human experience (Geertz, 1974; Rosaldo, 1984; Benedict, 1934; Shweder et al., 1984), arguing that there is no one universal psychiatric paradigm that is common to all human beings. At the other end of the spectrum, universalised bio-medical diagnostic psychiatry would argue that while the expression of symptoms may vary in different cultures, the underlying brain pathology behind, for instance, schizophrenia, is more or less the same irrespective of its varied expression. The cultural content is regarded as a secondary level or elaboration of defences arising out of particular socialisation practices (Spiro, 1984; Devereux, 1980; Kardiner, 1945).

It is important, then, to find a middle ground between the romanticism of extreme constructivism and the reductionism of bio-medical aetiology, which ignores the social and cultural forces that underpin well-being and give meaning to life (Kakar ,1982; Obeyesekere ,1985; Kleinman, 1988, 2009)

For many decades, cultural and medical anthropologists, as well as providers and advocates directly engaged with people experiencing psychosocial disability, have drawn attention to the diversity and importance of heterogeneous 'cultural explanatory frameworks' or 'illness narratives' (Kleinman et al., 1978; Kleinman, 1988; Kirmayer & Bhugra, 2009). Clinicians in this tradition place particular emphasis on the importance of understanding the individual patient's or service user's perspective on their own experiences, identification with particular social and cultural explanatory frameworks, and subjective sense of how these frameworks influence expectations for support/treatment and recovery. As many scholars have noted, these frameworks are rarely 'monolithic'; rather, patients – as we all do – tend to draw on many explanations and beliefs, in part reflecting the complexities of contemporary multicultural, globalised societies (Charles et al., 2007; Jones et al., 2016; Legare et al., 2012). In the Indian context, historical traditions of Ayurvedic medicine, religious beliefs including Jainism, Hinduism, Buddhism, Indian Christianity, Islam and Sikhism, as well as British colonialism and exchange Asian traditions, have influenced ways in which communities might understand 'illness' (Senel, 2019; Weiss et al., 1988; Raguram et al., 1996).

Both older and more contemporary research on explanatory frameworks in India identify a range of beliefs and illness narratives, but has consistently found that only a minority of patients attribute their problems mainly to biological causes, even in the case of psychosis (Banerjee & Roy, 1998; Chadda et al., 2001; Charles et al., 2007; Saravanan et al., 2007; Srinivasan & Thara, 2001; Weiss et al., 1986); although studies have also found a potentially significant number of patients who deny that they are experiencing any 'mental' problems but concede physical illness (Shankar et al., 2006). This body of literature also suggests that most patients in India at some point consult traditional healers (including Ayurvedic, folk healers, and temple-based healers). Explanatory motifs include situational stress (marital affair, domestic discord, conflicts with neighbours), supernatural causes (divine punishment or retribution, 'black' magic, sorcery or witchcraft), and karma as well as social disadvantage, unbearable suffering or structural violence linked with inequalities related to caste, gender and class. Stress and intergenerational distress owing to dominant norms and mores have been shown to have an impact on mental health and 'recovery' trajectories, since perpetual emotional pain is often associated with these traditions and social systems.

Research on Indian explanatory frameworks for intellectual disability identified at birth is much more limited but seems to suggest a much higher prevalence of attributions to genetic, environmental and psychological causes during pregnancy and/or birth, including malnutrition, birth injury, and physical illnesses during pregnancy (Edwardraj et al., 2010; Thara et al., 1998).

Explanatory frameworks can significantly affect service users' or patients' perspectives on and decisions about treatment, as well as family and community views (Bannerjee & Roy, 1988) and the degree of stigma (Charles et al., 2007). It is therefore vital to understand and work strategically with explanatory frameworks not only directly with patients, but also in understanding the pathways to homelessness (including lack of access to care, family rejection or estrangement) and, eventually (and when appropriate), family (and neighbourhood/community) reunification. Formal or informal strategies for exploring individual and family explanatory frameworks and responding to these as appropriate (i.e. intervening when necessary, for instance when explanations are fuelling stigma or rejection) are a critical component of the long-term improvement of homelessness involving psychosocial disability and the population-level improvement of outcomes.

Section I

Learning Health Systems and Quality Audits

I. 1 Learning Health Systems and quality audits

Although formally conceptualised by the Institute of Medicine in the US (Olsen et al., 2007), the ideas behind 'learning healthcare systems' (LHS) are older and more diverse, including broader principles of continuous learning (Shrivastava,1983; London & Sessa, 2007), and practice-based research (e.g. Christoffel, 1988; Fox, 2003). The IoM working group defined LHS as a system that 'generates and applies the best evidence for the collaborative healthcare choices of each patient and provider; drives the process of discovery as a natural outgrowth of patient care; and ensures innovation, quality, safety and value in healthcare' (Olsen et al., 2007). Unlike earlier 'top-down' approaches to quality improvement in which models are developed in an academic setting (mainly in higher-income countries), the LHS framework shifts the focus to localised, culturally and organisationally embedded, practice-based learning. Many recent iterations of LHS have explicitly centred the roles of both ongoing involvement of service users and broader cross-systems community engagement with the aim of meeting needs and priorities that arise from practice rather than being externally imposed (Mullins et al., 2018). Although LHS has been implemented within systems of single hospitals and clinics, there are also numerous examples of distributed, multi-site and/or multi-system LHS.

Quality audits based on engaging service users are fundamental to LHS, helping ensure transparency and accountability and revealing priorities for improvement as well as broader opportunities for system learning. The existence of multiple diverse programmes and sites, as The Banyan already practises, amplifies opportunities for learning, as plurality allows system leaders to better understand the underlying causes of differences in practices and outcomes across sites, including complex interactions between local communities, the demographics of service users, and emergent (localised) provider practices. A further advantage of the LHS model and quality audit processes is the integration of mixed-methods, such as qualitative and

ethnographic approaches to understanding the needs and experiences of service users as well as larger-scale quantitative (e.g. clinical and administrative) data.

While the specifics of service-user involvement in LHS and quality audits continue to evolve (see Devine et al., 2013;Dixon-Woods et al., 2020), a long-term goal is the continual strengthening of the involvement of users and direct providers in setting priorities, decisions regarding what to measure and how, and strategies for strengthening two-way exchanges between users, providers and surrounding communities. In the context of homelessness-focused systems of care, for example, key stakeholders and sources of learning clearly include current/formerly homeless service users, community-based bodies and institutions (cross-disability organisations, religious entities, government officials, police, other health and social service providers) engaged in the complex chains of referral to homelessness-focused services as well as subsequent discharge and reintegration in the community.

Similarly, transdisciplinary research both seeks to understand implementation challenges and – with consistent and careful monitoring of the results of planned activities and shared reflection on challenges and opportunities with a team of experts and stakeholders – attempts to introduce mid-course reviews and adaptation of activities. Multiple mixed-methods approaches are used to acquire the necessary impact data, such as surveys, FGDs, interviews, or ethnographic notes. (See Brorese and Bunders (2010) for further analysis and assessment procedures of the transdisciplinary approach.)

In relation to measuring policy impact and auditing outcomes on the linked experiences of poverty, homelessness and mental illness, understanding, reflexivity and iterative responsiveness are the essential basis for dealing with complexity and intersectionality. At the level of policy development, it has already been mentioned that there is complexity both in the problem analysis and in terms of the diverse groups of actors and stakeholders involved. The starting point for work on policy implementation therefore involves a transdisciplinary approach that captures the needs and interests of all groups in order to foster collective action. It is also essential not to lose sight of the perspectives and experiences of those for and about whom policy is being developed, and to treat them as the focal point and unifying force in the process. While many forms of modelling and measuring intersectionality have been developed in recent years, most are centred on intersecting identities with distinct validity prominence in individual lived experiences and thus fail to accommodate the interdependency inherent in the experiences under consideration. The complexity arising from how these experiences intersect and reinforce each other results in the need for pluralist understanding as a basis for outcome measurement.

Given that the heterogenous experiences of complexity take diverse pathways, however, it is essential to treat any outcomes of qualitative impact measurement that arise from the initial exploratory research as iterative starting points in order to facilitate responsiveness to real-world situations and occurrences.

I.2 Understanding granular-level dynamics

Successful quality audits and impact evaluation need a detailed understanding as a baseline against which to anticipate and prevent implementation-related issues. This baseline would involve the following levels of analysis:

a) In-depth study of individual pathways of experience relating to the nexus of poverty, homelessness and mental illness, including barriers to intervention and support.
b) Recognition of patterns relating to disadvantage with an emphasis on identifying key tipping-points and triggers of decline in the quality of life.
c) Identification of alternative responses to tipping-points as precursors of resilience.

Understandings of prevention are not static in every phase of intervention and response, so an analysis of intervention outcomes needs to consider all levels of action. For instance, individual pathways and experiences pertaining to emergency care will not uniformly overlap with those of long-term interventions. For this reason, the three levels of analysis and understanding should be applied at each anticipated level of policy implementation to study the differential pathways of experience. This should form the basis for mutual learning across levels and the comparison of pathways and responses that might also prevent unanticipated problems in policy implementation.

I.3 Responsiveness and collaboration

In order that policy is responsive to individual realities and needs, it is essential to be proactive in including and evaluating experiential knowledge and in facilitating collaboration with the individuals themselves. This involves active consideration of experiential knowledge and individual pathways of intersectional experience as an applied approach to understanding needs and their complexity. For this reason, policy implementation should seek to work with embedded peer researchers to focus on reflexive evaluation of problem analysis and research priorities at all levels of intervention on a voluntary case-specific basis. This would entail treating everyone with experiential knowledge as stakeholders on equal footing and in active collaboration as researchers. This aligns well with the transdisciplinary approach to policy and intervention development, in which all stakeholders are treated as equal participants contributing valuable knowledge and information.

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ANNEXURE

Annexure 1 – Mental Health Care Act 2017 and Homeless Persons with Mental Health Issues

Mental Healthcare Act, 2017 for Homeless Persons

Introduction

The Mental Healthcare Act, 2017 (MHCA) was enacted in compliance with India's obligations under the UN Convention on the Rights of Persons with Disabilities with the objective "to

provide mental healthcare and services for persons with mental illness and to protect, promote and fulfil rights of such persons during delivery of mental health and services and for matters connected therewith and incidental to". The MHCA is guided by universally accepted principles based on the CRPD as a rights-based legislation for providing mental healthcare and treatment. These principles include:

- All individuals are entitled to basic human rights, including the right to equality, liberty and dignity;
- Every person must be given the autonomy to make the choices they consider the best for themselves and this extends to decisions about their mental health care and treatment;
- Everyone has the right to full participation and inclusion in society;
- No person can be discriminated against on grounds such as caste, class, ethnicity, sex, gender, sexual orientation, religion, disability, social, political or cultural beliefs;
- Receiving appropriate and varying levels of support (supported decision-making) is integral to exercise one's right to make their own decisions.

The MHCA recognizes the rights of all persons with mental illness while receiving mental healthcare and treatment. It also recognizes the right to access mental healthcare and treatment for all persons without discrimination. For this purpose, the MHCA places responsibilities on mental health professionals, caregivers, law enforcement officials and the government to provide rights-based mental healthcare and treatment. Further it also puts in place procedures and safeguards to ensure that persons with mental health problems are protected and not discriminated. The MHCA makes it mandatory for all mental health professionals in India to make changes to their clinical practice so that they can comply with the law.

Specific Provisions Applicable to Homeless Persons & Wandering Persons with Mental Illness

<u>Procedure to be followed by Law Enforcement Officials for Protecting Homeless & Wandering Persons with Mental Illness</u>

The MHCA places duties on police officials for taking into protection homeless and wandering persons who are suspected of having a mental illness. According to Section 100, the officer-in-charge of a police station has a duty to take into protection:

i) Any person who is wandering within the limits of the police station and who the police officer believes has a mental illness and is incapable of taking care of themselves
ii) Any person that the officer believes is a risk to themselves or any other person due to a mental illness. Such person or their nominated representative should be informed of the grounds for being taken into protection.

It is important to remember that such a person is taken into "protection" and not "custody" which means that the person cannot be arrested or treated as an accused or criminal.

a) Assessment of a Homeless or Wandering Person

After taking the person into protection, the police officer should send such person to the nearest public health establishment within 24 hours for assessment of the person's healthcare needs. Such person cannot be detained in a lock up or prison.

b) Assessment According to Provisions of MHCA

The medical officer in charge of the public health establishment will have to arrange for the assessment of the person and their needs. The same will be done in accordance with the provisions of the MHCA. The mental health professional or medical officer in charge will have to assess whether such a person has a mental illness of a nature or degree which requires admission. If yes, the person shall be admitted as per the provisions of admission in the MHCA.

c) If Admission Not Required:

If person doesn't require admission, then the mental health professional or medical officer in charge will have to inform the police officer of the assessment. Such person will be taken to their residence by the police officer. If the person is homeless, they shall be taken to a government establishment for homeless persons.

d) Lodge FIR:

For persons homeless, or found wandering in the community, a FIR for missing person should be lodged at the concerned police station by the police officer who finds the person. The officer shall trace the family and inform them of the location of such person. If a homeless or wandering person approaches the mental health establishment directly, then the mental health establishment will have to report the same to the nearest police station.

e) Role of Judicial Magistrates:

Judicial magistrates have no powers to issue reception orders or authorise admission of homeless and wandering persons in mental health establishments. However, if the judicial magistrate is informed about and takes cognizance of any homeless or wandering person who may have a mental illness, then the magistrate should order the police officials in that jurisdiction to comply with the procedure under Section 100 for protecting such homeless or wandering person.

General Provisions Applicable to Homeless Persons with Mental Illness

The right to equality and non-discrimination is integral to the MHCA. This means that all provisions of rights and access to mental healthcare and treatment of persons with mental illness applies equally to all persons whether they have identified families or not. This section

elaborates on certain general provisions that are important for the purpose of homeless persons with mental illness.

a. Nominated Representative (NR):

Section 14 of the MHCA provides for the appointment of NR for every person (whether or not they have a mental illness). The NR has the duty to support person when they are receiving mental healthcare and treatment; represent them in matters regarding their mental healthcare and treatment; provide the person adequate and appropriate support to make their own decisions. Some persons with mental illness may require varying levels of support from a trusted person while they are receiving mental health treatment and care. A NR can take decisions relating to mental healthcare, admission and treatment, on behalf of the individual. These decisions by the NR are temporary and last only till the individual re-gains their capacity to make decisions. Additionally, the NR can file appeals for discharge or complaints if there are any violations of the rights of the persons living with mental illness. The mental health professional is mandated to consult the nominated representative while planning treatments.

Further, Section 14 provides for a list of deemed NR, in cases where any individual including a homeless and wandering person has not appointed a NR or has been abandoned by their family and is unable to appoint a NR. In order of precedence these are:

a) Individual appointed as Nominated Representative in the Advance Directive; or
b) Relative; or
c) Care-giver; or
d) Suitable person appointed by the Mental Health Review Board; or
e) Director, Department of Social Welfare or representative as appointed by the Mental Health Review Board.
f) A representative of a registered organisation working for persons with mental illness can submit a written application to the medical officer or mental health professional in charge of the person's treatment. Such a person can be accepted by the medical personnel as a temporary nominated representative till the Mental Health Review Board appoints another NR.

b. Advance Directives

According to Section 5 of the MHCA, all persons (including homeless and wandering persons) have the right to prepare an advance directive specifying how they wish to be cared or and treated for a mental illness if they are unable to make decisions or don't have a NR to assist them in decision-making. The advance directive can be written in the format prescribed by the Central Mental Health Authority and must be registered with the local Mental Health Review Board.

c. Right to Community Living

The MHCA emphasizes a shift from institutionalization to community-based treatment and care. This means that any person can be admitted to a mental health only as a last resort and as the least restrictive option if they meet the relevant criteria for admissions. As far as possible community-based mental health treatment and care options are to be provided to persons seeking these services.

To this effect, the MHCA also recognizes a right to community living for all persons with mental illness. Section 19 states that every person has a right to live in, be part of and not be segregated from the society. Further no person shall continue to remain in mental health establishment merely because he does not have a family or is not accepted by his family or is homeless or due to absence of community-based facilities. The law provides that where it is not possible for a person with mental illness to live with their family or relatives, or where such person has been abandoned by their family or relatives, the appropriate Government shall provide support as appropriate including legal aid and to facilitate exercising their right to living in the family home.

The appropriate Government shall also, within a reasonable period, establish less restrictive community-based establishments including half-way homes, rehabilitation facilities and supported accommodations for persons who no longer require treatment in more restrictive settings such as long stay in mental health establishments.

d. Admission & Discharge

The MHCA recognizes that determination of mental illness and authorization of admissions in mental health establishments is a clinical decision. Therefore, under the MHCA admission of a person to a mental health can be authorized only by the designated mental health professional (MHP) or the medical officer (MO). Therefore, the law no longer recognizes reception orders by judicial magistrates for authorizing admissions and discharge. There are two kinds of admission methods recognized for persons with mental illness – independent admission and supported admission.

(i) *Independent Admissions*

In case of independent admission, a person voluntarily requests to be admitted to the mental health establishment for treatment. Upon receiving such a request, the MHP/MO reviews the application based on the criteria laid down by the law and decides whether admission is to be approved or not. In this kind of admission, the patient can anytime ask for discharge. The right to seek discharge voluntarily has to be informed to the independent patient at the time of their admission.

(ii) *Supported Admissions*

For supported admission, the NR requests for admission of the person with mental illness (the consent of the person with mental illness is not required). Supported admissions are authorized

in exceptional circumstances wherein the individual does not have capacity to make treatment decisions and/or requires very high support and any one of the following situations are met: (i) recently threatened/attempted or is threatening/attempting to cause bodily harm to the self (ii) has behaved/is behaving violently towards another person or causing them to fear bodily harm to themselves (iii) they are at risk to the self due to an inability to take care of themselves

2 MHPs are required to independently examine the individual based on the criteria in the Act for supported admission and certify whether the latter requires admission. Supported admission at the first instance is for 30 days only and can be extended further to 90 days, 120 days and eventually 180 days by repeating the admission process at each stage. The supported patient's capacity has to assessed frequently, at least once in 7 days. On regaining the capacity, the supported patient can seek to be discharge or continue admission as independent patient.

When homeless person with mental illness is brought to a mental health establishment by the police, the criteria for admission and assessment remain the same. The mental health establishments according to the MHCA can refuse admission of person with mental illness if the necessary criteria for admission are not met. However, a mental health establishment is under an obligation to protect the rights of persons with mental illness and thus provide appropriate healthcare and treatment as required.

e) Rights of Persons with Mental Illness

All homeless and wandering persons with mental illness have the same rights mentioned in the MHCA as other enjoy which include: (i) right to equality and non-discrimination (ii) right to medical insurance (iii) right to community living (iv) right to protection from cruel, inhuman and degrading treatment (v) right to information (vi) right to confidentiality (vii) right to access medical records (viii) right to personal contacts and communication (ix) right to legal aid (x) right to make complaints about deficiencies in services

f) Custodial Institutions

If any homeless or wandering person is residing in a state-run shelter home or establishment for homeless persons and if they appear to have a mental illness, then the person in-charge of the establishment or institution should take the person to the nearest public mental health establishment for assessment and treatment as per the MHCA's provisions.

g) Mental Health Review Board (MHRB):

The MHRB is a district level quasi-judicial body. The role of the MHRB is to protect the rights of persons with mental illness and ensure proper implementation of the MHCA. If any person's rights have been violated or they wish to challenge any decision of the mental health establishment or law enforcement official, then a complaint can be submitted to the MHRB for redressal of their grievances. The MHRB will conduct a proceeding and after hearing both

authorities shall pass a brining order. The MHRB is also authorised to register advance directives and appoint/revoke/modify a nominated representative.

Challenges in Protecting Homeless Persons with Mental Illness

a) Lack of awareness amongst the stakeholders, service providers such as MHPs, MHRBs, Police, Judicial Officers, government and nongovernment officials about their role and obligations under the MHCA.
b) The statutory bodies under the MHCA are either not constituted or are not fully functional to monitor implementation and redress rights violations.
c) Lack of government facilities such as shelter homes, halfway homes, supported homes where homeless and wandering persons can reside and rehabilitate if they don't require admissions or have been abandoned by families.
d) Misconception that all persons with mental illness need to be admitted to the mental health establishments irrespective of whether they actually require admission as the MHCA's criteria.
e) Mental health establishments, civil society organizations and law enforcement officials are still referring cases of homeless persons to judicial magistrates for issuing reception orders. Under the MHCA, magistrates cannot issue reception orders to authorize admissions of homeless or any persons.
f) Lack of inter-sectoral coordination between the government and non-government stakeholders leading to role confusion and non-compliance with the MHCA's procedures.

Annexure -2

TAMIL NADU STATE MENTAL HEALTH AUTHORITY
Institute of Mental Health Campus,
Medavakkam Tank Road, Kilpauk, Chennai-600 010

PROVISIONAL REGISTRATION OF MENTAL HEALTH ESTABLISHMENTS

SI. No	Name & Address of the applicant	Name of the establishment & Address	Date of Registration	No. of bed	Remark
1	**R. Praveen,** No.43, V.G.P. Amutha Nagar, Vengayamandi Bus Stop, Maduravoyal, Chennai.	**Turning Point Foundations**, No.43, V.G.P. Amutha Nagar, Vengayamandi Bus Stop, Maduravoyal, Chennai – 600095.	23.10.2020	25	**De-addiction cum Rehabilitation Centre**

	PinCode – 600095.				
2	**P. Sathyaraj,** No.62, 4th Cross Street, Farm Grove, Srinivasa Nagar, Kazhipattur, OMR Road, Chennai. PinCode – 603103.	**Nanmayam Wellness & Lifecare,** No.62, 4th Cross Street, Farm Grove, Srinivasa Nagar, Kazhipattur, OMR Road, Chennai, PinCode – 603103.	23.10.2020	40	**Psychiatric Hospital & De-addiction cum Rehabilitation Centre**
3	**Y. Simon Prabhu**, No.15/179, Rajaji Street, Moovar Nagar, Pozhichalur, Chennai. PinCode – 600074.	**Go Green Care Centre,** No.15/179, Rajaji Street, Moovar Nagar, Pozhichalur, Chennai – 600074.	22.10.2020	50	**De-addiction Pcum Rehabilitation Centre**
4	**G. Arumugam**, No.12,13,14, Bharathidasan Street, Venkateshwara Nagar, Oragadam Village, Ambattur, Chennai. PinCode – 600053.	**Helping Hearts De-Addiction-Cum-Rehabilitation & Mental Health Care Centre,** No. 12, 13, 14, Bharathidasan Street, Venkateshwara Nagar, Oragadam Village, Ambattur, Chennai – 600053.	27.10.2020	41	**De-addiction cum Rehabilitation Centre**
5	**J. Senthil Kumar**, No. Q1, 301, The Metro Zone, J.N. Road, Anna Nagar, Chennai. PinCode – 600040.	**Waves Home For Rehabilitation,** No. 19, C.V.M. Annamalai Street, Manavalan Nagar, Thiruvallur District. PinCode – 602002.	30.10.2020	150	**-**
6	**Dr. R. Srinivas**, No. 90, Thayumanava Sundaram Street, Poondurai Main Road, Kollampalayam, Erode – 638002.	**Lotus Hospitals and Research Centre Limited,** No. 90, Thayumanava Sundaram Street, Poondurai Main Road, Kollampalayam Erode – 638002.	31.10.2020	6	**Psychiatric Hospital**
7	**J. Devaraj**, No. 170, Kundan Nagar, Nellikuppam Road, Kannivakkam, Guduvanchery, PinCode – 603202.	**Keerthi Foundation,** No. 170, Kundan Nagar, Nellikuppam Road, Kannivakkam, Guduvanchery, PinCode – 603202.	31.10.2020	40	**Psychiatric Nursing Home & De-addiction cum Rehabilitation Centre**
8	**I.Dhanasekaran** No. 137/1, Sairam Nagar, Sankagiri Main Road, Nethimedu, Salem.	**Salem Care Foundation,** No. 137/1, Sairam Nagar, Sankagiri Main Road, Nethimedu, Salem. Pin Code – 636002.	02.11.2020	50	**Psychiatric Nursing Home & De-addiction cum Rehabilitation**

	PinCode – 636002.				**Centre**
9	**K. Nageswaran**, No. 2/122, Thanthai Selva Nagar, Puthenthal, Ramanathapuram District. PinCode – 623502.	**Humanitarian Trust, Chencholai Mental Health Archive**, No. 2/122, Thanthai Selva Nagar, Puthenthal, Ramanathapuram District. PinCode – 623502.	04.11.2020	100	**De-addiction cum Rehabilitation Centre**
10	**C. Jegan**, No. 4/147-1, Raja Ganapathi Illam, 6th Main Road, Annai Indira Nagar, Near Law College, Kannankurichi, Salem. PinCode – 636008.	**K.C. Foundation Trust,** No. 4/147-1, Raja Ganapathi Illam, 6th Main Road, Annai Indira Nagar, Near Law College, Kannankurichi, Salem. PinCode – 636008.	04.11.2020	20	**De-addiction cum Rehabilitation Centre**
11	**Dr. K. RadhaKrishnan** No.6A, Kalyan Nagar, Municipal Colony, Thanjavur. PinCode – 613403.	**Nila Psychiatric Hospital,** No. 9, Sennampatti Road, Vallam, Thanjavur. PinCode – 613403.	04.11.2020	90	**De-addiction cum Rehabilitation Centre**
12	**Dr. K. RadhaKrishnan** No.6A, Kalyan Nagar, Municipal Colony, Thanjavur. PinCode – 613403.	**Vaigarai Hospital,** No. 27, Shivaji Nagar, Near Membalam, Thanjavur. PinCode – 613007.	04.11.2020	20	**De-addiction cum Rehabilitation Centre**
13	**V.Kandavelu**, Plot No. 9, V.G.N Garden, No.62, Nolambur, Mogappair West, Chennai. PinCode – 600037.	**The Best life Foundation,** Plot No. 9, V.G.N Garden, No.62, Nolambur, Mogappair West, Chennai. PinCode – 600037.	06.11.2020	30	**De-addiction cum Rehabilitation Centre**
14	**T. Rajasimmon**, No. D-21, 1st Floor, M.T.H Road, Ambattur, Chennai. Pincode – 600058.	**Revamp Hospital,** No. D-21, 1st Floor, M.T.H Road, Ambattur, Chennai. PinCode – 600058.	06.11.2020	30	**Psychiatric Hospital & De-addiction cum Rehabilitation Centre**
15	**S.Vijaya**, Annai Theresa Nagar, Koottampuli, Tuticorin District, Pincode – 628103.	**Anbu Ullangal,** Annai Theresa Nagar, Koottampuli, Tuticorin District, PinCode – 628103.	06.11.2020	60	**De-addiction cum Rehabilitation Centre**
16	**Y. Sivalingam** No. 12/219, Vishnu Nagar Extension, Vinayaga Nagar,	**Ayya Trust** **De-Addiction and Psychiatric Rehabilitation Center,**	07.11.2020	20	**Psychiatric Nursing Home &**

	Padappai, Kancheepuram District – 601301.	No. 12/219, Vishnu Nagar Extension, Vinayaga Nagar, Padappai, Kancheepuram District – 601301.			**De-addiction cum Rehabilitation Centre**
17	**A.Elayaraja**, No. 4/10, 9th Street, Aandal Nagar, Alapakkam, Porur, Chennai. PinCode – 600116.	**Divine Life Foundation De-Addiction Cum Rehabilitation Center,** No. 29, Srinivasa Nagar, 2nd Street, Maduravoyal, Chennai. PinCode – 600095.	07.11.2020	45	**De-addiction cum Rehabilitation Centre**
18	**Dr. R. Reuben Paul**, No. 73, Vijaya Nagar, Thandal Kazhani, Kavangarai, Puzhal, Chennai. PinCode – 600066.	**Pioneer Rehabilitation Center,** No. 73, Vijaya Nagar, Thandal Kazhani, Kavangarai, Puzhal, Chennai. PinCode – 600066.	09.11.2020	50	**De-addiction cum Rehabilitation Centre**
19	**S. Kedharnath**, No. 102/1B, Arumbanoor Main Road, Othakadai Post, Madurai, PinCode – 625104.	**Spark Medical Centre De-Addiction & Psychiatric Care** No. 102/1B, Arumbanoor Main Road, Othakadai Post, Madurai, PinCode – 625104.	10.11.2020	100	**Psychiatric Hospital & De-addiction cum Rehabilitation Centre**
20	**M.P. Mohammed Rafi**, No. 5, Subbarayan Main Street, Nammalwarpet, Otteri, Chennai, PinCode – 600012.	**Anbagam Rehabilitation Centre,** No. 5, Subbarayan Main Street, Nammalwarpet, Otteri, Chennai, PinCode – 600012.	10.11.2020	40	**De-addiction cum Rehabilitation Centre**
21	**M.P. Mohammed Rafi**, Thirunilai Village, Vichur Post, Chennai, PinCode – 600103.	**Anbagam Rehabilitation Centre,** Thirunilai Village, Vichur Post, Chennai, PinCode – 600103.	10.11.2020	125	**De-addiction cum Rehabilitation Centre**
22	**K. Suresh**, No. 44, Thirumalai Nagar, Kundrathur, Chennai. PinCode – 600069.	**Confident Care Centre,** No. 44, Thirumalai Nagar, Kundrathur, Chennai. PinCode – 600069.	11.11.2020	15	**De-addiction cum Rehabilitation Centre**
23	**K. Suresh**, No. 5/134, G.S.T Road, Singaperumal Koil, Chengalpet. PinCode – 603204.	**Re – Life Foundation De – Addiction cum Psychiatric Care Centre** No. 5/134, G.S.T Road, Singaperumal Koil, Chengalpet. PinCode – 603204.	11.11.2020	10	**De-addiction cum Rehabilitation Centre**
24	**R. Panneer Selvam**, No. 12, 3rd Cross Street,	**Hope Research Foundation, Hope Alcohol/Drug and**	11.11.2020	21	**De-addiction cum Rehabilitation**

	Meenakshi Nagar, Villangudi, Madurai. PinCode – 625018.	**Psychiatric Treatment Centre,** No. 12, 3rd Cross Street, Meenakshi Nagar, Villangudi, Madurai. PinCode – 625018.			**Centre**
25	**P. Sakthi Kumar**, No.86/2A, 14/4C, 1st Floor, 200 Feet Service Road, Kanniamman Nagar Main Road, Maduravoyal Earikarai, Vanagaram, Chennai. PinCode – 600095.	**Serene Life Hospital,** No.86/2A, 14/4C, 1st Floor, 200 Feet Service Road, Kanniamman Nagar Main Road, Maduravoyal Earikarai, Vanagaram, Chennai. PinCode – 600095.	11.11.2020	45	**Psychiatric Hospital**
26	**Dr. S. Radhakrishnan**, No. 96 Am, Sathy Main Road, Via S.S. Kulam, Kurumbapalayam, Coimbatore. Pincode – 641107.	**The United Home For The Adult Mentally Ill,** No. 96 Am, Sathy Main Road, Via S.S. Kulam, Kurumbapalayam, Coimbatore. Pincode – 641107.	12.11.2020	50	**Psychiatric Nursing Home (Closed)**
27	**B. Kumaran**, Old. No. 47, New No. 16/1, Vivekananthar Street, Kadapperi, Maduranthagam, Kanchipuram. PinCode – 603306.	**Miracle Foundation,** Old. No. 47, New No. 16/1, Vivekananthar Street, Kadapperi, Maduranthagam, Kanchipuram. PinCode – 603306.	12.11.2020	20	**De-addiction cum Rehabilitation Centre**
28	**S. Vidyaakar**, No. 112/3,4,5 & 6 Block – I, S.No.111/7 & 115/15A Block-II, Girivalan Road, Adiannamalai village, Thiruvannamalai. PinCode – 606604.	**Udavum Karangal,** No. 112/3,4,5 & 6 Block – I, S.No.111/7 & 115/15A Block-II, Girivalan Road, Adiannamalai village, Thiruvannamalai. PinCode – 606604.	13.11.2020	45	**Long Stay Rehabilitation Centre**
29	**M. Sumathi**, No. 4/481 C, Ganapathy Quarters, Soolakarai Medu, Virudhunagar. PinCode – 626003.	**M.K. Foundation De-Addiction cum Rehabilitation Centre,** No. 4/481 C, Ganapathy Quarters, Soolakarai Medu, Virudhunagar. PinCode – 626003.	13.11.2020	25	**De-addiction cum Rehabilitation Centre**
30	**J. Selvakumar**, No. 13, 200 Feet Road, Vanasakthi Nagar, Kolathur, Chennai, PinCode – 600009.	**V Can Foundation,** No. 13, 200 Feet Road, Vanasakthi Nagar, Kolathur, Chennai, PinCode – 600009.	16.11.2020	45	**De-addiction cum Rehabilitation Centre**

31	**V.R. Anna Durai**, No. 3, Sigmund Freud Block, Ragumaniapuram, Thillai Nagar, Trichy, PinCode – 620018.	**Mercy Hospital,** No. 3, Sigmund Freud Block, Ragumaniapuram, Thillai Nagar, Trichy, PinCode – 620018.	16.11.2020	20	**Psychiatric Hospital**
32	**N. D. Ravikumar**, No. 11/655, Janakiram Nagar, Paraniputhur, Iyyappanthangal, Chennai, PinCode – 600122.	**Ree Life Foundation De-Addiction Cum Rehabilitation Center,** No. 11/655, Janakiram Nagar, Paraniputhur, Iyyappanthangal, Chennai, PinCode – 600122.	16.11.2020	30	**De-addiction cum Rehabilitation Centre**
33	**B. Kumaran**, No. 306/42, Ottraivadai Street, Puzhal, Chennai, PinCode – 600066.	**Miracle Foundation,** No. 306/42, Ottraivadai Street, Puzhal, Chennai, PinCode – 600066.	16.11.2020	20	**De-addiction cum Rehabilitation Centre**
34	**P.C. Rafiya**, No. 1A, Airport Road, Poomambbakkam, Ulundoorpetai, Kallakurichi, PinCode – 606107**.**	**Anbagam Residential Care Home,** No. 1A, Airport Road, Poomambbakkam, Ulundoorpetai, Kallakurichi, PinCode – 606107.	16.11.2020	50	**De-addiction cum Rehabilitation Centre**
35	**S.R. Reeba Antony**, Ummancode, Emmausnager, Mekkamandapam Post, Kanniya Kumari District, PinCode – 629116.	**Emmaus Rehabilitation Centre For Mentally Ill Women,** Ummancode, Emmausnager, Mekkamandapam Post, Kanniya Kumari District, PinCode – 629116.	16.11.2020	100	**Psychiatric Nursing Home**
36	**S. Vidyaakar**, S.No. 83/4B2A1, 4B2B1, 4B3A & 4B3B, Madurai – Tuticorin National Highway, S. Kallupatti Village, Kariapatti Taluk, Virudhunagar District.	**Udavum Karangal Shanthivanam,** S.No. 83/4B2A1, 4B2B1, 4B3A & 4B3B, Madurai – Tuticorin National Highway, S. Kallupatti Village, Kariapatti Taluk, Virudhunagar District.	1.11.2020	75	**Long Stay Rehabilitation Centre**
37	**M. Asirvatham**, No. 244, Ramalayam Colony, Courttalam, Tenkasi, PinCode – 627802.	**Velicham Psychiatric Nursing Home,** No. 244, Ramalayam Colony, Courttalam, Tenkasi, PinCode – 627802.	18.11.2020	22	**Psychiatric Nursing Home**
38	**V. Vinoth Kumar**, Door. No. 1, Plot No. 1&1A,Om Sakthi Nagar, Valasaravakkam, Chennai, PinCode – 600087.	**Green Life Foundation,** Door. No. 1, Plot No. 1&1A,Om Sakthi Nagar, Valasaravakkam, Chennai, PinCode – 600087.	18.11.2020	30	**De-addiction cum Rehabilitation Centre**

39	**R. Aravindaraj,** No. 30, Panchalam Road, Near Government Hospital, Thindivanam, PinCode – 604001.	**Trust Way Foundation – Unit II,** No. 30, Panchalam Road, Near Government Hospital, Thindivanam, PinCode – 604001.	18.11.2020	30	**De-addiction cum Rehabilitation Centre**
40	**A.Selvaraj**, No. 6-6-2A, Bathlagundu, Madurai Road, Nilakkottai Taluk, Dindugal District.	**Smile Hospital For De-Addiction & Psychiatric Care,** No. 6-6-2A, Bathlagundu, Madurai Road, Nilakkottai Taluk, Dindugal District.	18.11.2020	50	**Psychiatric Hospital & De-addiction cum Rehabilitation Centre**
41	**S. Vidyaakar**, Burial Ground Street, Maduravoyal, Chennai, PinCode – 600095.	**Udavum Karangal,** Burial Ground Street, Maduravoyal, Chennai, PinCode – 600095.	18.11.2020	90	**Long Stay Rehabilitation Centre**
42	**G. Manikandan**, No. 4/133/4, Chardep Nagar, Achankulam, Potrayadi Post, Kanyakumari District, PinCode – 629703.	**Manolaya,** No. 4/133/4, Chardep Nagar, Achankulam, Potrayadi Post, Kanyakumari District, PinCode – 629703.	20.11.2020	60	**Psychiatric Nursing Home**
43	**R. Panneer Selvam**, Plot. No. 222, AIBEA 'A' Colony, 6th Street, Paravai, Madurai, PinCode – 625018.	**Hope Research Foundation – Unit II,** Plot. No. 222, AIBEA 'A' Colony, 6th Street, Paravai, Madurai, PinCode – 625018.	20.11.2020	40	**De-addiction cum Rehabilitation Centre**
44	**S. Sathya Seelan**, Plot. No. 1, V.G.P Pon Nagar, 1 st Main Street, Near by Samraj 8th Cross, Sembakkam, Chennai, PinCode – 600073.	**Moonshine Alco Care Foundation,** Plot. No. 1, V.G.P Pon Nagar, 1st Main Street, Near by Samraj 8th Cross, Sembakkam, Chennai, PinCode – 600073.	20.11.2020	30	**Psychiatric Nursing Home & De-addiction cum Rehabilitation Centre**
45	**S.R. Jolly**, Melsi Thamur, Vallam Post, Gingee Taluk, Villupuram District, PinCode – 604206.	**St. Joseph's Mercy Home De – Addiction Centre,** Melsi Thamur, Vallam Post, Gingee Taluk, Villupuram District, PinCode – 604206.	23.11.2020	15	**De-addiction cum Rehabilitation Centre**
46	**Swamynathan Wilfred**, No.50/2, Meenavayal Village, Ariyakudi Post, Karaikudi Taluk, Sivagangai District, PinCode – 630202.	**St. Giuseppe Moscati Psycho-Social Rehabilitation Centre,** No.50/2, Meenavayal Village, Ariyakudi Post, Karaikudi Taluk, Sivagangai District, PinCode – 630202.	23.11.2020	51	**Psychiatric Nursing Home**
47	**S. Anbazhagan**, No. 1, Puthira Goundanpalayam	**S.R.D Foundation,** No. 1, Puthira Goundanpalayam	27.11.2020	15	**De-addiction cum Rehabilitation**

	Post, Puthiragoundampalayam, Salem, PinCode – 636119.	Post, Puthiragoundampalayam, Salem, PinCode – 636119.			**Centre**
48	**V. Kathirvel**, No. 169, Sri Ayyappa Nagar, 1st Cross Street, Chinmaya Nagar, Koyambedu, Chennai, PinCode – 600092.	**Recovery Home Foundation,** No. 169, Sri Ayyappa Nagar, 1st Cross Street, Chinmaya Nagar, Koyambedu, Chennai, PinCode – 600092.	27.11.2020	20	**De-addiction cum Rehabilitation Centre**
49	**T. Saravanan**, No. 421 & 427, Singapore Nagar, Kallampatti, Alagarkoil, Madurai, PinCode – 625014.	**Peace Psychiatric / De – Addiction Treatment Centre,** No. 421 & 427, Singapore Nagar, Kallampatti, Alagarkoil, Madurai, PinCode – 625014.	27.11.2020	150	**De-addiction cum Rehabilitation Centre**
50	**S. Vidyaakar**, No. 93, Car Street, Behind Amman Temple, Thiruverkadu, Chennai, PinCode – 600077.	**Udavum Karangal,** No. 93, Car Street, Behind Amman Temple, Thiruverkadu, Chennai, PinCode – 600077.	28.11.2020	200	**Long Stay Rehabilitation Centre**
51	**C. Panneer Selvan**, No. 12, South Bye Pass Road, Vannarpettai, Tirunelveli, PinCode – 627005.	**Sneka Mind Care Centre,** No. 12, South Bye Pass Road, Vannarpettai, Tirunelveli, PinCode – 627005.	28.11.2020	40	**Psychiatric Hospital**
52	**Dr. V. Ramanujam**, Madurai – Tuticorin Ring Road, Near Chinthamani Toll Gate, Anuppanadi, Madurai, PinCode – 625009.	**Velammal Medical College Hospital & Research Institute,** Madurai – Tuticorin Ring Road, Near Chinthamani Toll Gate, Anuppanadi, Madurai, PinCode – 625009.	28.11.2020	30	**Psychiatric Hospital**
53	**Dr. M. Chandrasekaran**, Etchikulam, Rama Goundampatti, Palamedu, Madurai, PinCode – 625503.	**Agam Mentally Ill Home De – Addiction & Rehabilitation Centre,** Etchikulam, Rama Goundampatti, Palamedu, Madurai, PinCode – 625503.	01.12.2020	50	**De-addiction cum Rehabilitation Centre**
54	**S. Rajesh Kumar**, No. 25, Karunanidhi 1st Street, NandavanaMettur, Avadi, Chennai, PinCode – 600071.	**SRN Foundation,** No. 25, Karunanidhi 1st Street, NandavanaMettur, Avadi, Chennai, PinCode – 600071.	02.12.2020	21	**De-addiction cum Rehabilitation Centre**

55	**S. Sathya Seelan**, Plot No. 104, V.P. Chinthan Street, Annai Sathya Nagar, Chengalpet, Kancheepuram District, PinCode – 603001.	**Moon Shine De – Addiction Cum Rehabilitation Centre,** Plot No. 104, V.P. Chinthan Street, Annai Sathya Nagar, Chengalpet, Kancheepuram District, PinCode – 603001.	04.12.2020	25	**Psychiatric Nursing Home** **&** **De-addiction cum Rehabilitation Centre**
56	**A. Kesavarajan**, No. 27, Sub – Collector Office Road, Near Krishnan Kovil, Y.M.R Patty, Dindigul, PinCode – 624001.	**Ramana Hospital,** No. 27, Sub – Collector Office Road, Near Krishnan Kovil, Y.M.R Patty, Dindigul, PinCode – 624001.	04.12.2020	30	**Psychiatric Hospital**
57	**P.Raja**, Plot No. 5, 1st Cross Street, V.K. Ramasami Nagar, Perumbakkam Road, Thiruvannamalai, Pincode – 606603.	**A.S.R. Foundation,** Plot No. 5, 1st Cross Street, V.K. Ramasami Nagar, Perumbakkam Road, Thiruvannamalai, Pincode – 606603.	05.12.2020	15	**De-addiction cum Rehabilitation Centre**
58	**Pirmanayagam**, No. 265, Zion Nagar, Vanchuvancherry, Padappai, PinCode – 601301.	**Brahma Psychiatric Rehabilitation Centre,** No. 265, Zion Nagar, Vanchuvancherry, Padappai, PinCode – 601301.	05.12.2020	50	**Psychiatric Nursing Home**
59	**S. Vidyaakar,** No. 308, Pollachi Main Road, Myleripalayam, Coimbatore, Pincode – 641032.	**Udavum Karangal,** No. 308, Pollachi Main Road, Myleripalayam, Coimbatore, Pincode – 641032.	05.12.2020	250	**Long Stay Rehabilitation Centre**
60	**Dr. K. Regunathan,** No. 6, Mullai Nagar, Masakkalipalayam, Coimbatore, Pincode – 641015.	**Srinivas Hospital,** No. 6, Mullai Nagar, Masakkalipalayam, Coimbatore, Pincode – 641015.	04.12.2020	14	**Psychiatric Hospital**
61	**M. Ganesan,** No. 12/11 C, Sengulam East 1st Street, Thirumangalam, Madurai, Pincode – 625706.	**Goodwill Foundation De – Addiction Cum Rehabilitation Centre,** No. 12/11 C, Sengulam East 1st Street, Thirumangalam, Madurai, Pincode – 625706.	08.12.2020	15	**De-addiction cum Rehabilitation Centre**

62	**A.V. Thomas,** Karode, Arumanai Post, KanyaKumari District, Tamil Nadu, PinCode – 629151.	**Devasagayam Nalvazhvu Nilayam Treatment & Rehabilitation Centre For Mentally ill ,** Karode, Arumanai Post, Kanya Kumari District, Tamil Nadu, Pincode – 629151.	08.12.2020	45	**Psychiatric Nursing Home & De-addiction cum Rehabilitation Centre**
63	**A.Sasikumar,** No. 4/2, Aadhi Sakthi Nagar, Lourdhuburam, Kattupakkam, Poonamallee High Road, Chennai, Pincode – 600056.	**Jananam Care Centre,** No. 4/2, Aadhi Sakthi Nagar, Lourdhuburam, Kattupakkam, Poonamallee High Road, Chennai, Pincode – 600056.	08.12.2020	14	**De-addiction cum Rehabilitation Centre**
64	**Y. Purushothaman,** No. 650/2, I.O.B. Nagar, Nehruji Street, Maniyampattu Road, Sipcot, Ranipet, Pincode – 632403.	**Paasam Foundation De – Addiction Cum Rehabilitation Centre,** No. 650/2, I.O.B. Nagar, Nehruji Street, Maniyampattu Road, Sipcot, Ranipet, Pincode – 632403.	08.12.2020	30	**De-addiction cum Rehabilitation Centre**
65	**Dr. A. Victor Jayaseelan,** No. 1, Chengalpattu Road, Paruthi Kollai Village, Vadanallur Post, Uthiramerur, Kanchipuram, Pincode – 603406.	**Moonlight Alco Care Foundation "De – Addiction Cum Rehabilitation Centre",** No. 1, Chengalpattu Road, Paruthi Kollai Village, Vadanallur Post, Uthiramerur, Kanchipuram, Pincode – 603406.	08.12.2020	20	**De-addiction cum Rehabilitation centre**
66	**S. Ilayaraja,** Koliyanur Coot Road, Panruti Main Road, Sri Ram Nagar, Ramaiyan Paalayam, Villupuram, Pincode – 605103.	**Higher Power Foundation,** Koliyanur Coot Road, Panruti Main Road, Sri Ram Nagar, Ramaiyan Paalayam, Villupuram, Pincode – 605103.	10.12.2020	73	**De-addiction cum Rehabilitation Centre**
67	**Soosai Antony,** No. 2/110, Vaithiyar Street, Thirusulam, Chennai – 600043.	**Manasu,** No. 2/110, Vaithiyar Street, Thirusulam, Chennai – 600043.	10.12.2020	42	**Psychiatric Nursing Home**
68	**S. Pari,** No. 50, 2nd Floor, Chettiar Agaram Main Road, Vanagaram, Chennai – 600095.	**Phoenix Social Service Trust,** No. 50, 2nd Floor, Chettiar Agaram Main Road, Vanagaram, Chennai – 600095.	10.12.2020	45	**Psychiatric & De-addiction Centre**
69	**Jaisy Jacob,** No. 58/812, C.T.H. Road, Thirumullaivayal Post, Chennai, PinCode –	**Friends For The Needy,** No. 58/812, C.T.H. Road, Thirumullaivayal Post, Chennai, PinCode – 600062.	10.12.2020	40	**Psychiatric Nursing Home**

	600062.				
70	**R. Palani,** No.2/1, Ganapathy Nagar Main Road, Odama Nagar, Vanagaram, Chennai, PinCode – 600095.	**Ashram Foundation,** No.2/1, Ganapathy Nagar Main Road, Odama Nagar, Vanagaram, Chennai, PinCode – 600095.	11.12.2020	40	**Psychiatric Nursing Home** **&** **De-addiction cum Rehabilitation Centre**
71	**C. Johnson Paulraj,** No. 41, Malligai Street, Rajeshwari Nagar, Vallancheri, Guduvancheri, PinCode – 603202.	**India Forum For The Mentally Handicapped Psychiatric Rehabilitation Centre,** No. 41, Malligai Street, Rajeshwari Nagar, Vallancheri, Guduvancheri, Pincode – 603202.	11.12.2020	25	**Psychiatric Nursing Home**
72	**D. Gasper,** No. 6, 2nd Cross Street, 'J' Nagar, East Coast Road, Panaiyur, Chennai, Pincode – 600119.	**Desire Home De – Addiction Centre,** No. 6, 2nd Cross Street, 'J' Nagar, East Coast Road, Panaiyur, Chennai, Pincode – 600119.	14.12.2020	25	**De-addiction cum Rehabilitation Centre**
73	**Albert Rathish Balan,** No. 42/7, Krishnan Street, Kodungaiyur, Chennai, Pincode – 600118.	**First Step Trust De – Addiction Cum Rehabilitation Centre,** No. 42/7, Krishnan Street, Kodungaiyur, Chennai, Pincode – 600118.	14.12.2020	10	**De-addiction cum Rehabilitation Centre**
74	**A.S. Gnaneswaran** No: 45, Meenakshi Nagar, 1st Colony, Sakkimangalam, Madurai - 625 201.	**Wisdom Hospital & Psychotherapy Home,** No: 45, Meenakshi Nagar, 1st Colony, Sakkimangalam, Madurai -625 201.	15.12.2020	30	**Psychiatric Nursing Home** **&** **De-addiction cum Rehabilitation Centre**
75	**M.V. Preethi,** No. 63, South Veli Street, South Gate Signal, Madurai – 625 001	**Dr. Preethi's Child Guidance Centre and Hospital,** No. 63, South Veli Street, South Gate Signal, Madurai – 625 001	16.12.2020	05	**Psychiatric Hospital**
76	**Dr. M. Murugan**, No: S-61, 20th Street, Anna Nagar, Chennai – 600 040.	**Sundance Medical Centre**, No: S-61, 20th Street, Anna Nagar, Chennai – 600 040.	16.12.2020	20	**Psychiatric Nursing Home**
77	**P. Muthu Vellappan**, No: 479, Kamarajar Road, Varatharajapuram, Coimbatore – 641 015.	**Kasturba Gandhi De-Addiction & Rehabilitation Centre,** No: 479, Kamarajar Road, Varatharajapuram, Coimbatore – 641 015.	26.12.2020	30	**De-addiction cum Rehabilitation Centre**
78	**G. Ashok** No. 3, Kalasathamman	**The Grace Foundation, A Centre for De-Addiction Cum**	26.12.2020	20	**De-addiction cum Rehabilitation**

	Kovil Street, Selavoil, Kodungaiyur, Chennai – 118.	**Rehabilitation**, No. 3, Kalasathamman Kovil Street, Selavoil, Kodungaiyur, Chennai – 118.			**Centre**
79	**G. Gandhi** No: 3, Thiru.Vi.Ka.Nagar, 5th Street, Crystal Garden, Thundalam, Chennai – 600 077.	**Super Natural Dream,** No: 3, Thiru.Vi.Ka.Nagar, 5th Street, Crystal Garden, Thundalam, Chennai – 600 077.	26.12.2020	16	**De-addiction cum Rehabilitation Centre**
80	**Dr. M. Arivazhagan,** No: 306, Kalakadi Street, Tenkasi – 627 811	**Sri Ramakrishna Seva Nilayam**, No: 306, Kalakadi Street, Tenkasi – 627 811	26.12.2020	30	**De-addiction cum Rehabilitation Centre**
81	**S. Murugan,** No: 19, Karumariamman Nagar, Mudichur Road, West Tambaram, Chennai – 600 045.	**Adapt Home**, No: 19, Karumariamman Nagar, Mudichur Road, West Tambaram, Chennai – 600 045.	26.12.2020	50	**De-addiction cum Rehabilitation Centre**
82	**K. Saravanan**, No: 12/4-2, Sastha Nagar, 1st Street, Anayur Main Road, Mudakkathan, Madurai – 625 017.	**Strength Foundation,** No: 12/4-2, Sastha Nagar, 1st Street, Anayur Main Road, Mudakkathan, Madurai – 625 017.	26.12.2020	15	**De-addiction cum Rehabilitation Centre**
83	**S. Thirugnana Sampanthan**, Vembulaiyan Nagar, Vannivelam patty, Peraiyur Taluk, Madurai – 625 702.	**Annai De-Addiction Centre,** Vembulaiyan Nagar, Vannivelam patty, Peraiyur Taluk, Madurai – 625 702.	28.12.2020	10	**De-addiction cum Rehabilitation Centre**
84	**Dr. S. Sakthivel** Plot No: 18, Vasantham Nagar – II, Golden Temple Road, Ariyur, Vellore – 632 055.	**Nesam Seva Foundation - De-Addiction Cum Rehabilitation Centre,** Plot No: 18, Vasantham Nagar – II, Golden Temple Road, Ariyur, Vellore – 632 055.	28.12.2020	20	**De-addiction cum Rehabilitation Centre**
85	**R. Selvi Axliya**, No: 174, 5th Street, Saraswathi Nagar, Thirumullaivoyal, Chennai – 600 062.	**Corner Stone, A Centre For De-Addiction Cum Rehabilitation Centre,** No: 174, 5th Street, Saraswathi Nagar, Thirumullaivoyal, Chennai – 600 062.	28.12.2020	50	**De-addiction cum Rehabilitation Centre**

86	**K. Santhanam,** No: 7/176-3, London House Bus Stop, Athikulam-Manakadhan (Via), Devarkulam Main Road, Athikulam (PO), Kayathar (Taluk), Tuticorin (DT) – 628 952	**Amends Foundation Unit -2 De-Addiction & Psychiatric Rehabilitation Centre,** No: 7/176-3, London House Bus Stop, Athikulam-Manakadhan (Via), Devarkulam Main Road, Athikulam (PO), Kayathar (Taluk), Tuticorin (DT) – 628 952	29.12.2020	31	**De-addiction cum Rehabilitation Centre**
87	**K. Santhanam,** No: 1A, P & T Nagar Main Road, Meenakshi Nagar (Bus Stop), Madurai – 625 017.	**Amends Foundation Unit – 1, De-Addiction & Psychiatric Rehabilitation Centre,** No: 1A, P & T Nagar Main Road, Meenakshi Nagar (Bus Stop), Madurai – 625 017.	30.12.2020	21	**De-addiction cum Rehabilitation Centre**
88	**R. Srinivasan,** Pralayambakkam Village, Thirupalaivanam Post, Ponneri, Thiruvallur District – 601 205.	**J.S.V. De-Addiction Cum Rehabilitation Centre**, Pralayambakkam Village, Thirupalaivanam Post, Ponneri, Thiruvallur District – 601 205.	31.12.2020	30	**De-addiction cum Rehabilitation Centre**
89	**Pavayee,** No: 64/1, Poosala Gengu Reddy Street, Egmore, Chennai – 600 008.	**Putholi Health Care,** No. 64/1, Poosala Gengu Reddy Street, Egmore, Chennai – 600 008.	31.12.2020	10	**Psychiatric Nursing Home**
90	**S. Sakthivel,** No. 9/2 B, Ramakrishna Street, Krishnamurthy Nagar, Kodungaiyur, Chennai – 600 118.	**S.N. Foundation**, No.9/2 B, Ramakrishna Street, Krishnamurthy Nagar, Kodungaiyur, Chennai – 600 118.	31.12.2020	20	**De-addiction cum Rehabilitation Centre**
91	**P. Vedachalam,** Samathuvapuram, Pulivalam, Pudukottai District – 622 507.	**Card De-Addiction Hospital**, Samathuvapuram, Pulivalam, Pudukottai District – 622 507.	04.01.2021	20	**De-addiction cum Rehabilitation Centre**
92	**P. Kalaiyarasan,** No: 11/148, Munusamy Nagar, Velachery – Tambaram Main Road, Medavakkam, Chennai – 600 100.	**Gaba Health Care,** No: 11/148, Munusamy Nagar, Velachery – Tambaram Main Road, Medavakkam, Chennai – 600 100.	04.01.2021	10	**Psychiatric Hospital**
93	**M. Perumal,** No: 150, Kamarajar Nagar, 4th Street, Avadi, Chennai.	**New Life Foundation,** No: 150, Kamarajar Nagar, 4th Street, Avadi, Chennai.	04.01.2021	30	**Psychiatric & De-addiction cum Rehabilitation Centre**
94	**Dr. K. Ramakrishnan,** No: 12 B & C, 10th Cross	**Athma Hospitals and Research Pvt. Ltd,**	05.01.2021	30	**Psychiatric Hospital**

	East, Thillai Nagar, Trichy – 620 018.	No: 12 B & C, 10th Cross East, Thillai Nagar, Trichy – 620 018			
95	**R. Siva Subramanian,** No: 62, 62-1, ATC Colony Back Side, Near Railway Gate, Ayothiya Pattinam, Salem – 636 103.	**New Life Foundation,** No: 62, 62-1, ATC Colony Back Side, Near Railway Gate, Ayothiya Pattinam, Salem – 636 103.	05.01.2021	40	**Psychiatric & De-addiction Centre**
96	**S. Gokulakannan,** No: 23/50, Dr. Ramanathan Street, Near Salem Dist.Central Co-op. Bank, Salem – 636 001.	**Vidiyal Life Trust, De-Addiction Cum Rehabilitation Centre,** No: 23/50, Dr. Ramanathan Street, Near Salem Dist.Central Co-op. Bank, Salem – 636 001.	05.01.2021	20	**Psychiatric & De-addiction Centre**
97	**Dr. Paul Swamidhas Sudhakar Russell,** Bagayam, Vellore – 632 002.	**Christian Medical College & Hospital,** Bagayam, Vellore – 632 002.	06.01.2021	122	**Psychiatric Hospital**
98	**A.C.N. Aruna,** No.12, Velan Nagar, 4th Street, Valasaravakkam, Chennai – 600 087.	**Jeeva Rakshai De-addiction Cum Rehabilitation & Psychiatric Care,** No.12, Velan Nagar, 4th Street, Valasaravakkam, Chennai – 600 087.	06.01.2021	20	**Psychiatric & De-addiction cum RehabilitationCentre**
99	**P. Prem Kumar,** No. 44, Samathanam Nagar, 2nd Street, Alamelumangapuram, Vellore – 632 009.	**Carewell Rehabilitation Trust,** No.44, Samathanam Nagar, 2nd Street, Alamelumangapuram, Vellore – 632 009.	07.01.2021	25	**De-addiction cum Rehabilitation Centre**
100	**A.Johnselvakumar,** No. 38, 4th Street, Jothi Nagar, Thiruvettiyur, Ernavoor, Chennai – 600 057.	**Sugam Foundation Trust De-Addiction Cum Rehabilitation Centre,** No. 38, 4th Street, Jothi Nagar, Thiruvettiyur, Ernavoor, Chennai – 600 057.	07.01.2021	30	**De-addiction cum Rehabilitation Centre**
101	**R. Sathies,** No. 1403/1A & 1B, Kandamanur Road, Pandhuvar Patti Vilakku, Thirumalapuram Panchayat, Andipatti Taluk, Theni – 625 531.	**Arpanam Development Trust**, No. 1403/1A & 1B, Kandamanur Road, Pandhuvar Patti Vilakku, Thirumalapuram Panchayat, Andipatti Taluk, Theni – 625 531.	07.01.2021	30	**De-addiction cum Rehabilitation Centre**
102	**K.P.M. Raja,** No. 4/126, V.R.S. Nagar, 1st Street, Alapakkam Main Road, Maduravoyal, Chennai – 600 095.	**Confident Health Centre**, No. 4/126, V.R.S. Nagar, 1st Street, Alapakkam Main Road, Maduravoyal, Chennai – 600 095.	08.01.2021	15	**De-addiction cum Rehabilitation Centre**

103	**R.Muruganandham,** No. 18, Karuppa Goundampalayam Road, Veerapandi Post, Tirupur – 641 605.	**Tirupur Care Rehabilitation Centre,** No.18, Karuppa Goundampalayam Road, Veerapandi Post, Tirupur –641 605.	11.01.2021	45	**De-addiction cum Rehabilitation Centre**
104	**M.S. Gugan,** No. 223, Forest Road, Behind GTM College, Gandhi Nagar, Kondasamudhiram, Gudiyatham, Vellore – 632 601.	**Kan Voli Foundation,** No. 223, Forest Road, Behind GTM College, Gandhi Nagar, Kondasamudhiram, Gudiyatham, Vellore – 632 601.	12.01.2021	21	**Psychiatric & De-addiction Centre**
105	**Dr. K. Deepak Kumar,** D-98, 9th Cross, Thillai Nagar, Thiruchirappalli – 620 018.	**Visranthi Mental Health Centre**, D-98, 9th Cross, Thillai Nagar, Thiruchirappalli – 620 018.	12.01.2021	08	**Psychiatric Nursing Home**
106	**Dr. K. Ramakrishnan,** Seethapatti, Pulutheri Panchayat, Poolangulathuppalli, Ramji Nagar, Kulithalai, Karur – 620 009.	**Trust Shanthivanam (Home for Mentally ill),** Seethapatti, Pulutheri Panchayat, Poolangulathuppalli, Ramji Nagar, Kulithalai, Karur – 620 009.	12.01.2021	150	**De-addiction cum Rehabilitation Centre**
107	**Dr. K. Ramakrishnan,** C-101, North East Extension, 7th Cross, Thillai Nagar, Trichy – 620 018.	**Athma De-Addiction Centre,** C-101, North East Extension, 7th Cross, Thillai Nagar, Trichy – 620 018.	12.01.2021	32	**De-addiction cum Rehabilitation Centre**
108	**M. Selvakumar,** No. 36, Muthu Vinayagar Kovil Street, Tiruvannamalai -606 601.	**Appa Mental Health Facility,** No. 36, Muthu Vinayagar Kovil Street, Tiruvannamalai - 606 601.	13.01.2021	60	**Psychiatric & De-addiction Centre**
109	**Dr. M. Rajeswari,** No. 8, Fort Main Road, Shevapet, Salem – 636 002	**Department of Psychiatry, Government Mohan Kumaramangalam Medical College and Hospital,** No. 8, Fort Main Road, Shevapet, Salem – 636 002	20.01.2021	40	**Govt. Medical College Hospital**
110	**P. Kasi Krishnaraja,** NH47, Perundurai Saniatorium, Erode – 638 053.	**Department of Psychiatry, Government Erode Medical College And Hospital,** NH47, Perundurai Saniatorium, Erode – 638 053.	20.01.2021	10	**Govt. Medical College Hospital**

111	**C. Bhaskar** Sankari Main Road (NH47), Seeragapadi, Salem – 636 308.	**Department of Psychiatry, Vinayaka Mission's Kirupananda Variyar Medical College & Hospitals, Salem** Sankari Main Road (NH47), Seeragapadi,Salem – 636 308	21.01.2021	30	**Private Medical College / Hospital**
112	**Arul Maria,** No. 59A, South Veeravanallur, S.No. 410/3A, Cheranmahadevi Taluk, Thirunelveli District – 627 426	**St. Dymphna Rehabilitation Centre for Homeless Mentally Ill Women at Aussi Community Development and Educational Society,** No.59A, South Veeravanallur, S.No. 410/3A, Cheranmahadevi Taluk, Thirunelveli District – 627 426	21.01.2021	40	**Psychiatric & De-addiction Centre**
113	**Thresia Dias** Hobbart Road, Nondimedu, Lovedale Junction, Ooty – 643001.	**Bethesda Mental Health Rehabilitation Centre,** Hobbart Road, Nondimedu, Lovedale Junction, Ooty – 643001.	21.01.2021	16	**De-addiction cum Rehabilitation Centre**
114	**S. Madhu Sudhanan** No. 30, 30/1, Kasimali Nagar, Natham Road, Dindigul – 624003.	**Brindhavan De-Addiction, Psychiatric Treatment Cum Rehabilitation Centre,** No. 30, 30/1, Kasimali Nagar, Natham Road, Dindigul – 624003.	22.01.2021	25	**De-addiction cum Rehabilitation Centre**
115	**R. AravindaRaj** Plot No. 8 & 9, Lakshmi Nagar, By Pass Service Road, Anakaputhur, Chennai – 600 070.	**Trustway Foundation De-Addiction cum Rehabilitation Centre** Plot No. 8 & 9, Lakshmi Nagar, By Pass Service Road, Anakaputhur, Chennai – 600 070.	25.01.2021	50	**De-addiction cum Rehabilitation Cen tre**
116	**A. Tamil Vendan** No. 6A, 4th Street, Rasi Nagar, Collector Nagar Main Road, Kathirvedu, Chennai – 600 066.	**Rebirth Foundation,** No. 6A, 4th Street, Rasi Nagar, Collector Nagar Main Road, Kathirvedu, Chennai – 600 066.	25.01.2021	50	**De-addiction cum Rehabilitation Centre**
117	**Dr. M. Sreeprathap** House No. 2/18 & 18A, Veteran Lines, Pallavaram, Chennai – 600 043.	**Shadithya Rehabilitation Centre, Unit – 2,** House No. 2/18 & 18A, Veteran Lines, Pallavaram, Chennai – 600 043.	25.01.2021	15	**Psychiatric Nursing Home**
118	**Dr. M. Sreeprathap** No. 7, Tannery Street, Pallavaram, Chennai – 600 043.	**Shadithya Hospital,** No. 7, Tannery Street, Pallavaram, Chennai – 600 043.	25.01.2021	34	**Psychiatric Hospital**

119	**Dr. M. Sreeprathap** No. 768, Pammal Main Road, Pallavaram, Chennai - 600 043	**Shadithya Rehabilitation Centre,** No. 768, Pammal Main Road, Pallavaram, Chennai - 600 043	25.01.2021	45	**Psychiatric Nursing Home& De-addiction cum Rehabilitation Centre**
120	**Dr. M. Sreeprathap** No. 4, 2nd Munaver Avenue, Pallavaram, Chennai – 600 043.	**Shadithya Rehabilitation Centre, Unit – 4** No. 4, 2nd Munaver Avenue, Pallavaram, Chennai – 600 043.	25.01.2021	12	**Psychiatric Nursing Home**
121	**Dr. M. Sreeprathap** No. 2, 1st Street, Somasundharam Nagar, Pallavaram, Chennai – 600 043.	**Shadithya Rehabilitation Centre, Unit – 3** No. 2, 1st Street, Somasundharam Nagar, Pallavaram, Chennai – 600 043.	29.01.2021	08	**Psychiatric Nursing Home**
122	**Dr. R. Karthik Deivanayagam,** Dr. Muthulakshmi Memorial Government Hospital, West Main Street, Pudukkottai – 622 001.	**Emergency Care and Recovery Centre,** Dr. Muthulakshmi Memorial Government Hospital, West Main Street, Pudukkottai – 622 001.	30.01.2021	50	**Emergency Care & Recovery Centre**
123	**Dr. R. Karthik Deivanayagam**, Dr. Muthulakshmi Memorial Government Hospital, West Main Street, Pudukkottai – 622 001.	**District Mental Health Programme, Pudukkottai** Dr. Muthulakshmi Memorial Government Hospital, West Main Street, Pudukkottai – 622 001.	30.01.2021	06	**District Mental Health Programme**
124	**K. Pugazhendhi** Medical College Road, Mundiyampakkam, Villupuram, Tamil Nadu – 605 601	**Department of Psychiatry, Government Villupuram Medical College and Hospital Villupuram** Medical College Road, Mundiyampakkam, Villupuram, Tamil Nadu – 605 601	01.02.2021	30	**Govt. Medical College Hospital**
125	**Binu Varghese,** Senthil Nagar, Opp. Kalpana Kalyana Mandapam, Kavundampalayam, Coimbatore – 641 030.	**Preshitha Karunai Illam,** Senthil Nagar, Opp. Kalpana Kalyana Mandapam, Kavundampalayam, Coimbatore – 641 030.	01.02.2021	30	**De-addiction cum Rehabilitation Centre**

126	**S. Samuel Gunasekaran,** No. 54, Spencer Compound, Dindigul – 624 003.	**Mesmer Mental Health Home For Long Term Care,** No. 54, Spencer Compound, Dindigul – 624 003.	01.02.2021	09	**Psychiatric Nursing Home**
127	**S. Samuel Gunasekaran**, No. 93, Spencer Compound, Dindigul – 624 003	**Mesmer Neuro Psychiatric Hospital, De – Addiction Cum Rehabilitation Centre** No. 93, Spencer Compound, Dindigul – 624 003	01.02.2021	40	**Psychiatric Hospital**
128	**Dr. T. Ramesh** G.S.T. Road, Melmaruvathur, Chengalpattu – 603 319	**Department of Psychiatry, Melmaruvathur Adhiparasakthi Institute of Medical Sciences And Research**, G.S.T. Road, Melmaruvathur, Chengalpattu – 603319	02.02.2021	30	**Psychiatric Hospital**
129	**P. Rajesh** NO. 11/199-1, Kandasamy Nagar, Bharathiyar Road, Ganapathy, Coimbatore – 641 006.	**Lakshmi Mental Health Care Centre,** No.11/199-1, Kandasamy Nagar, Bharathiyar Road, Ganapathy, Coimbatore – 641 006**.**	03.02.2021	60	**Psychiatric Hospital**
130	**S Shanmugavel,** No. 9384, Ayappakkam, Housing Board, Ayappakkam, Thiruverkadu, Chennai – 600 077.	**Valli Care Foundation Trust De-Addiction cum Rehabilitation Centre,** No.9384, Ayappakkam, Housing Board, Ayappakkam, Thiruverkadu, Chennai – 600 077.	03.02.2021	20	**De-addiction cum Rehabilitation Centre**
131	**Dr. M. Priya Subhashini,** Department of Psychiatry, Government Medical College, Omandurar Government Estate, Chennai – 2.	**Department of Psychiatry, Government Medical College, Omandurar Government Estate, Chennai – 2.** Department of Psychiatry, Government Medical College, Omandurar Government Estate, Chennai – 2.	04.02.2021	10	**Govt. Medical College Hospital**
132	**R. Nithyanantham** No.1463, Shanmugasiga Mani Street, Royappa Nagar, Varadharajapuram, Chennai – 600 048.	**Udhayam Public Charitable Trust,** No.1463, Shanmugasiga Mani Street, Royappa Nagar, Varadharajapuram, Chennai – 600 048	04.02.2021	15	**Psychiatric & De-addiction Centre**
133	**R. Charuhasan,** No. 8, Kamatchi Amman	**Nivarthi Trust De-Addiction cum Rehabilitation Centre,**	06.02.2021	25	**De-addiction cum Rehabilitation**

	Nagar, Karanai Puducherry, Urapakkam, Kanchipuram – 603 202.	No.8, Kamatchi Amman Nagar, Karanai Puducherry, Urapakkam, Kanchipuram – 603 202.			**Centre**
134	**B. Indharakumar** No. 147/4, C.T.H. Road, Thiruninravur, Chennai – 602 024.	**Udhayam Trust De-Addiction cum Rehabilitation Centre,** No. 147/4, C.T.H. Road, Thiruninravur, Chennai – 602 024	06.02.2021	15	**De-addiction cum Rehabilitation Centre**
135	**Dr. M.B. Abdul Rahuman,** Department of Psychiatry, Kanyakumari Government Medical College Hospital, Asaripallam, Kanyakumari – 629 201.	**Department of Psychiatry, Kanyakumari Government Medical College Hospital**, Asaripallam, Kanyakumari – 629 201.	06.02.2021	20	**Govt. Medical College Hospital**
136	**S. Sakthivel** No. 21, Vadivel Balamani Nagar, Muthiyal Pettai, Kanchipuram – 631 601.	**S.N. Foundation, De-Addiction cum Rehabilitation Centre**, No. 21, Vadivel Balamani Nagar, Muthiyal Pettai, Kanchipuram – 631 601.	06.02.2021	30	**De-addiction cum Rehabilitation Centre**
137	**P. Rajesh** No. 11/1, Azhagepalayam, Kuppanur Post, Annur, Coimbatore – 641 653.	**HCA Mentally Ill Home,** No. 11/1, Azhagepalayam, Kuppanur Post, Annur, Coimbatore – 641 653.	09.02.2021	75	**Psychiatric Hospital**
138	J. Shanthakumar J.C.K. Nagar, Near Bus Stand, Kondapuram Post, Kaveripakkam, Ranipet District – 632 508.	**Vidiyal Foundation De-Addiction cum Rehabilitation Centre,** J.C.K. Nagar, Near Bus Stand, Kondapuram Post, Kaveripakkam, Ranipet District – 632 508.	09.02.2021	20	**De-addiction cum Rehabilitation Centre**
139	**Kannan .S** No. 1/180, Astalakshmi Nagar, 1st Main Road, Varadharajapuram, Mudichur, Chennai – 600 048.	**New Deepam Foundation Psychiatry & Alcohol Drug De-Addiction Centre,** No.1/180, Astalakshmi Nagar, 1st Main Road, Varadharajapuram, Mudichur, Chennai – 600 048.	09.02.2021	20	**De-addiction cum Rehabilitation Centre**
140	**M. Kumarasamy** No. 2, Pallikuppam, Avadi to Poonamallee Main Road, Vetrilai Thotam Bus Stand to Thiruverkadu Main Road, Chennai – 77.	**Mother Foundation De-Addiction Cum Rehabilitation Centre,** No. 2, Pallikuppam, Avadi to Poonamallee Main Road, Vetrilai Thotam Bus Stand to Thiruverkadu Main Road,	11.02.2021	30	**Psychaiatric & De-addiction Centre**

		Chennai – 77			
141	**Dr. Malar Moses** Thirinjapuram Union, Outer Ring Road, New Town, Vegikkal, Thiruvannamalai – 606 604.	**Department of Psychiatry, Government Thiruvannamalai Medical College And Hospital,** Thirinjapuram Union, Outer Ring Road, New Town, Vegikkal, Thiruvannamalai – 606 604.	12.02.2021	12	**Govt. Medical College Hospital**
142	**M.V. Muthukumar** No. 2/282, Muthu Bhavanam, Arulmigu Kallalagar Nagar, Aattukulam, Melur, Madurai – 625 106.	**Vishalam Foundation, A Centre For De-Addiction Cum Rehabilitation**, No. 2/282, Muthu Bhavanam, Arulmigu Kallalagar Nagar, Aattukulam, Melur, Madurai – 625 106.	12.02.2021	32	**De-addiction cum Rehabilitation Centre**
143	**Dr. Jaya Prakash.J** No. 37/68, Kavin Hospital Premises, Gandhi Nagar Colony, Perundurai Road, Erode – 638 011.	**Eyalbagam – Manathin Maiyam,** No. 37/68, Kavin Hospital Premises, Gandhi Nagar Colony, Perundurai Road, Erode – 638 011.	16.02.2021	15	**Psychiatric Hospital**
144	**B. Vinoth Kumar**, Old No. 3, New No. 5, Gandhi Nagar, 6th Street, Bye Pass Road, Thiruvannamalai – 606 601.	**Idayam Home Foundation, De-Addiction cum Rehabilitation Centre,** Old No. 3, New No. 5, Gandhi Nagar, 6th Street, Bye Pass Road, Thiruvannamalai – 606 601.	16.02.2021	15	**De-addiction cum Rehabilitation Centre**
145	**R. Shymala,** No. 140, Punitha Anthoniyar Koil 3rd Street, Puzhal, Chennai - 66	**Nalam Foundation, De-Addiction cum Rehabilitation Centre,** No. 140, Punitha Anthoniyar Koil 3rd Street, Puzhal, Chennai - 66	16.02.2021	20	**Psychiatric & De-addiction Centre**
146	**Nelson Mariya Susai,** No. 129-B, Bye Pass Road, Pulliline Village, Near Kamatchi Amman Temple, Redhills, Chennai – 600 052	**Redemptive Recovery Care De-Addiction Cum Rehabilitation Centre,** No.129, B, Bye Pass Road, Pulliline Village, Near Kamatchi Amman Temple, Redhills,	16.02.2121	30	**De-addiction cum Rehabilitation Centre**

		Chennai – 600 052			
147	**P. Sugumar,** No. 390/6, Modern Nagar, Oil Mill Bus Stop, Near Nandavanapatti Bye Pass, Dindigal- 624 001.	**K P T Bliss, A Psycosocial Rehabilitation Centre,** No. 390/6, Modern Nagar, Oil Mill Bus Stop, Near Nandavanapatti Bye Pass, Dindigal-624 001	17.02.2021	50	**De-addiction cum Rehabilitation Centre**
148	**R. Prasad,** No. 39,40 Kamatchi Salai, Sri Chakara Nagar, Mangadu, Chennai – 600 122.	**Jeevan Care Centre,** No. 39,40, Kamatchi Salai, Sri Chakara Nagar, Mangadu, Chennai – 600 122.	17.02.2021	100	**Psychiatric & De-addiction centre**
149	**Dr. M. Sreeprathap,** No. 3/1, Tannery Street, Pallavaram , Chennai – 43.	**Madhavi Ammal Psychiatric Unit, (A Unit of Shadithya Health Care)** No. 3/1, Tannery Street, Pallavaram , Chennai – 43	19.02.2021	38	**Psychiatric Nursing Home**
150	**A.Francis Jayapathy,** St. Joseph's College Farm, Keela Mullaikudi, Tiruchirappalli – 620 010.	**AHEAD – (Arrupe Health Enclave for Alcohol / Drugs De-Addiction),** St. Joseph's College Farm, Keela Mullaikudi, Tiruchirappalli – 620 010.	19.02.2021	20	**De-addiction cum Rehabilitation Centre**
151	**K. M. Ramesh Krishna Kumar,** No. 6, New Alagar Garden, (MAVMM Polytechnic Behind), Moonur Village, Alagar Kovil Main Road, Alagarkovil, Madurai – 625 301.	**SACC – (Substance Abuse Care Centre) Psychiatric / De-Addiction Centre,** No. 6, New Alagar Garden, (MAVMM Polytechnic Behind), Moonur Village, Alagar Kovil Main Road, Alagarkovil, Madurai – 625 301.	19.02.2021	50	**Psychiatric & De-addiction Centre**
152	**R. Prasad,** No. 1, Aandavar Street, Anna Nedumpathai, Choolaimedu, Chennai – 600 094.	**Chennai De-Addiction Centre,** No. 1, Aandavar Street, Anna Nedumpathai, Choolaimedu, Chennai – 600 094.	19.02.2021	50	**Psychiatric & De-addiction Centre**

153	**Dr. Magesh Rajagopal,** No. 21, 4th Cross Street, Ramalinga Nagar South Extn, Vayalur Road, Trichy – 620 017.	**Aram Hospital,** No.21, 4th Cross Street, Ramalinga Nagar South Extn, Vayalur Road, Trichy – 620 017.	23.12.2021	32	**Psychiatric Hospital**
154	**Mini Mathew @ Macreenamma**, No.150, Annai Maria Colony, Veerapuram, (Near T.S.P. Camp), Avadi, Chennai – 600 055.	**Parisutha Narkarunai Illam Charitable Trust,** No. 150, Annai Maria Colony, Veerapuram, (Near T.S.P. Camp), Avadi, Chennai – 600 055.	24.02.2021	150	**Psychiatric & De-addiction Rehabilitation Centre**
155	**M. Sivakumar,** No. 532, Attur Main Road, Near Kongu Vellaler Mandapam, K.N. Colony, Ammapet, Salem – 636 014**.**	**SSS Yogi Foundation Trust, Alcohol & Drugs Abuse Treatment, Rehabilitation Centre,** No. 532, Attur Main Road, Near Kongu Vellaler Mandapam, K.N. Colony, Ammapet, Salem – 636 014.	26.02.2021	14	**De-addiction cum Rehabilitation Centre**
156	**A.Monica,** No. 6A, Madhavaram High Road, Grandline Village, Redhills, Chennai – 600 052.	**Annai Psychiatric Karunai Illam,** No. 6A, Madhavaram High Road, Grandline Village, Redhills, Chennai – 600 052.	26.02.2021	50	**Psychiatric & De-addiction Centre**
157	**A. Joseph Baskaran,** No. 3/1, Thanneer Pandal, Sathy Sirumugai Road, Chinnakallipatty, Coimbatore – 641 302.	**FFIRE De-Addiction Cum Rehabilitation Centre,** No. 3/1, Thanneer Pandal, Sathy Sirumugai Road, Chinnakallipatty, Coimbatore – 641 302.	27.02.2021	15	**De-addiction cum Rehabilitation Centre**
158	**A. Joseph Baskaran,** No. 2/175, Lurthupuram, Thandukaran Palayam Post, Avinashi Taluk, Tiruppur District – 641 655.	**FFIRE De-Addiction Cum Rehabilitation Centre,** No. 2/175, Lurthupuram, Thandukaran Palayam Post, Avinashi Taluk, Tiruppur District – 641 655.	27.02.2021	15	**De-addiction cum Rehabilitation Centre**
159	**Dr. Vikhram Ramasubramanian**, No. 11, Subburaman Street, Gandhi Nagar, Madurai – 625 020.	**Ahana Hospitals LLP,** No. 11, Subburaman Street, Gandhi Nagar, Madurai – 625 020.	02.03.2021	20	**Psychiatric Hospital**

160	**Dr. Vikhram Ramasubramanian**, No. 25, Jawahar Street, Gandhi Nagar, Shenoy Nagar, Madurai – 625 020.	**Ahana Hospitals LLP, Acute Care Branch,** No. 25, Jawahar Street, Gandhi Nagar, Shenoy Nagar, Madurai – 625 020.	02.03.2021	10	**Psychiatric Hospital**
161	**Dr. Vikhram Ramasubramanian**, No. 16/2A, Iyyanar Kovil 2nd Street, Managiri, Madurai – 625 020.	**Ahana Hospitals LLP,** No. 16/2A, Iyyanar Kovil 2nd Street, Managiri, Madurai – 625 020.	03.03.2021	20	**Psychiatric Hospital**
162	**Dr. Vikhram Ramasubramanian**, No. 16, S.F. Nagar, Bhuvaneshwari Colony, Sakkimangalam, Elamanur Post, Madurai – 625 201.	**Ahana Hospitals LLP,** No. 16, S.F. Nagar, Bhuvaneshwari Colony, Sakkimangalam, Elamanur Post, Madurai – 625 201.	03.03.2021	30	**Psychiatric Hospital**
163	**Dr. Vikhram Ramasubramanian**, No. 611, K.K. Nagar, Madurai – 625 020.	**Ahana Hospitals LLP,** No. 611, K.K. Nagar, Madurai – 625 020.	03.03.2021	**Out Patient Service Only**	**Psychiatric Hospital**
164	**Dr. Vikhram Ramasubramanian**, No. 7, Subburaman Street, Gandhi Nagar, Madurai – 625 020.	**Ahana Hospitals LLP,** No. 7, Subburaman Street, Gandhi Nagar, Madurai – 625 020	03.03.2021	12	**Psychiatric Hospital**
165	**Dr. D. Sivalingam**, Department of Psychiatry, Government Thoothukudi Medical College Hospital, Thoothukudi	**Department of Psychiatry, Government Thoothukudi Medical College Hospital,** Thoothukudi	03.03.2021	20	**Govt. Medical College Hospital**
166	**J. Yusuf,** No. 78B, English Electrical Nagar, Om Sakthi Nagar Extn, Nemilichery, Chrompet, Chennai – 600 044.	**M.S. De-Addiction Cum Rehabilitation Centre,** No. 78B, English Electrical Nagar, Om Sakthi Nagar Extn, Nemilichery, Chrompet, Chennai – 600 044	03.03.2021	30	**De-addiction cum Rehabilitation Centre**
167	**SR. P. Anthoni Deva Thilagam,** Arockia Nagar, Sarugani, Devakottai Taluk, Sivagangai District – 630 411	**The Immaculate Heart of Mary Society of Rehabilitation Home for Mentally Ill Persons,** Arockia Nagar, Sarugani, Devakottai Taluk, Sivagangai District – 630 411	03.03.2021	50	**Psychiatric Nursing Home**

168	**J. Selvaraj,** No. P20, Guru Street, Bishop Sargent Campus, Trivandrum Road, Murugan Kuruchi, Palayamkottai, Tirunelveli – 627 002.	**Bishop Sargent Anbin Illam For Men,** No. 20, Guru Street, Bishop Sargent Campus, Trivandrum Road, Murugan Kuruchi, Palayamkottai, Tirunelveli – 627 002.	04.03.2021	43	**Psychiatric Nursing Home**
169	**J. Selvaraj,** No. 20, Guru Street, Bishop Sargent Campus, Trivandrum Road, Murugan Kuruchi, Palayamkottai, Tirunelveli – 627 002.	**Bishop Sargent Anbin Illam For Women,** No. 20, Guru Street, Bishop Sargent Campus, Trivandrum Road, Murugan Kuruchi, Palayamkottai, Tirunelveli – 627 002.	04.03.2021	50	**Psychiatric Nursing Home**
170	**A.Velayuthan,** No. 8, Balaji Nagar, Thondamuthur Road, Vadavalli, Coimbatore – 641 041.	**Puthiya Pathai De-Addiction Center,** No. 8, Balaji Nagar, Thondamuthur Road, Vadavalli, Coimbatore – 641 041.	05.03.2021	20	**De-addiction cum Rehabilitation Centre**
171	**SR. Usha sahaya Rani. S,** Amala Nagar, V. Ammapatti, Kodaneri Post, T. Kallupatti (Via), Madurai District – 625 702.	**Amala Home For Mentally Ill And Rehabilitation for Women,** Amala Nagar, V. Ammapatti, Kodaneri Post, T. Kallupatti (Via), Madurai District – 625 702.	05.03.2021	30	**Psychiatric Nursing Home**
172	**Manikandan. D** No. 12, 12th Cross, Kumaran Nagar, Vayalur Road, Trichy - 620 017	**Jaithra Foundation,** No. 12, 12th Cross, Kumaran Nagar, Vayalur Road, Trichy - 620 017	06.03.2021	20	**De-addiction cum Rehabilitation Centre**
173	**Dr. R. Padmavati,** No. 72, New East Coast Road, Mammalapuram – 603 104.	**Bhagavan Mahavir Manav Sanmarga Seva Kendra (A Unit of SCARF),** No. 72, New East Coast Road, Mammalapuram – 603 104.	06.03.2021	50	**Psychiatric Hospital**
174	**Dr. R. Padmavati,** New No. 12, Old No. 2, Bharathi Nagar, Thiruverkadu, Chennai – 600 077.	**Bhavishya Bhavan (A Unit of SCARF),** New No. 12, Old No. 2, Bharathi Nagar, Thiruverkadu, Chennai – 600 077.	06.03.2021	60	**Psychiatric Hospital**
175	**Dr. R. Padmavati,** No. R/7A, 2nd Floor, Anna Nagar West Extn, North Main Road, Chennai	**DR. Sarada Menon Centre for Schizophrenia Care, (A Unit of SCARF),** No. R/7A, 2nd Floor,	06.03.2021	50	**Psychiatric Hospital**

	– 600 101.	Anna Nagar West Extn, North Main Road, Chennai – 600 101.			
176	**R. Karthick,** No. 234, Rajeswari Nagar, 6th Street, Thaiyur, Kelambakkam, Chennai – 603 103.	**Sai Puthiya Kudumbam De-Addiction Cum Rehabilitation Trust,** No. 234, Rajeswari Nagar, 6th Street, Thaiyur, Kelambakkam, Chennai – 603 103.	09.03.2021	25	**Psychiatric Nursing Home& De-addiction Cum Rehabilitation Centre**
177	**Dr. I. Meenakshi,** Department of Psychiatry, Thanjavur Medical College Hospital, Thanjavur – 613 004.	**Department of Psychiatry, Thanjavur Medical College Hospital, Thanjavur.**	10.03.2021	30	**Govt. Medical College Hospital**
178	**Dr. G. Ramanujam,** Department of Psychiatry, Tirunelveli Medical College Hospital, Tirunelveli – 11.	**Department of Psychiatry, Tirunelveli Medical College Hospital, Tirunelveli - 11**	10.03.2021	30	**Govt. Medical College Hospital**
179	**T. Leela,** No. 14, K.V.R. Building, Ramamoorthy Nagar, Old Karur Bye Pass Road, Chathiram Bus Stand, Trichy – 620 002.	**Kharunya Drug Awareness Counselling And Rescuing Centre,** No. 14, K.V.R. Building, Ramamoorthy Nagar, Old Karur Bye Pass Road, Chathiram Bus Stand, Trichy – 620 002.	12.03.2021	10	**De-addiction cum Rehabilitation Centre**
180	**Fr. I. Antony John Kennedy,** Koodal Nagar, Madurai – 625 018.	**Halcyon Home De-Addiction Centre Madurai,** Koodal Nagar, Madurai – 625 018.	12.03.2021	10	**De-addiction cum Rehabilitation Centre**
181	**J. Selvaraj,** No. 20, Guru Street, Bishop Sargent Centre, Trivandrum Road, Murugankurichi, Palayamkottai, Tirunelveli – 627 002.	**Bishop Sargent New Life Centre Tirunelveli,** No. 20, Guru Street, Bishop Sargent Centre, Trivandrum Road, Murugankurichi, Palayamkottai, Tirunelveli – 627 002.	12.03.2021	20	**De-addiction cum Rehabilitation Centre**
182	**Dr. P. Balu,** No. 6AB, 7, 7A, 8, Swaranambika Layout, Ramnagar, Coimbatore – 641 009.	**Krishna Nursing Home,** No. 6AB, 7, 7A, 8, Swaranambika Layout, Ramnagar, Coimbatore – 641 009.	12.03.2021	35	**Psychiatric Nursing Home**

183	**G. Krishnamurthy** No. 25, East Agraharam, Kudavasal, Thiruvarur District – 612 601.	**Sakthi De-Addiction Centre,** No. 25, East Agraharam, Kudavasal, Thiruvarur District – 612 601.	16.03.2021	10	**De-addiction cum Rehabilitation Centre**
184	**S. Masilamani** No. 1-17A, Gopalapuram, Aruppukottai – 626 112.	**Siva Sundara Foundation, A Centre for De-Addiction Cum Rehabilitation,** No. 1-17A, Gopalapuram, Aruppukottai – 626 112.	16.03.2021	20	**De-addiction cum Rehabilitation Centre**
185	**S. Arivudai Nambi** No. 2/21, Melur Main Road, Uthangudi, Madurai – 625 107.	**Aathmik Institute of Mental Health And Neuro Sciences,** No. 2/21, Melur Main Road, Uthangudi, Madurai – 625 107	19.03.2021	50	**Psychiatric Nursing Home**
186	**Dr. K. Selvaraj,** Nehru Street, Avinashi Road, Peelamedu, Coimbatore - 641004	**Vazhikatti Mental Health Centre & Research Institute,** Nehru Street, Avinashi Road, Peelamedu, Coimbatore - 641004	19.03.2021	29	**Psychiatric & De-addiction Centre**
187	**S.R. Madhavan,** No. 19/103, Vinayagar Kovil 2nd Cross Street, Raj Bai Nagar, Goverthanagiri, Avadi, Chennai – 600 071.	**New Way Foundation De-Addiction Cum Rehabilitation Centre,** No. 19/103, Vinayagar Kovil 2nd Cross Street, Raj Bai Nagar, Goverthanagiri, Avadi, Chennai – 600 071.	19.03.2021	30	**Psychiatric & De-addicton Centre**
188	**K.Ravindar,** D.No: 553, Udavayal, Keeranur Post, Kulathur Taluk, Pudukkottai – 622 502	**Ookamadhu Kaividael, De-Addiction Treatment Rehabilitation Centre,** D.No: 553, Udavayal, Keeranur Post, Kulathur Taluk, Pudukkottai – 622 502	30.03.2021	10	**De-addiction cum Rehabilitation Centre**
189	**K.P. Gautam Srinivas,** Department of Psychiatry, Chikkarayapuram, Near Mangadu, Chennai – 600 069.	**Department of Psychiatry, Sri Muthukumaran Medical College Hospital And Research Institute Chennai,** Department of Psychiatry, Chikkarayapuram, Near Mangadu, Chennai – 600 069	30.03.2021	30	**Private Medical College / Hospital**
190	**C. Regina,** No.627, Thomas Street, Aorun Ullasa Nagar, Pulliline Village, Redhills, Chennai - 52	**New Born Foundation,** No.627, Thomas Street, Aorun Ullasa Nagar, Pulliline Village, Redhills, Chennai – 52	31.03.2021	45	**Psychiatric Nursing Home**

191	**V. Kalyanakumar,** No.4/236, Ariyampalayam Nadu Street, Ariyanur, veerapandi, Salem – 636 008.	**Life Recovery Foundation, Psychiatric & De-Addiction Centre,** No.4/236, Ariyampalayam Nadu Street, Ariyanur, veerapandi, Salem – 636 008.	31.03.2021	12	**Psychiatric & De-addiction cum Rehabilitation Centre**
192	**K.K. Siva Shanmugam,** KME Unnamalai Street, Sakthi Nagar, Kondasamudram Panchayat, Pichnoor, Gudiyattam – 632 602.	**New Life House De-Addiction Cum Rehabilitation Centre,** KME Unnamalai Street, Sakthi Nagar, Kondasamudram Panchayat, Pichnoor, Gudiyattam – 632 602.	01.04.2021	20	**De-addiction cum Rehabilitation Centre**
193	**Dr. G. Shefali Singh,** No.80, Bypass Road, Madurai – 625 010.	**Rathina Mental Health Centre,** No.80, Bypass Road, Madurai – 625 010.	09.04.2021	20	**Psychiatric & De-addiction Centre**
194	**B. Ramesh,** No.18, Bharathi Nagar, Kottakuppam, Villupuram, Tamil Nadu.	**Mother Care Foundation,** No.18, Bharathi Nagar, Kottakuppam, Villupuram, Tamil Nadu.	09.04.2021	30	**Psychiatric & De-addiction Centre**
195	**B. Ayyappan,** No.2/74 A,B,C,D, Block, Thidiyoor Road, Tharuvai Palai Taluk, Tirunelveli	**Bala Saranya Rehabilition Centre,** No.2/74 A,B,C,D, Block, Thidiyoor Road, Tharuvai Palai Taluk, Tirunelveli	09.04.2021	180	**De-addiction cum Rehabilitation Centre**
196	**AnbuKumar.S,** No.5/314F, Vellakkal, Opp KSR College (ASS School Backside), Thokkavadi, Tiruchengode, Namakkal – 637 215.	**Living Sober Foundation,** No.5/314F, Vellakkal, Opp KSR College (ASS School Backside), Thokkavadi, Tiruchengode, Namakkal – 637 215.	15.04.2021	30	**De-addiction cum Rehabilitation Centre**
197	**Raj Kumari.R,** Government Mental Health Hospital Cum Rehabilitation Centre, Erwadi Dharga, Ramnad – 623 566	**Mi Home Erwadi – Home For Persons with Mental Illness,** Government Mental Health Hospital Cum Rehabilitation Centre, Erwadi Dharga, Ramnad – 623 566	15.04.2021	50	**Psychiatric Hospital**
198	**Dr. N.D. Ravi Kumar** No.5, Srinivasa Garden, Anaikkattuchery Village, Amudhurmedu, Pattabiram, Chennai – 600 072	**Ree Life Foundation II De-Addiction Cum Rehabilitation Center,** No.5, Srinivasa Garden, Anaikkattuchery Village, Amudhurmedu, Pattabiram, Chennai – 600 072	15.04.2021	20	**De-addiction cum Rehabilitation Centre**

199	**Raja.C** Unnamalai Nagar, Venkikal, Puthur, Tiruvannamalai-606 054.	**Tiruvannamalai Recovery De-Addiction & Rehab Home,** Unnamalai Nagar, Venkikal, Puthur, Tiruvannamalai-606 054.	15.04.2021	30	**De-addiction cum Rehabilitation Centre**
200	**Dr. R. Sathianathan,** No.1, Ramachandra Nagar, Porur, Chennai – 600 116.	**Sri Ramachandra Hospital,** No.1, Ramachandra Nagar, Porur, Chennai – 600 116.	16.04.2021	45	**Psychiatric Hospital**
201	**R. Panneer Selvam,** D.No.7-3-112, AIBEA 'B' Colony, Near Karpagam Matric School, Dindigul Main Road, Paravai, Madurai – 625 402	**Hope Research Foundation, (Hope Alcohol / Drug and Psychiatric Treatment Centre),** D.No.7-3-112, AIBEA 'B' Colony, Near Karpagam Matric School, Dindigul Main Road, Paravai, Madurai – 625 402	16.04.2021	75	**Psychiatric & De-addiction Centre**
202	**Raj Kumari. R** No.1, Ayathampatti Village, Near Alagar Kovil, Melur Taluk, Madurai – 625 106.	**Bothi Rehabilitation Centre For The Mentally Ill,** No.1, Ayathampatti Village, Near Alagar Kovil, Melur Taluk, Madurai – 625 106	16.04.2021	100	**Psychiatric Hospital**
203	**Sathish Kumar.A** No: 4, Dhanalakshmi Nagar, Alinjivakkam, Vadakarai, Redhills, Chennai – 600 052.	**Vaanavil De-Addiction Cum Rehabilitation Centre,** No: 4, Dhanalakshmi Nagar, Alinjivakkam, Vadakarai, Redhills, Chennai – 600 052.	19.04.2021	30	**De-addiction cum Rehabilitation Centre**
204	**Dr. R. S. Praveen Kumar,** No.391, Bangalore Trunk Road, Varadharajapuram, Nazarethpet, Poonamallee, Chennai – 600 123.	**Department of Psychiatry, Panimalar Medical College Hospital & Research Institute,** No.391, Bangalore Trunk Road, Varadharajapuram, Nazarethpet, Poonamallee, Chennai – 600 123.	20.04.2021	08	**Private Medical College / Hospital**
205	**Dr. A. Niranjana Devi,** EVR Road, Puthar, Bharthi Nagar, Tiruchirappalli – 620 017.	**Department of Psychiatry, Mahatma Gandhi Memorial Govt. Hospital, Trichy,** EVR Road, Puthar, Bharthi Nagar, Tiruchirappalli – 620 017.	20.04.2021	40	**Govt. Medical College / Hospital**
206	**N. Raja,** No.65, Kuppa Goundan Palayam, Green Park School Bus Stop, Goundachipalayam Post, V.Vellode (Via), Kanagapuram, Erode – 638 112.	**We Care Foundation, Psychiatric & De-Addiction Centre,** No.65, Kuppa Goundan Palayam, Green Park School Bus Stop, Goundachipalayam Post, V.Vellode (Via), Kanagapuram, Erode – 638 112.	20.04.2021	20	**Psychiatric & De-addiction Centre**

207	**T. Mokkesh,** No.79, 8th Street, Jakkappan Nagar, Krishnagiri – 635 001.	**Sri Siva Kavidhalaya Charitable Trust, De-Addiction / Psychiatric Treatment Centre,** No.79, 8th Street, Jakkappan Nagar, Krishnagiri - 635 001	27.04.2021	10	**Psychiatric & De-addiction Centre**
208	**D.A. Masilla Mani,** Ongur Village, Kuppayanallur, Uthiramerur, Kancheepuram – 603 406.	**Jesuit Ministry To Alcohol And Drug Dependents,** Ongur Village, Kuppayanallur, Uthiramerur, Kancheepuram- 603 406	27.04.2021	20	**De-addiction cum Rehabilitation Centre**
209	**R. Maria Alesthar Reno,** No.5/B, Madurai Road, Nehruji Nagar, St.Francis Xavier School Opp, Begambur Post, Dindigul – 624 002.	**Real Hospital & Foundation For De-Addiction Cum – Rehab Centre,** No.5/B, Madurai Road, Nehruji Nagar, St.Francis Xavier School Opp, Begambur Post, Dindigul – 624 002.	27.04.2021	20	**De-addiction cum Rehabilitation Centre**
210	**S. Narmatha,** No.6, Chozhambedu Main Road, Chozhapuram, Ambattur, Chennai – 600 053.	**Sri Foundation De-Addiction Cum Rehabilitation Centre,** No.6, Chozhambedu Main Road, Chozhapuram, Ambattur, Chennai – 600 053.	29.04.2021	40	**De-addiction cum Rehabilitation Centre**
211	**Dr. K. Veeramuthu,** Arani Road, Opposite Staff Quarters, Adukkamparai, Vellore – 632 011	**Department of Psychiatry, Govt. Vellore Medical College Hospital, Vellore,** Arani Road, Opposite Staff Quarters, Adukkamparai, Vellore – 632 011	29.04.2021	10	**Govt. Medical College Hospital**
212	**Dr. N. S. Kumar,** GMC Campus, Kulantha Goundanoor, Gandhigramam, Karur – 639004.	**Department of Psychiatry, Govt. Karur Medical College Hospital, Karur,** GMC Campus, Kulantha Goundanoor, Gandhigramam, Karur – 639004.	29.04.2021	30	**Govt. Medical College Hospital**
213	**P. Ilayaraja,** No.3/625, Periyapalayam, Uthukuli Main Road, Tirupur – 641 607.	**R.M. Foundation, De-Addiction Cum Rehabilitation Centre,** No.3/625, Periyapalayam, Uthukuli Main Road, Tirupur – 641 607.	03.05.2021	30	**De-addiction cum Rehabilitation Centre**
214	**Dr. R. Arul Kannan,** No.7-46B, Naduvoorkarai Road, Mondaikadu, Kanyakumari – 629 252	**Athencottasan Muthamizh Kazhagam, De-Addiction Centre,** No.7-46B, Naduvoorkarai Road, Mondaikadu,	07.05.2021	15	**De-addiction cum Rehabilitation Centre**

		Kanyakumari – 629 252			
215	**R. Karthikeyan,** No. 4/44A, Plot No.10&11, Bharathiyar Nagar, 10th Street, Nagamalai Pudukottai, Madurai – 626 019.	**Vigilance Foundation,** No. 4/44A, Plot No.10&11, Bharathiyar Nagar, 10th Street, Nagamalai Pudukottai, Madurai – 626 019.	04.06.2021	21	**Psychiatric & De-addiction Centre**
216	**A.M. Francis Jayapathy,** Carmel Higher Secondary School Campus, Nagercoil, KanyaKumari -629 004.	**Jesuit Ministry To Alcohol And Drug Dependents,** Carmel Higher Secondary School Campus, Nagercoil, KanyaKumari-629 004.	24.06.2021	20	**De-addiction cum Rehabilitation Centre**
217	**B.R. J. Level Joseph,** Mekkalur, Kilpennathur Taluk, Thiruvannamalai District – 604 601.	**St. Amalarakkini MI Home For Women (CURE),** Mekkalur, Kilpennathur Taluk, Thiruvannamalai District – 604 601	30.06.2021	50	**Psychiatric Nursing Home**
218	**FR. N. John Benhar,** No.17/370, Near Block Office, Tholayavattam, Kanyakumari – 629 157.	**Puthuvasantham Addiction Treatment Ministry,** No.17/370, Near Block Office, Tholayavattam, Kanyakumari – 629 157.	05.07.2021	24	**De-addiction cum Rehabilitation Centre**
219	**R. Suresh Kumar,** No.46, Vasantham Nagar, Karuppur Village, Maruthanallur, Kumbakonam – 612 402.	**Vidivelli Public Charitable Trust De-Addiction Cum Rehabilitation Centre,** No.46, Vasantham Nagar, Karuppur Village, Maruthanallur, Kumbakonam – 612 402.	06.07.2021	20	**De-addiction cum Rehabilitation Centre**
220	**M.S. Iyengaran,** No: 3/90, Manthikulam, New Natham Road, Karavanur Post, Madurai – 625 014.	**Iyengaran Faith Care Centre Private Limited (OPC), Rehabilitation Centre For Drug Addicts And Alcoholics,** No: 3/90, Manthikulam, New Natham Road, Karavanur Post, Madurai – 625 014.	13.07.2021	100	**Psychiatric & De-addiction Centre**
221	**David. D** Plot No: 57, Vishnu Nagar Anex, Madhavaram Redhills Road, Grantline, Chennai – 600 052.	**Aalam Trust De-Addiction Cum Rehabilitation Center,** Plot No: 57, Vishnu Nagar Anex, Madhavaram Redhills Road, Grantline, Chennai – 600 052.	13.07.2021	20	**De-addiction cum Rehabilitation Centre**

222	**K.Emmanuvel,** No: 9, Padasalai Street, Mel Ayanambakkam, Chennai – 600 095.	**Blessan De-Addiction Centre,** No:9, Padasalai Street, Mel Ayanambakkam, Chennai – 600 095	13.07.2021	25	**De-addiction cum Rehabilitation Centre**
223	**M. Kiran,** No: 96, Toyota Showroom Backside, Opp.VIT, Rajavalli Nagar, Katpadi Taluk, Vellore District – 632 007.	**New Life Care De-Addiction Rehabilitation Trust,** No:96, Toyota Showroom Backside, Opp.VIT, Rajavalli Nagar, Katpadi Taluk, Vellore District – 632 007	13.07.2021	25	**De-addiction cum Rehabilitation Centre**
224	**Sivaraman.S,** SRM Nagar, Irungalur, Trichy – 621 105.	**Department of Psychiatry, Trichy SRM Medical College Hospital And Research Centre,** SRM Nagar, Irungalur, Trichy – 621 105.	15.07.2021	30	**Private Medical College / Hospital**
225	**T. Saravanan,** No: 112, AVM Complex, 1st Floor, Surveyor Colony, Alagarkovil Main Road, Madurai – 625 007**.**	**3 Neurotic – Addiction Psychosis Hospice,** No: 112, AVM Complex, 1st Floor, Surveyor Colony, Alagarkovil Main Road, Madurai – 625 007**.**	20.07.2021	40	**Psychiatric Hospital**
226	**SR. Vineetha (Superior),** No: 303, Middle Street, J.J. Colony, Vadaputhupatty, Annanji Post, Theni - 625 531.	**Anbu Illam, Franciscan Charitable Trust, Rehabilitation Centre,** No: 303, Middle Street, J.J. Colony, Vadaputhupatty, Annanji Post, Theni - 625 531.	23.07.2021	75	**De-addiction cum Rehabilitation Centre**
227	**K. Vijayakumar**, No: 2/226, Janapachatram Koot Road, Periyapalayam Road, Alinjivakkam Post, Chennai - 600 067.	**A Best Care Foundation De-Addiction Cum Rehabilitation Centre,** No: 2/226, Janapachatram Koot Road, Periyapalayam Road, Alinjivakkam Post, Chennai - 600 067.	02.08.2021	17	**De-Addiction cum Rehabilitation centre**
228	**Gnanasekaran. D** No: 238, 239, Golden Royal City, Sikkanam Patty Village, Omalur, Salem – 636 309.	**Omalur Hope Life Foundation De-Addiction & Rehabilitation Centre,** No: 238, 239, Golden Royal City, Sikkanam Patty Village, Omalur, Salem – 636 309.	02.08.2021	20	**De-Addiction cum Rehabilitation centre**
229	**Dhandapani.V,** Plot No: 28, Kuruvi Karan Salai, 1st Cross Street, Sathamangalam, Anna Nagar, Madurai - 625 020.	**Ananda Priya Hospital,** Plot No: 28, Kuruvi Karan Salai, 1st Cross Street, Sathamangalam, Anna Nagar, Madurai - 625 020.	02.08.2021	14	**Psychiatric Hospital**

230	**S. Jeeva Kumar,** No.16, Lalitha Nagar, 1st Main Road, Madambakkam, Guduvancherry – 603 202.	**Peace Life Care Centre De-Addiction Cum Rehabilitation Centre,** No.16, Lalitha Nagar, 1st Main Road, Madambakkam, Guduvancherry – 603 202.	03.08.2021	30	**De-Addiction cum Rehabilitation centre**
231	**D. Daniel Luke,** No: 1, Paruthi Kottai Village, Vadanallur Post, Uthiramerur Taluk, Kanchipuram District – 603 406	**Delfina Seva Memorial Foundation Trust, De-Addiction Cum Rehabilitation Centre For Addicts,** No: 1, Paruthi Kottai Village, Vadanallur Post, Uthiramerur Taluk, Kanchipuram District – 603 406.	03.08.2021	20	**De-Addiction cum Rehabilitation centre**
232	**M. Ravi Varman,** No: 73, 74, Siddha Garden, Moratandi Village, Pattanur, Villupuram District -605 101.	**Dream Residential Psychiatric Reehab Facility,** No: 73,74, Siddha Garden, Moratandi Village, Pattanur, Villupuram District -605 101.	04.08.2021	25	**De-Addiction cum Rehabilitation centre**
233	**Dr. G.S. Chandraleka**, Saveetha Nagar, Thandalam, Kancheepuram District - 602 105	**Department of Psychiatry, Saveetha Medical College And Hospital,** Saveetha Nagar, Thandalam, Kancheepuram District - 602 105.	07.08.2021	40	**Private Medical College / Hospital**
234	**B. Meena Ravi,** No: 338, Vilapakkam Main Road, Vilapakkam Village, Karikalavakkam Post, Thiruvallur District - 602 021.	**Kokilam Balakrishnan Old Age Home And Mental Health Care,** No: 338, Vilapakkam Main Road, Vilapakkam Village, Karikalavakkam Post Thiruvallur District - 602 021.	07.08.2021	25	**Psychiatric Nursing Home**
235	**Dr. Venkatesh Kumar** D.No: 116,116A, Elachipalayam Road, Behind Kovai Public School, Karumathampatti Village, Sulur Taluk, Coimbatore – 641 659	**Ahal Neuro Psychiatry And De-Addiction Hospital,** D.No: 116,116A, Elachipalayam Road, Behind Kovai Public School, Karumathampatti Village, Sulur Taluk, Coimbatore – 641 659	12.08.2021	25	**Psychiatric & De-Addiction Centre**
236	**Selvakumar Parthiban.R** No: 1/497, Kathir Arts College Road, Neelambur, Coimbatore – 641 062	**Saaral Psychiatric And De-Addiction Centre,** No: 1/497, Kathir Arts College Road, Neelambur, Coimbatore – 641 062	17.08.2021	60	**Psychiatric & De-Addiction Centre**

237	**R. Rajan** No:1/170, Anna Main Road, Kolapakkam, Chennai – 600 128	**East Eden Foundation,** No:1/170, Anna Main Road, Kolapakkam, Chennai – 600 128	19.08.2021	30	**Psychiatric Nursing Home**
238	**V. Sivaselvan** No: 1-2A, Ponnkaala Towers, Vadugapatti, Madurai – Dindigul Highway, Vadipatti Taluk, Madurai – 625 221	Akrura Hospital Psychiatric & De-Addiction Hospital, No: 1-2A, Ponnkaala Towers, Vadugapatti, Madurai – Dindigul Highway, Vadipatti Taluk, Madurai – 625 221	24.08.2021	35	**Psychiatric Hospital**
239	**Mohanraj. M** No: 6/150, Main Road, Ramasamy Doss Park Opposite, Inammaniyachi, Kovilpatti, Thoothukkudi – 628 502.	**New Happy Life Foundation De-Addiction Cum, Rehabilitation Centre,** No: 6/150, Main Road, Ramasamy Doss Park Opposite, Inammaniyachi, Kovilpatti, Thoothukkudi – 628 502.	25.08.2021	20	**De-addiction cum Rehabilitation Centre**
240	**Dr. Siva Ilango. T** G.S.T. Road, Chinna Kolambakkam, Palayanoor Post, Madhuranthagam Taluk, Chengalpattu District – 603 308	**Department of Psychiatry, Karpaga Vinayaga Institute of Medical Sciences & Research Centre,** G.S.T. Road, Chinna Kolambakkam, Palayanoor Post, Madhuranthagam Taluk, Chengalpattu District – 603 308	25.08.2021	30	**Private Medical College / Hospital**
241	**C. Selvaraj Bovas,** No. 1, Erikarai Road, Melathur – Nallur Junction, Somangalam Village, Kanchipuram – 602 109	**Little Drops Unit – 2,** No. 1, Erikarai Road, Melathur – Nallur Junction, Somangalam Village, Kanchipuram – 602 109	25.08.2021	80	**Psychiatric & De-addiction Centre**
242	**Gokulakrishnan. C** No: 6/11- A, Pillaiyar Koil Street, Shozhiapalayam, Orakkadu Road, Sholavaram, Chennai – 600 067.	**Aadharikkum Annai Care Centre De-Addiction Cum Rehabilitation Centre,** No: 6/11- A, Pillaiyar Koil Street, Shozhiapalayam, Orakkadu Road, Sholavaram, Chennai – 600 067.	26.08.2021	12	**De-Addiction Cum Rehabilitation Centre**

243	**Joy Rosalin. G** No: 367/3B, Senguttai Kadu, Canara Bank Branch Back Side, Chandrasegarapuram Post, Rasipuram Taluk, Namakkal District – 637 408.	Anaikkum Karangal Mental Illness Rehabilitation Centre for Women, No: 367/3B, Senguttai Kadu, Canara Bank Branch Back Side, Chandrasegarapuram Post, Rasipuram Taluk, Namakkal District – 637 408.	31.08.2021	30	**De-addiction cum Rehabilitation Centre**
244	**R. Raj kumar** No. 7, Works Road, Chrompet, Chennai – 600 044.	Department of Psychiatry, Sree Balaji Medical College & Hospital No. 7, Works Road, Chrompet, Chennai – 600 044	06.09.2021	30	**Private Medical College/Hospital**
245	**Dr. Kailash Suresh Kumar** Rajiv Gandhi Salai, Kelambakkam, Chengalpattu – 603 103.	Department of Psychiatry, Chettinad Hospital And Research Institute Rajiv Gandhi Salai, Kelambakkam, Chengalpattu – 603 103.	08.09.2021	30	**Private Medical College**
246	**Dr. Jeshoor Kumar** Plot: 84 to 87, No: 3/157 & 3/158, Four Way City, Reddiyarpatti, Tirunelveli - 627 007	Hebron De-Addiction Cum Rehabilitation Centre Plot: 84 to 87, No: 3/157 & 3/158, Four Way City, Reddiyarpatti, Tirunelveli - 627 007.	08.09.2021	40	**De-addiction Cum Rehabilitation Centre**
247	**Praveena. M** No: 39/559, 5th Main Road, RTO Office Road, Phase-II, Ethiraj School Opp, Sathuvachari, Vellore – 632 009.	Mithran De-Addiction Cum Rehabilitation Center No: 39/559, 5th Main Road, RTO Office Road, Phase-II, Ethiraj School Opp, Sathuvachari, Vellore – 632 009.	08.09.2021	25	**De-addiction Cum Rehabilitation Centre**
248	**K. Dhanasekaran** No: 58, Annai Indra Nagar, Vyasarpadi, Chennai – 600 039.	N.M. Foundation, De-Addiction Cum Rehabilitation Center No: 58, Annai Indra Nagar, Vyasarpadi, Chennai – 600 039.	09.09.2021	25	**De-addiction Cum Rehabilitation Centre**
249	**S. Prem Kumar** No. 250, Redhills Road, Kalikuppam, Ambathur, Chennai – 600 053.	Mercy Foundation De-addiction Rehabilitation + Mental Health Care No. 250, Redhills Road, Kalikuppam, Ambathur, Chennai –	18.09.2021	20	**De-addiction Cum Rehabilitation Centre + Mental Health Care**

		600 053.			
250	**Senthil Kumar. S** No. 25, Sri Ganapathy Nagar Pollikalipalayam Bus Stop, Peruntholuvu Road, Muthanampalayam, Tirupur – 641 606.	Akam Psychiatric Rehabilitation Centre No. 25, Sri Ganapathy Nagar, Pollikalipalayam Bus Stop, Peruntholuvu Road, Muthanampalayam, Tirupur – 641 606.	22.09.2021	30	**Psychiatric & De-addiction Centre**
251	**M.N. Arvind Mohanraj** No. 500/3, 4, 5 Kannapiran Mill Road, Sowripalayam, Coimbatore – 641 028.	Abhasa Wellness Retreat No. 500/3, 4, 5 Kannapiran Mill Road, Sowripalayam, Coimbatore – 641 028.	27.09.2021	30	**De-addiction Cum Rehabilitation Centre**
252	**Prem Chandran** Shree Vijayalakshmi Nagar, Ramanujapuram, Kovilankulam Village, Aruppukottai, Virudhunagar District – 626 101.	Annai Illam Shree Vijayalakshmi Nagar, Ramanujapuram, Kovilankulam Village, Aruppukottai, Virudhunagar District – 626 101.	27.09.2021	48	**De-addiction Cum Rehabilitation Centre**
253	**Bhanu Suresh Babu** No. 5, Manickam Nagar, 3rd Main Road, Nuthancherry, Madambakam, Chennai – 600 126.	Concern No. 5, Manickam Nagar, 3rd Main Road, Nuthancherry, Madambakam, Chennai – 600 126.	27.09.2021	20	**Psychiatric & De-addiction Centre**
254	**Dr. V. Mugilarasi** Government Head Quarters Hospital, Mohanur – Namakkal Road, Thillaipuram, Namakkal – 637 001.	District Mental Health Programme, Government Head Quarters Hospital – Namakkal Government Head Quarters Hospital, Mohanur – Namakkal Road, Thillaipuram, Namakkal – 637 001.	29.09.2021	10	**Dist. Mental Health Programme**
255	**Dr. G. Raghuthaman** Peelamedu, Coimbatore – 641 004.	Department of Psychiatry, PSG Institute of Medical Sciences & Research – Coimbatore Peelamedu, Coimbatore – 641 004.	28.09.2021	53	**Private Medical College/Hospital**
256	**L. Easwaran** No. 135, Agraharam Street, Perundurai, Erode – 638 052.	LG Foundation No. 135, Agraharam Street, Perundurai, Erode – 638 052.	01.10.2021	20	**De-addiction Cum Rehabilitation Centre**

257	**S. Raj Kumar** No. 3, Molandipatty, Mattukaranur Post, Omalur Taluk, Salem – 636 011.	Salem Sober Home No. 3, Molandipatty, Mattukaranur Post, Omalur Taluk, Salem – 636 011.	01.10.2021	40	**De-addiction Cum Rehabilitation Centre**
258	**Rosamma K.K** Assisi Nagar, Kothalampallam, Palkulam Post, Thadikkarakonam (via), Kanyakumari District – 629 851.	Assisi Rehabilitation Centre for Mentally Ill Women Assisi Nagar, Kothalampallam, Palkulam Post, Thadikkarakonam (via), Kanyakumari District – 629 851.	04.10.2021	60	**Rehabilitation Centre for Mentally Ill Women**
259	**S. Ravindran** No. 150-G, Deputy Collector Colony, K.K. Nagar, Madurai – 625 020.	Madurai Vel Foundation No. 150-G, Deputy Collector Colony, K.K. Nagar, Madurai – 625 020.	04.10.2021	30	**De-addiction Cum Rehabilitation Centre Psychiatric & De-addiction Centre**
260	**K. Ramakrishnan** Plot No: 556, 4th Cross Street, K.K. Nagar West, Madurai – 625 020.	Gratitude Hospital Psychological & Psychiatric/De-Addiction Center Plot No: 556, 4th Cross Street, K.K. Nagar West, Madurai – 625 020.	05.10.2021	20	**De-addiction Cum Rehabilitation Centre Psychiatric & De-addiction Centre**
261	**E.R. Sivakumar** D. No: 852/3, Bannari Amman Nagar, Karattupalayam Pirivu, Old Imayam School Opp, Kavundappadi Road, Chithode, Erode – 638 102.	Sakthi De-Addiction Cum Rehabilitation Center D. No: 852/3, Bannari Amman Nagar, Karattupalayam Pirivu, Old Imayam School Opp, Kavundappadi Road, Chithode, Erode – 638 102.	12.10.2021	25	**De-addiction Cum Rehabilitation Centre**
262	**Dr. Karthik Duraisamy** No. 22, Kuttralam Main Road, Nannagaram, Melagaram Town, Tenkasi – 627 811.	Bodhi Mind Hospital No. 22, Kuttralam Main Road, Nannagaram, Melagaram Town, Tenkasi – 627 811.	20.10.2021	20	**Psychiatric Nursing Home**
263	**V. Sathish Kumar** No. 20, 1st & 2nd floor, Shastri Nagar Main Road, Adambakkam, Chennai – 600 088.	INSIGHT REHABS DE-ADDICTION CUM REHABILITATION No. 20, 1st & 2nd floor, Shastri Nagar Main Road, Adambakkam, Chennai – 600 088.	20.10.2021	30	**De-addiction Cum Rehabilitation Centre**

264	**Dr. Thila Rajagopalan Yeshwanth** No. 3, 3 A/16, Plot No. 16, Kanniappan Salai, Ranganathan Nagar, Porur, Chennai – 600 116.	HOME FOR CHANGE No. 3, 3 A/16, Plot No. 16, Kanniappan Salai, Ranganathan Nagar, Porur, Chennai – 600 116.	27.10.2021	40	**Psychiatric Nursing Home/De-addiction cum Rehabilitation Centre/Psychiatric & De-addiction Centre**
265	**V. Sampath** T.S. No: 72/1B2, Collector Office Road, Chennai – Bangalore National Highway – 48, Vellore – 632 004.	NARUVI HOSPITALS, A UNIT OF M/S SANCO FOUNDATION T.S. No: 72/1B2, Collector Office Road, Chennai – Bangalore National Highway – 48, Vellore – 632 004	29.10.2021	03	**Psychiatric Hospital**
266	**N. Vanitha Rengaraj** 221/2A1, Singarampalayam, Kinathukadavu Taluk, Coimbatore – 642 109.	SHARANALAYAM JOTHI 221/2A1, Singarampalayam, Kinathukadavu Taluk, Coimbatore – 642 109.	12.11.2021	15	**Psychiatric Rehabilitation Centre**
267	**Dr. S. Vijaya Rengan** No. 41, Andal Street, Tuticorin – 628 002.	RENGASAMY NURSING HOME No. 41, Andal Street, Tuticorin – 628 002.	16.11.2021	22	**Private Hospital/Nursing Home with Psychiatric Facility**
268	**B. Vinoth Kumar** No: 32 E/1, Vettavalam Road, Thiruvannamalai – 606 601.	IDHAYAM HOSPITAL No: 32 E/1, Vettavalam Road, Thiruvannamalai – 606 601.	17.11.2021	10	**Private Hospital/Nursing Home with Psychiatric Facility**
269	**A. Senthil** No: 332/5, Nehru Nagar West, Kalapatti Main Road, Sitra, Coimbatore – 641 014.	MAATRAM DE-ADDICTION AND REHABILITATION CENTRE No: 332/5, Nehru Nagar West, Kalapatti Main Road, Sitra, Coimbatore – 641 014.	19.11.2021	25	**De-addiction Cum Rehabilitation Centre**
270	**V. Karthigeyan** K.S.S Nagar, Kelambakkam, Chengalpattu district – 603 103.	BRIGHT LIFE FOUNDATION AND CHARITABLE TRUST K.S.S Nagar, Kelambakkam, Chengalpattu district – 603 103.	22.11.2021	35	**Psychiatric Nursing Home/Psychiatric & De-addiction Centre**
271	**S. Krishnan** 1/179, Kallar Street, Kumaravayalur, Srirangam Taluk, Tiruchirapalli – 620 102.	SHRI VRUDHASHRAM 1/179, Kallar Street, Kumaravayalur, Srirangam Taluk, Tiruchirapalli – 620 102.	22.11.2021	20	**De-addiction cum Rehabilitation Centre (Old age home & Disability Rehabilitation Centre)**

272	**A. Jeyan** 7-A, Chettiapalayam Road, Podanur (PO), Coimbatore – 641 023.	S.M. CLINIC 7-A, Chettiapalayam Road, Podanur (PO), Coimbatore – 641 023.	22.11.2021	05	**Psychiatric Hospital**
273	**The Secretary** **Fr. B. John Selvaraj** 49 K, Bharathiar Salai, Post Box No. 12, Tiruchirappalli – 620 001.	TIRUCHIRAPPALLI MULTI PURPOSE SOCIAL SERVICE SOCIETY (TMSSS) 49 K, Bharathiar Salai, Post Box No. 12, Tiruchirappalli – 620 001.	25.11.2021	17	**De-addiction Cum Rehabilitation Centre**
274	**Dr. Vandana Gopikumar** 6th Main Road, Mogappair Eri Scheme, Mogappair West, Chennai – 600 037.	THE BANYAN 6th Main Road, Mogappair Eri Scheme, Mogappair West, Chennai – 600 037.	25.11.2021	150	**Psychiatric Hospital**
275	**G. MANI** 1/92, East Street, Periyavetakkudi, T.V. Puthur (PO), Virudhachalam, Cuddalore District	GOD MERCY HOSPITAL AND FOUNDATION DE-ADDICTION CENTRE CUM REHABILITATION CENTRE 1/92, East Street, Periyavetakkudi, T.V. Puthur (PO), Virudhachalam, Cuddalore District	02.12.2021	25	**De-addiction cum Rehabilitation Centre**
276	**DR. Vandana Gopikumar** No: 5/244, Pillaiyar Kovil Street, Kovalam Village, Chengalpet District – 603 112.	THE BANYAN HEALTH CENTRE No: 5/244, Pillaiyar Kovil Street, Kovalam Village, Chengalpet District – 603 112.	02.12.2021	12	**Psychiatric Hospital**
277	**DR. Vandana Gopikumar** No: 45, Sannathi Street, Thiruvidanthai, Near Kovalam Village, Chengalpet District – 603 112.	THE BANYAN CLUSTERED GROUP HOME No: 45, Sannathi Street, Thiruvidanthai, Near Kovalam Village, Chengalpet District – 603 112.	02.12.2021	60	**Psychiatric Hospital**
278	**DR. VENKATESH RAMACHANDRAN** No: 49/2, Harrington Road, Chetpet, Chennai – 600 031.	PSYMED HOSPITAL PVT. LTD No: 49/2, Harrington Road, Chetpet, Chennai – 600 031.	02.12.2021	27	**Psychiatric Hospital**

279	**D. KOTTESWARA RAO** No: 705, Periyapalayam – Aarani Main Road, Near Sai Baba Temple, Rallapadi Village, Thiruvallur District – 601 102.	AADHARAVU HOME (MEN) No: 705, Periyapalayam – Aarani Main Road, Near Sai Baba Temple, Rallapadi Village, Thiruvallur District – 601 102.	08.12.2021	75	**De-addiction cum Rehabilitation Centre** **Psychiatric Rehabilitation Centre**
280	**A. JEEVA** No: 705, Periyapalayam – Aarani Main Road, Near Sai Baba Temple, Rallapadi Village, Thiruvallur District – 601 102.	AADHARAVU HOME (WOMEN) No: 705, Periyapalayam – Aarani Main Road, Near Sai Baba Temple, Rallapadi Village, Thiruvallur District – 601 102.	08.12.2021	50	**De-addiction cum Rehabilitation Centre** **Psychiatric Rehabilitation Centre**
281	**I. RITA IYYAPPAN** No: 56, Nallur Village, Kadapakkam Post, Cheyyur Taluk, Chengalpattu District – 603 304.	LITTLE HEARTS REHABILITATION CENTRE FOR THE PERSONS WITH MENTAL ILLNESS No: 56, Nallur Village, Kadapakkam Post, Cheyyur Taluk, Chengalpattu District – 603 304.	13.12.2021	125	**Psychiatric Nursing Home**