The Foundation and Good Practices around Halfway Homes in India: A discussion paper

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BACKGROUND NOTE:

Several strides have been made in the understanding of mental health and disability in India but one of the consistent challenges has been the sheer number of people who need treatment and care versus the social and physical infrastructure that exists to support those needs. This is one of main reasons why people with psychosocial disabilities continue to stay in hospitals despite recovery without either the opportunity to move back into society or being wanted by (or unable to trace) their families.[1]

The discourse in mental health has seen a lot of conceptual changes, with firm voices emphasising deinstitutionalization of mental health and increased community involvement. The UN Convention on the Rights of Persons with Disabilities (CRPD), an international human rights treaty, to which India is a signatory, recognizes the right of persons with disabilities to not be confined to institutions. It emphatically upholds their rights to live without discrimination, in communities and as full and equal citizens. The CRPD paved the way for the shift in the international disability community and national legislations like Rights of Persons with Disabilities and Mental Health Care Act 2017 to employ a human rights based perspective for persons with disabilities. The Mental Healthcare Act of India 2017 is a legislation that attempts to replicate this holistic approach and directs accountability and service delivery to the public health system.

Yet implementation is slow, lacks political will and is still entrenched in various manifestations of the institutional system of care. Civil society initiatives have occupied this space to provide for the gaps in services and support, from which emerged the halfway home model. The model of a halfway home is considered to be that bridge that allows persons to have a temporary place to learn or relearn skills that would help them live a more independent life as they integrate with the world outside. However, half way homes are built on the foundation of the medical approach which propagates a 'deficit model' and does not recognize the capacities of individuals unlike the human rights model espoused by the CRPD.[2] Unfortunately, it is this same philosophy of the medical model that underpins the conviction that halfway homes are a miraculous gateway to the community.

[1] https://timesofindia.indiatimes.com/india/declared-fit-yet-3000-languishing-in-mental-health-centres-data/articleshow/100058211.cms
[2] https://subjectguides.lib.neu.edu/disability/models

We cannot underestimate the influence of paternalistic and protectionist attitudes from the larger culture on mental health systems. It is no surprise that a large number of persons who languish in mental health apparatuses are women which brings the question of the gendered nature of pathways of recovery and reintegration.[3]The degree of supervision and regulations, lack of privacy, expenses (particularly in private sector run halfway homes) as well as the ways in which halfway homes often "prepare" the clients to reenter society may not always be accompanied by a rights based approach.

The focus on vocational training and income generating activities in halfway homes tends to present almost as a showcase of their clients' productive capacity and readiness as capable citizens ignoring other aspects that make life and a sense of community meaningful. Halfway homes tend to also be isolated, situated in locations far from socio-economic centres of activity and residential neighbourhoods. In 2023, even the Supreme Court of India observed that the practice of creating physical infrastructure whether it is redesigning existing spaces as halfway homes or creating new ones needs to be complemented with actual services that support persons with mental illness.[4] Martha Nussbaum talks about how the neo-liberal policy era led fixation on economic development has spawned approaches that ignore the basic need for agency, human dignity and self-respect. Economic security alone may not provide this to the clients.[5]

This is not to suggest that the halfway home has been a static entity. Medico Pastoral Association, which pioneered the concept of Halfway homes in India back in 1976, has evolved with time to acknowledge and speak about 'consent' of clients when they are admitted within such arrangements. At the same time, endeavours such as Paripurnata, another NGO which was held as an example to be replicated across the state of West Bengal in a Supreme Court commission's report[6], operates on a philosophy of restoring clients to 'wholeness' which implies that those with psychosocial disabilities have some kind of deficit in them. The halfway home exists within this odd spectrum of being an innovation wrapped in old school notions about what illness, therapy and recovery mean.

Why a discussion paper on good practices?

There exist numerous halfway homes run by the state, the private sector as well as NGOs. Yet detailed publicly available information and evaluations on the working of these institutions is lacking. Notwithstanding the potential, the geographical expanse and cultural diversity of India proves to be a challenge where one size approach does not fit all. There also exists no independent accreditation system to ensure that halfway homes meet minimum set standards.

The difference between a good idea and a good practice is that good practices can be shared for the larger good and adaptation. The FAO defines good practices as 'a successful

[3] National Strategy for Inclusive and Community Based Living for Persons With Mental Health Issues, The Hans Foundations, 2019
[4]https://www.ndtv.com/india-news/supreme-court-on-states-redesignating-old-age-homes-as-halfway-homes-2526719
[5] https://www.thenation.com/article/archive/what-makes-life-good/
[6] Unlock the Padlock-Mental Health Care in West Bengal (Jan. 1993)

experience that has been tested and replicated in several contexts and therefore be recommended as a model'. As the public health services begin to design new and renovate existing spaces into halfway homes, it is paramount that further research and multi-stakeholder consultations on what would constitute the theoretical and practical aspects of successful halfway homes are held alongside.

This discussion paper looks at what are common, good practices that halfway homes can offer as well as where there are deficits. Examples from assisted living facilities have also been included in this review due to some similarities in the template of their structure and practise with halfway homes. Yet it needs to be noted that assisted living facilities, while residential, cater to clients recovering from substance abuse disorder, prisoners and elderly clients who need more intensive day to day assistance and do not focus on reintegration back into society as halfway homes do with their clients.[7]

METHODOLOGY:

The paper uses a combination of different approaches to brief readers about the existing situation and recommendations based on it.

Field visits were conducted to a halfway home in Patna, Bihar and Iswar Sankalpa at Durganagar. Secondary research was done on specific organisations, using publicly available documents. They are listed in alphabetical order:

- Anjali, Kolkata
- Ashiana Care Home, Pan India
- Athulya Living Home, Pan India
- CADABAMS, Bangalore
- Deshbandhu Club, Assam
- Iswar Sankalpa, Kolkata
- Medico Pastoral or Richmond Fellowship, Bangalore
- Paripurnata, Kolkata
- The Banyan, Chennai
- Tulasi Mental Health, New Delhi
- Various community based interventions in Kerala

In line with the rights based approach, the terms 'clients' and 'users' are used instead of referring to persons using these services as patients.

The first part of this paper identifies select existing practices and presents their qualities against various criteria: the attributes that make them a useful and common practice, how do they fare as innovations, are they practical, participatory and sustainable? Do they - ultimately - uphold a consistently ethical and human rights perspective?

[7] Senior care arrangements also may be of different lengths of stay unlike halfway homes which are usually provisional and temporary.

The criteria for the good practices have been developed using the inspiration from FAO's standard template on Good Practices and modified for the purposes of this paper.[8]

The second part showcases three case studies illustrating in detail some of the practices.

The third and final part enlists a few recommendations sourced from experimental and successful models in other contexts or existing projects in India that could supplement or bolster these practices.

PART ONE: GOOD PRACTICES

I. Providing continuum of care

Key features:

- Offers an integrated system of care that looks at the larger picture for the clients: their medical and social history, the diagnosis, treatment and post-rehabilitation care.
- Accommodates different socio-economic and cultural diversity among clients and their families/caregivers.

Why is it innovative?

- Understands and centers the role of caregivers and families as part of the continuum of support and care for clients.
- Act as a bridge between the various stages of treatment and care.
- Potential to incorporate tech based innovations (e.g. digital or phone counselling) especially when distance and time are factors.

Feasibility:

- This practice is suited particularly for settings where caregivers and family members have been identified.
- May require additional human and financial resources but the benefits outweigh the costs in the long term because of the comprehensive nature of services provided as well as increased capacity of caregivers/families.
- Reduced the burden on the existing public health system in the long term.

Participation of key stakeholders:

- Centering the knowledge, experience and constraints of caregivers and families as part of the assistance. Paramedical professionals or trained volunteers (e.g. to run support hotlines for suicide prevention or check adherence to medical treatment) can be involved instead of relying only on medical expertise.

[8] https://www.fao.org/capacity-development/resources/good-practices/en/

Affordability:

- Several non-profits that run this kind of service also experience several operational costs which make long term provisioning precarious, especially considering the demand and supply. Private sector enterprises come with huge costs to the user hence can only be availed by very few.

Where in practice?

- CADABAM's Amitha - a private facility - uses this multi-pronged approach, however the costs are disproportionate and not accessible to all clientele. Reviews from clients and families suggest that there is lack of consistency in services provided over the time period since it was established.

II. **Creating foster families and volunteer networks as part of extended community response**

Key features:

- Focuses on clients who experience homelessness and destitution, are diagnosed with HIV/AIDS and those who do not wish to return to their families, who wish to be reunited with families but are not accepted by the latter and those whose families cannot be traced.
- Reimagines what a familial and a community space are.

Why is it innovative?

- Reimagines what a familial and a community space can look like for the client.
- Deinstitutionalization of existing crowded institutional spaces.
- Creates awareness as well as responsibility in the community around mental health.
- Relies on the goodwill of ordinary citizens but also trains them in providing care and support to the clients.

Feasibility:

- When provided with regular training and support and financial incentive - ordinary citizens can champion these roles almost in the same manner ASHA workers have been instrumental in public health care delivery in rural parts of India.
- One of the earliest successful models was driven through faith based actors in Kerala.
- Requires regular capacity building of volunteers and some level of monitoring.

Participation of key stakeholders:

- This process should be carried out only with the informed consent of the clients, as they may prefer more traditional arrangements. Foster families and volunteers become one of the stakeholders. Some of these initiatives have relied on public donations which increase interest and monitoring over these initiatives. Training and support is provided by public health facilitators and experts who are still engaged in the community level programme delivery.

Affordability:

- Old estimates indicate that organisations such as Medico Pastoralist charge anywhere between 3000-7000 INR for stay where such practices are followed.
- In other contexts, community drives through donations funded the centres.

Where in practice?

- Medico Pastoral provides a feature of 'surrogate parents' which is an elderly couple that adopts a client and can provide guidance and support.[9]
- In Kerala, estimates indicate that homeless persons with psychosocial disabilities were provided housing, medicines and care in 60 centres run by volunteer families. These centres were managed by volunteers, who attended state level workshops for capacity building.
- In Belgium, the Geel program is considered the gold standard of psychiatric care, the ultimate community-based model. The current care model in Geel is based on the Assertive Community Treatment model, an approach developed in Madison in the late 1960s.[10]

III. **A rights based approach where consent, self-determination, autonomy is integral and non-negotiable**

Key features:

- Recognizes that clients have the right to self-determination and relies on alternative therapy / capacity building sessions outside of just access to medical treatment and care.
- Informed Consent at every stage is essential.
- Apart from ensuring right to medical care, this approach utilises cultural and socially appropriate capacity building sessions that incorporate dance, music, yoga and other visual art forms.

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[9] https://www.tatatrusts.org/upload/pdf/report-on-old-age-facilities-in-india.pdf

[10] https://www.jsonline.com/in-depth/archives/2021/08/31/system-doesnt-heal-part-three-families-geel-belgium-take-those-mental-illness/8115365002/

- Mental health spaces are often gendered, so thoughtfully designed activities can avoid reinforcing gender stereotypes.
- Clear criteria and operational procedure exist to assess consent, selection and readiness of clients to live in halfway homes and participate in activities within them.

Why is it innovative?

- Strengthens the belief that clients' identity and recovery journey is more than a biomedical process but ultimately relies on their consent and participation in the process as part of the Social Recovery Model, which is understood as people's ability to lead meaningful and contributing lives as active citizens while experiencing mental ill health.[11] The focus of this approach is building active citizenship and participation in the labour market through employment or self entrepreneurship.

Feasibility:

- When implemented as locally driven initiatives, there will be costs but in the long run, regularising such processes can only increase quality, efficiency and effectiveness of service.
- There are costs involved in setting up selection committees and providing compensation for their time and services and ability to meet regularly.

Participation of key stakeholders:

- Clients get to experience their full spectrum of rights, while the administrative and management process involve a range of stakeholders

Affordability:

- Facilities such as Pratyay by Anjali which are government funded managed by non -profit and The Banyan's Home Away model which is a non-profit model relies on donor funding. Many privately run institutions such as Tulasi Mental Health offer a similar approach with considerably higher costs.

Where in practice?

- There are several organisations, particularly initiatives of civil society organisations such as Iswar Sankalpa, Anjali, The Banyan. Private sector facilities run an extensive array of programmes, such as Tulasi Healthcare.

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6025044/

However there is a lack of detailed information on Tulasi's screening process and problematic language in describing their approach. An example is the website stating that their rehabilitation programme includes "contracting with patients using the carrot and stick approach (to reward good behaviour and to punish bad behaviour can improve treatment outcomes)". [12]

IV. Accommodate accessibility, age and recreation specific needs in the design of living spaces

Key features:

- Accessibility for specific disabilities and age (wheelchair ramps, emergency on-call buttons, appropriate bedding, slopes).
- Open and recreational space available for clients.
- Reasonable accommodations being made available.

Why is it innovative?

- Moves away from a prison/confinement/asylum framework of intervention.
- Recognizes that clients are not a homogenous group but will have specific needs. The physical environment they inhabit is an extensive part of their treatment journey.
- Aligns with the principles of reasonable accommodation.

Feasibility:

- Requires overhaul of existing spaces, if they were not built with accessibility and recreation in mind but incremental changes also be brought about.
- There are few basic principles and minimum standards to adhere to even if extensive redesign and technology updating is not possible.

Participation of key stakeholders:

- Existing standards around accessibility, and assisted living include user feedback, learning from models for elderly care, de addiction centres and prison reform.

Affordability:

[12] https://www.tulasihealthcare.com/about-us/

- Costs of such homes, found often in the private sector, are expensive. Rents and services range up to Rs. 50,000 and upwards.

Where in practice?

- Ashiana Care Home, Bangalore that provides assisted living for senior citizens has incorporated accessibility. However the exorbitant costs are discouraging.

V. Representative bodies for clients

Key features:

- Keeps the flow of communication between clients and service providers.
- Voluntary nature of the committees, so only those who are interested can form part of it.
- Can take various forms: only be composed of residents, and management, or include external members along with clients, management**.**

Why is it innovative?

- An inherently participatory paradigm.
- Allows facilitated communication between management and clients through the committee.
- Incentivized by users' advocacy and well being instead of only accommodating the organisational perspective.

Feasibility:

- Is very easy to incorporate, implement and scale across different institutional setups.
- Does not require any significant financial or human resources to be allocated to it.
- As it is voluntary, there needs to be enough initiative within the members to regularise this practise.

Participation of key stakeholders:

- Users/clients advocating on behalf of themselves and management representing the organisational side but also their perspective on concerns of clients

Where in practice?

- The Banyan in Chennai as part of their Community Mental Health Programme in Kovalam worked with a model of leadership of recovered clients.

PART TWO: CASE STUDIES

1. Home Again - The Banyan

The Banyan is a mental health organisation working at the intersection of mental illness and homelessness in Chennai, Tamil Nadu.

As part of experiments with providing long term care for clients, the Home Again is an innovative model developed over the years. The framework is, in practice, an inclusive space that recognizes and provides the range of services needed for long term users which increases their sense of well being and self-determination. To execute, multidisciplinary teams are involved, majority of whom are non-specialist personal assistants.

A typical home in this structure has 4-5 residents with 1-2 personal assistants visiting or living with them. There is a range of recreational options and support facilities. The facilities include housing, support services for health, household management, socialisation, economic transactions, support with government entitlements, the ability to work but also pursue leisure and pursuits with personal meaning. The set up mirrors a familial environment in almost an urban village shaped by the user's lived experiences. The uniqueness of this model is the high degree of regard given to the agency of the clients - their ability to make choices, navigate everyday decision making, choose a family, design and pursue activities that interest them, make them feel safe and secure.

The programme has been replicated in partnership with other civil society actors in Trichy in Tamil Nadu and in partnership with the state governments in Kerala and Maharashtra. This approach has also been featured as a successful model in the Lancet Commission on Global Mental Health and Sustainable Development.

2. Pratyay by Anjali

Pratyay is a collaborative initiative between the Government of West Bengal and Anjali that is implemented in the form of a Kolkata-based assisted living facility for people from vulnerable and marginalised socio-economic backgrounds who have psychosocial disabilities. The clients have lived in state-run mental institutions, namely, Calcutta Pavlov Hospital and Lumbini Park Mental Hospital before entering the Pratyay programme.

Four key elements are at the crux of Pratyay:

- Envisioning deinstitutionalisation
- Ending stigma and discrimination associated with mental illness/psychosocial disability
- Ensuring employment opportunities and participation of people with mental illness/ psychosocial disabilities in the labour force
- Enabling independent living

Individuals who have recovered from mental health conditions and who have no family or home to return to, and who have the capability to participate in the labour force are its more direct users. Consent is integral for them to enter this programme to live in Pratyay. Clients are selected following a systematised screening process set up by the state government in collaboration with Anjali. The screening process is conducted by medical professionals and the Anjali team. The Anjali team has also been in the process of exploring options of bringing recovered clients as part of the screening committee.

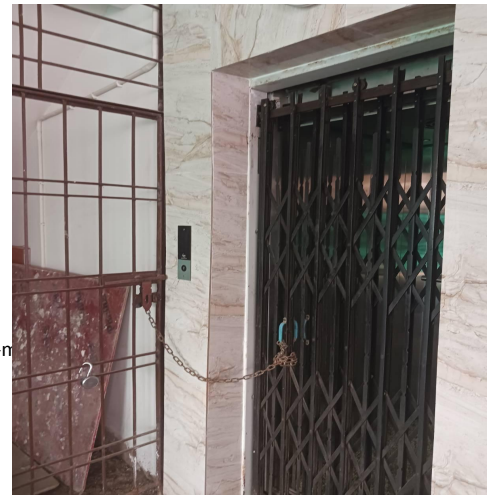
Once selected, the clients enter Pratyay, they are gradually engaged in a variety of engagement sessions and dialogues to further enhance their capacities, skills and to also nurture their ‘self’. A range of opportunities from capacity building (using art, pottery and dance), enterprise building (teaching clients to make dolls, printmaking, soap making and baking), counselling and legal support is provided. Legal support is a crucial part at Pratyay as residents’ access to their rights, for eg, property rights, would also ensure their well-being and personhood. The residents are also supported here to get their citizenship documents done, which again, is a significant step to establish their citizenship rights. There exists a kitchen that is utilised by the clients for their own needs.

If the client is interested, there are services provided that can help them tracing families, integration with them and regular home visits.

Pratyay presents the opportunity for a community where the idea of normalcy and what a family is or can be can be reimagined. Designed with the aspiration, fears and courage of users who have been through endless loops of the health system and social discrimination, this is a space where that promises them independence of the self alongside interdependence of a shared community.

3. Mentally Ill Cured - State Run Halfway Home in Danapur, Bihar

Mental health services in Bihar trail behind in several aspects. According to reports from 2020, only five public health facilities in the state have the capacity to accommodate clients with severe mental health issues. These facilities are concentrated in and around Patna, which is the capital and the state's largest city which means there is a larger demand and exorbitant costs for the users. In 2022, the Patna High Court observed how even a mental health authority that needed to be established in accordance with the Mental Health Act, 2017 had not been established.[13] Therefore it comes as no surprise that the halfway home run by the State



[13]https://www.hindustantimes.com/cities/patna-news/hc-raps-bihar-govt-on-lack-of-m
ority-101644771667786.html

Government in Patna is a skeletal system that has yet to deliver on the promise. Even the name of the home ‘Mentally Ill Cured” betrays the perspective towards mental health.

During a field visit to the male ward, it was observed that wards were running over capacity with no space or any modicum of privacy. There is no selection criteria for placing clients in the home, with persons who have different diagnosis and recovery levels being housed together. Detailed case files documenting the medical history, treatment and recovery plan for clients were not found. Clients were found wearing uniforms reminiscent of the dress codes for prison inmates. This is despite laundry facilities being available in house. The elevators were not functioning meaning persons with accessibility needs and their families would have to take the stairs.

The annual budget allocated to run this home is Rs. 66,45,400 with various provisions for services, hiring of different categories of staff and even allotments for a library for books and newspapers.

The partner NGO have reportedly not been paid for their work as yet, which creates further strain on collaborations. Yet all of this budget is underutilised showcasing the lack of will and coordination.

RECOMMENDATIONS

- **Championing the agency of clients and self governance:** All practices should be put in place with the fundamental goal of centering the clients and their empowerment. This may seem like a daunting task given the paucity of resources in India, lack of manpower and the pace at which ground level actions are implemented. But time and again, evidence has shown that when users are provided the ability to make choices on the kind of life they want to pursue after recovery or alongside their recovery, the results are tremendously positive for them at an individual level and a larger socio-economic level.[14]

- **Accountability lies with the state health and welfare system:** The private sector models have several innovative practices, but come with huge costs to the user and the community. There is a cautionary tale of not investing in one approach or component alone as 'cure all'. Halfway homes exist in a large ecosystem of mental health approaches which cannot work if the rights based approach is not ensured at all levels, within existing state and community level institutions. Civil society organisations have stepped up to plug in the gaps but need human and financial capacity for outreach and scaling up. As this paper demonstrates, there are a lot of models which can be scaled up but need the machinery and resourcing that only the public health system can provide. The accountability and onus of delivery of these services lies with the government system either on its own or through public private collaborations.

- **Assessing the role of the family and caregivers on a case by case basis:** A recovered client who moves back into the community may not necessarily experience less stigma and isolation. The family and community can often be a site of violence. Many families often do not want the clients back. This does not mean families and caregivers need to be eschewed entirely but a careful decision has to be made that considers the client's needs and desire, the family/caregiver' willingness and ability to support the client and what the myriad steps are at arriving at this consensus. In many parts of the world, extensive involvement of family members / caregivers in care plans has been explored to increase their preparation especially when the patient requires long term care. But this would require large community level education and support to the immediate caregivers. At the same time, alternatives to the concept of a heteronormative, biological family and caregiver for clients must be explored.

- **Appropriate diversity, inclusion and safeguarding policies:** The halfway home is not just a physical residential space. It needs to be accompanied with various other processes that provide for a holistic, stable and secure environment such as:

[14] For example: In many parts of the world, peer-supported communal living and self-governance models which are run by residents rather than professional staff, such as 'Oxford Living' exist. Each resident contributes equally towards the house expenses and management, and there is no maximum length of stay that is enforced.

- Detailed and systematic informed consent procedures
- Sexual health, reproductive health and well being policy
- Diversity policy for inclusion of gender diverse groups and other marginalised groups
- A functional and transparent grievance mechanism
- Duty of care to the clients where they are not forced to compromise on the quality of care or service because of costs or social discrimination and prejudices

It is important that these policies be guided by transdisciplinary knowledge and lived experiences. Formulation and administration of these policies should be overseen not just by medical experts, but also activists, paramedical professionals and when possible recovered clients themselves.

- **Quality over quantity:** The concepts of recovery, care, well being cannot be quantified in numbers. Health systems can only strive to provide facilities and support that have a greater uptake of services, create enabling conditions, and contribute to the well-being of the client. The number of clients who successfully enter and exit the halfway home does not mean much if they cannot access high standard services that guarantee them all their rights.

  In terms of numbers, there is a need for updated data: on availability of services, extent of mental health concerns across all populations particularly those who are underserved by the public health system and lastly, the numbers for human or financial resources needed for this undertaking.

The above mentioned recommendations are suggestions based on years of experiences and good practices followed and if co-opted, will bring about significant changes in the discourse of mental health and will be a remarkable step towards deinstitutionalisation and bridging existing gaps and building a continuum of care.

In conclusion, it can be observed that despite the halfway home having emerged out of medical approach, there exists immense opportunities to reimagine it as a rights based model in both theory and practice. While context, resources and political will determine the course and pace of implementation, having further conversations, engaging in stakeholder consultations (which includes clients) and employing these good practices are the only ways to strengthen the guarantee and fulfilment of the human rights, agency and empowerment of the clients.