EXECUTIVE SUMMARY

Situation analysis of
Homeless Women in Delhi
with special reference to
Mental Health and
Psychosocial Aspects

a study by

Institute of Human Behaviour and Allied Sciences (IHBAS)

Aashray Adhikar Abhiyan (AAA)

for

National Commission for Women

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Cover photo:
The cover photograph is a picture taken on meal times at Delhi's streets.

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Stuart Freedman

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Situation Analysis of Homeless Women in Delhi with Special Reference to Mental Health and Psychosocial Aspects

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for

National Commission for Women
New Delhi

2008

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OF THE MAIN REPORT

Preface

Homelessness is recognized as a serious and growing urban social problem. Though homelessness and mental morbidity are seen to be having a close link, the multi-dimensionality of the construct is yet to be fully understood. The present study was conducted by Institute of Human Behaviour and Allied Sciences (IHBAS) and Aashray Adhikar Abhiyan (AAA) with the major objective of providing the preliminary information about the life of homeless women, a largely unattended group till date, in Delhi. This study attempted to understand the socio-demographic profile, the difficulties, the mental health status and the psychosocial aspects among the homeless women in Delhi. This cross-sectional study was conducted with the help of multiple research methods – quantitative and qualitative research methods.

This study provides adequate and reliable information of useful nature on neutral topics of socio-demographic profile and the health status including issues of mental health. Additionally it also attempts to explore women's subjective experiences about sensitive issues like sexual abuse/exploitation and relationship of mental illness and homelessness by using Qualitative Research Methods (QRM) viz: Focus Group Discussions and Case Studies. The findings are discussed on the basis of the psychosocial aspects of mental health.

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Homelessness

Over the years homeless people have been viewed as a deviant group and have been labelled by society in different ways, often suggesting they were undeserving social inadequates rather than poor people in need of affordable housing. This historical perspective is important in understanding society's reaction to homeless people today.[1] The various literature reviews on homelessness dating from 1509 till date have studied the issues in relation with the existing society and its policies. Chadwick for the first time in 1842, assessed the relationship between poverty and ill health.[2] The subsequent work on homeless people from the health perspective led to change in the legal definition of homeless from criminals to ill people who needed treatment. Over past two decades there has been further shift and now the homelessness in western countries is seen mainly as a mental health service problem that has resulted from community care policies.[3]

Although homelessness is only one manifestation of class poverty and powerlessness, it is the most acute and visible form that affects a large section of the working class in most of the countries.[1] It is virtually impossible to have accurate figures of the homeless in any given geographical area. The lack of agreed upon definition of homelessness has been a significant problem in any rigorous research

on homelessness. The 'street people' may be the most visible group but they represent only one component. The heterogeneity of the population makes comprehensive classification difficult. The temporal classification by Arce et al, 1984 classify homeless as chronically homeless, episodically homeless and transiently homeless.[4] Geographical classification by Austerberry and Watson 1986, differentiate between street people, residents of shelters and hostels, residents of temporary accomodations.[5] A further classification based on the service needs include street people, chronic alcoholics, chronic mentally ill, situationally depressed, homeless families and homeless women either living alone or with children. Rossi et al (1987) in their study on urban homeless distiguished between literal homeless with no access to conventional dwelling and precariously housed with tenuous or very temporary claims to conventional dwelling of marginal adequacy.[6]

Among the various classifications and descriptions which are primarily about male population, women have been considered the ' Hidden Homeless' who are either ignored or not adequately represented in the various studies on the subject. They roughly represented 10-25% of the homeless population.[7,8] It is found that 60% women are aged 16-30 years and half accompanied by children.[8]

The number of homeless people worldwide has grown steadily in recent years. In some Third World nations such as Brazil, India, Nigeria, and South Africa, homelessness is rampant, with millions of children living and working on the streets. Homelessness has become a problem in the cities of China, Thailand, Indonesia, and the Philippines despite their growing prosperity, mainly due to migrant workers who have trouble finding permanent homes and to rising income inequality between social classes.[9,10,11] Women and families are the fastest growing segments of the homeless population.[12]

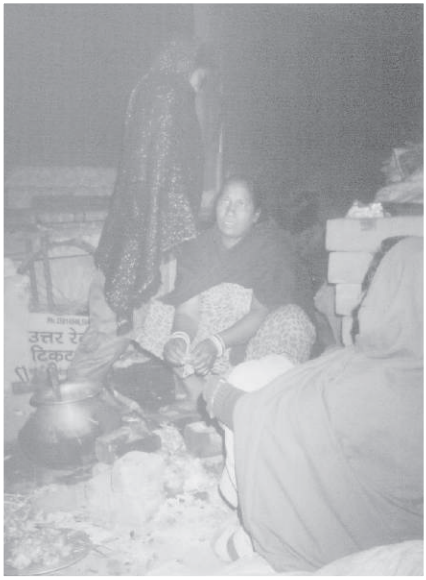
The major reasons and causes for homelessness as documented by many reports and studies include: lack of affordable housing, low paying jobs, substance abuse with lack of needed services, mental illness and lack of needed services, marital disharmony, domestic violence, unemployment, poverty, prison

release and re-entry into society, change and cuts in public assistance.[9,10,12,13] All these individually and in groups can affect men and women differently. However not many studies of this nature could be found in homeless literature.

Mental health and homelessness

The picture of the homeless population which is emerging from contemporary research on health and psychosocial aspects is of heterogeneous population with multiple mental health needs. Most of the studies conclusively report high mental morbidity in this population.[3, 14,15,16,17,18,19,20]

As many as 50% of the homeless population are reported to have some form of mental disorder with 70-80% receiving lifetime diagnosis.[10, 15, 16, 17,21,22,23] A study by Linn et al 1990 found that 80% of the homeless sample reported acute distress compared to 49% of control sample drawn from the general population.[19] The problems commonly encountered were substance abuse, severe mental illnesses like schizophrenia, depression, personality disorders and organic problems. While serious mental illness was overrepresented among the homeless, it represented just one of many important vulnerability factors for homelessness Substance abuse was far more prevalent than other Axis I disorders.[21] The rate of schizophrenia in homeless persons reported in the 33 published reports, representing eight different countries, ranged from 2 to 45 %.[22] These disorders were found to be either cause or consequence of homelessness. It was also noted that mental illness tends to worsen as homelessness continues. There is lack of



information on homeless women but some evidence suggests high rates (40-60%) of mental disorders.[10]

The homeless mentally ill often present with a complex combination of psychological, physical and social problems. But for most homeless people basic requirements of food, housing and clothing takes precedence over the treatment for mental health problems.[24] There are three important subpopulations identified within homeless mentally ill population, with differing service needs. These include those with severe mental illnesses who have been rendered homeless due to the illness, those who have the mental illness but never approached the treatment services with the underlying illness contributing to drift and those whose mental health problems are the consequence of becoming homeless.[25] More studies are recommended for understanding of these complex needs specific to the given homeless subpopulation and individuals.

Homeless women

Gender is known to play an important role in any discussion of health in general and mental health in particular owing to the biopsychosocial model of health. The homelessness thus is an important area to explore the impact of gender combined with

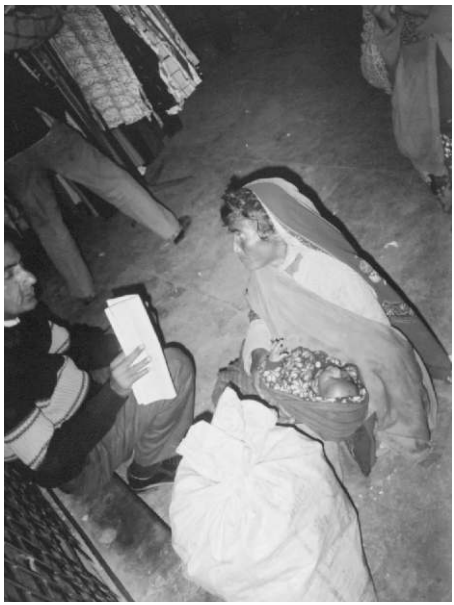
poverty and the extreme marginalization. As per Robertson and Winkleby 1996, although most homeless women do not have major mental illnesses, homeless women exhibit disproportionately high rates of major mental disorders and other mental health problems. Rates of mental disorders are highest among women without children.[26] Many homeless women with serious mental illness are not receiving needed care, apparently due in part to the lack of perception of a mental health problem and the lack of services designed to meet the special needs of homeless women.[12]

As mentioned earlier the duration of homelessness and the social network or support available was found to be directly proportional to mental morbidity. Thus even among the homeless women there are several subgroups depending on these factors. In a study by Tacchi and Scott 1996, older women had more serious mental illnesses and more problems with addiction.[27] Median length of stay in the hostels was much shorter than the median time since becoming homeless, supporting the findings that women form a "hidden-homeless" subgroup. The findings suggested that younger and older homeless women may have different health and social service needs. A similar study by Burt and Cohen 2007, which compared the data for homeless single women, women with children and single homeless men, also reported that each group differed from the other on many variables with implications for both the probable causes of their homelessness and preventive and ameliorative efforts.[28] This study used probability sampling for the first time in addition to large sample size and thus had the capacity to develop generalizations. The available data clearly indicates that the homeless women form a diverse group and each subgroup needs exclusive attention due to the differing needs.

For many of these women the experience of homelessness was stressful, but viewed as a respite because they had experienced violence and harassment prior to their homelessness.[29] For many, poor mental health was related to the conditions in shelters and traumas that they had experienced before becoming homeless. Though, more than half of them reporting mental health problems; only one third

reported to have received treatment at some time. The treatment gap has been the major concern in the service delivery as despite the availability, the utilization does not seem adequate. Mobility of the population , lack of sensitive services, lack of perceived need for treatment due to the inadequate awareness or due the psychopathology have been cited as some of the common reasons for the poor use of the health care services.[12,29] In India majority of the homeless population are working as daily wagers and find it difficult to attend the outpatient services of the government funded hospitals in daytime thus opting for help from emergency services as and when required.[13] This pattern leads to poor treatment compliance resulting in chronicity of the illnesses. The possibility of initiating involuntary treatment with periodic anti-psychotics long acting injectables is promising in clinical practice but has obvious ethical and legal dilemmas. As a result the treatment though available remains out of reach for many of the homeless women who are in need of treatment. This further increases the chronicity and resultant disability. This vicious cycle continues with the continued homelessness.

It is well established that the population of homeless women either single or those living with children is fast growing.[12] Yet the studies on homeless women classified as 'Hidden Homeless' group are still sparse and information available is inadequate. Most of the review in the subject has clearly pointed this lacuna. Understanding the intricate relationship between homelessness and mental illnesses and its possible impact on women, which is likely to be manifold, is important for effective interventions and planning policies.



The present study attempts to understand the basic profile of homeless women, the difficulties and problems faced by them with focus on psychosocial aspects and mental health. This is a preliminary effort to understand the relationship of homelessness and mental illnesses and psychological distress against the complex background of psychosocial adversities through woman's own perspective.

METHODOLOGY

The study used combination of quantitative and qualitative methods for data collection. The study was divided into three major steps, beginning with a survey of possible accessible homeless women living on the various streets and pavements of the city-state of Delhi by AAA in January 2006. A large sample of 4192 women was assessed with the help of semi-structured proforma (Annexure1) for analyzing the situation of homeless women in Delhi. In second step a further in-depth study of the sub-sample of 100 women was conducted to explore the mental health issues. The assessment included inquiry with help of a semi-structured proforma (Annexure 2), as well as assessment for psychological symptoms carried out using the widely used mental health screening instrument namely General Health Questionnaire (GHQ-12) (Annexure 3). The probable cases were then evaluated in detail and diagnosis was made by qualified mental health professionals, using the International Classification of Diseases (ICD-10) criteria, provided by the World Health Organization.

In the final step of the study, two Qualitative Research Methods (QRM) of Focus Group Discussion (FGD) and Case Studies (CS) were used for the twin purpose of (1) eliciting reliable and accurate information about sensitive issues like sexual abuse/exploitation which may not be picked up through other research methods and (2) to complement and corroborate the information elicited from the other research methods.

The data was analyzed for understanding the basic profile of the homeless women, the difficulties faced by them, personal experiences regarding physical and social safety, their access to health care and welfare services, their mental health status, coping difficulties and their expectations from future. The findings are discussed on the basis of the psychosocial aspects of mental health.

OBSERVATIONS

Observations of step I of the study (Survey of possible accessible sample using standard questionnaire)

The observations from the survey provided a panoramic view of the situation of homeless women. The overall impression was, the homeless women in Delhi are mostly young adults having migrated to Delhi with families or alone in search of better means of survival. The period of their homelessness is generally of long duration and coinciding with their migration. In large majority of homeless women, the reason for homelessness was lack of source of livelihood or income at their original place of domicile and migration in the hope of better livelihood. Although many of the homeless women living alone or with their families managed to attempt a life of some minimal dignity by working in different ways, the life on streets has had been full of difficulties and deprivation.

Observations of step II of study (In-depth study of sub-sample with focus on mental health)

The information on the exploitation and mental health was however incomplete and lacking in specific issues like relationship between mental illness and homelessness, sexual abuse/exploitation. This gap was filled in by in-depth study on sub-sample about the mental health and psychosocial aspects, which revealed that a majority of homeless women (77%) had psychological distress. The psychiatric disorders were diagnosed in 35% of them with 38% having depression and another 14% anxiety disorders. Only 8% of the women with diagnosable mental illness were receiving treatment. Patients with Severe Mental Illness were found to be low in this study as the relationship between severe mental illness such as schizophrenia and other psychosis is obviously complex and many of these patients could not be reached due to limitations of the Standard Interview Methods.

Observations of step III of the study(Focus group discussions and Case studies)

The Qualitative Research Methods (QRM) like Focus Group Discussion (FGD) in different locations and Case Studies (CS) of twenty women revealed sensitive issues like physical/sexual abuse and the exploitation and plight of homeless women, which were difficult to elicit using structured interview method. Multiple forms of harassment, exploitation and abuse were reported to be an extremely common occurrence – nearly universal. It was reported that women with severe mental illnesses or significant depression were the more marginalized and exploited group even amongst the homeless women. Specific instances and patterns of women being rendered homeless and in destitution by their husband/families on account of mental illnesses were reported as a distinct pattern.

CONCLUSIONS

This study, using multiple research methods in sequential order, and the complementarity of standard questionnaire methods and Qualitative Research Methods (QRM), has provided extremely useful observations. The important conclusions drawn from a combination of research methods are described here:

Conclusions of step I of the study (Survey of possible accessible sample using standard questionnaire)

1. A large majority of the homeless women were in the young adult group living on the streets with their families, with sizable group of them having migrated to Delhi along with their families in search of better jobs, income and economic prospects. On the other hand, a smaller proportion of homeless women who live alone, were found to be unemployed, depending on charity/alms for food with virtually no family/social support.

2. It is noteworthy that for the large majority of homeless women who had migrated to Delhi in search of livelihood and better prospects of living, the course of their homelessness has ended up being long term and chronic. As such, while addition of newer

homeless groups including women continues to occur, there is nearly no exit from the homeless populations, thus enlarging the total number continuously.

3. In the absence of basic need of shelter and any organized services being available, dealing with the difficulties and coping with problems of daily living was reported to be a continuous struggle and a huge burden. All the same, the women who had their families living with them, continued to manage living with some dignity by dealing with the difficulties and problems in a situation of deprivation and marginalization.

4. Although many of the homeless women living alone or with their families managed to attempt a life of some minimal dignity by working in different ways for their basic needs of food etc., the social milieu around them continued to jeopardize this attempt by various forms of harassment and exploitation including sexual abuse or rape.

Conclusions of step II of the study (In-depth study of sub-sample with focus on mental health)

5. The psychological state of homeless women was found to be mainly one of distress (77%) with also symptoms of mental disorders of depression (38%) and anxiety (14%). The symptoms of depression commonly found in homeless women viz. hopelessness, sadness of mood, inability to enjoy daily life, sleep disturbance can become difficult to distinguish from the possible effects of extreme marginalization and deprivation. So while following the clinical definition and models of mental health, many of the homeless women would be diagnosed to be suffering from depression requiring treatment. It may well be argued that their mental health status is not an artifact caused by their situation. Overwhelming majority (88%) of women reported to have no one to rely on in crisis irrespective of the availability of family or social network which itself is indicative of the vulnerability and insecurity faced by these women.

6. Situation of the homeless women in Delhi as in any other city is a constant struggle for survival against many odds with common experience of abuse/exploitation and substantial mental health problems of depression/anxiety and a psychological state of total helplessness.

Conclusions of step III of the study (Focus group discussions and case studies)

7. The relationship between severe mental illnesses like schizophrenia and other psychoses and homelessness is obviously complex, one contributing to the other. Both the well recognized patterns of severe mental illnesses leading to homelessness as well as homelessness contributing to severe mental illness are strikingly common and undesirable. Homeless women with mental illness often reach extreme levels of marginalization and deprivation leading to a state of destitution. The study found striking examples of such deprivation and destitution.

8. Many of these homeless mentally ill women do not receive treatment for their mental illness due to the procedural issues involved. The situation is much more alarming for those mentally ill women who do get treatment but end up being in a homeless situation or destitution owing to the gross inadequacy of rehabilitation services.

9. The experience generated also suggests that it is possible to explore successful alternatives to the destitution, for women with mental illnesses.

10. Some of the important solutions to destitution are ensuring treatment access, active collaboration between hospitals/ academic institutions and NGOs, development of many more rehabilitation facilities, sensitization of the police personnel, making legal services available, gender sensitivity in the law and provision of minimal shelter or housing.

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AASHRAY ADHIKAR ABHIYAN (AAA)

Aashray Adhikar Abhiyan (AAA), a programme of Action Aid India is a campaign for the rights of the homeless people in Delhi founded in the year 2000. AAA believes that homeless people (men, women and children) have the right to live in peace, dignity and security just like other Delhi citizens. This belief is supported by the United Nations Universal Declaration on Human Rights and the Indian Constitution. However, homeless people's rights are violated every single day and night in the city of Delhi. They are deprived of civic amenities such as water and sanitation; denied access to medical treatment; forced to work for below the minimum wage; face daily beatings and 'harassment from the police; and must sleep in the open because of a lack of shelter. AAA's aims to empower, mobilize and strengthen the capacity of homeless people so that they are able to assert their rights and live with honour and dignity; and to help the wider public; and government recognize that homeless people have inalienable rights and that it is the responsibility of everyone to ensure these rights are protected.

INSTITUTE OF HUMAN BEHAVIOUR AND ALLIED SCIENCES (IHBAS)

The Institute of Human Behaviour & Allied Sciences (IHBAS) an autonomous body under the govt. of national capital territory of Delhi is an apex level mental health institution in India, which provides state of the art patient care in the fields of Mental Health & Neurosciences with multidisciplinary approach. The hospital services at IHBAS include outpatient services, emergency services, inpatients services, intensive care unit (ICU), laboratory facilities, physiotherapy services and occupational therapy services. The institute provides many forms of community based outreach services including services for the homeless populations. The institute is actively involved in academic activities like post- graduate training and the postgraduate courses currently offered are MD in psychiatry, m. Phil in clinical psychology, and DNB neurology. The institute is involved in many research and development projects in collaboration with agencies like who, and ICMR, on important topics of Urban Mental Health, Suicide Behaviour, identification of psychoses in the community etc. IHBAS is jointly funded by govt. of India & Govt. of Delhi and is one of the three national resource centers for Govt. of India's National Mental Health Programme (NMHP).

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN,1979

"The States Parties to the present Convention,

Noting that the Charter of the United Nations reaffirms faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women,

Noting that the Universal Declaration of Human Rights affirms the principle of the inadmissibility of discrimination and proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, including distinction based on sex,

Noting that the States Parties to the International Covenants on Human Rights have the obligation to ensure the equal rights of men

and women to enjoy all economic, social, cultural, civil and political rights,

Considering the international conventions concluded under the auspices of the United Nations and the specialized agencies promoting equality of rights of men and women,

Noting also the resolutions, declarations and recommendations adopted by the United Nations and the specialized agencies promoting equality of rights of men and women, "……..

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