

Residential Rehabilitation Facilities for Persons with Mental Illness: Current Status and Future Directions Based on a Survey from Kollam District of Kerala

Ramkumar G. S.¹  and Anvar Sadath²

As persons suffering from chronic mental illnesses would require care for “medium and long term, in some cases lifelong,” India’s National Mental Health Policy (2014) espouses the “principle of continuing care.” It says all inpatient facilities must be linked to community care to support discharged patients or those managed in the community. However, the default community care model in the country is an informal family-based care system wherein the supporting family caretakers shoulder all the responsibilities even as they get little support from the state. Hence, when the family becomes unavailable because of the caretaker’s death or withdrawal from the caretaking role, the default community care withers away, resulting in homelessness.

The specific needs of this set of persons with psychosocial disabilities who are

homeless or orphaned have not been adequately addressed until recently in the policy space for mental health care and rehabilitation. It is common to see them “living rough,” wandering in the streets or languishing for years together in overcrowded wards in state or private psychiatric institutions. Nongovernmental organizations (NGOs) have stepped in a big way to fill this service gap, mainly by rescuing them from the streets and rehabilitating and reintegrating them with families.

Similarly, faced with the challenge of overcrowding in the state mental hospitals, focused initiatives have been taken to reintegrate the long-stay patients with their families. Despite these efforts, the issue of persons who cannot be integrated due to unavailable family remains. Incidentally, way back in 1970 itself, in his presidential address to the Indian Psychiatric Society, K. Bhaskaran, when

he dwelled on the long-stay patients in mental hospitals, chose to call them the “unwanted patient[s].”

The Need for transitional and Permanent Housing

In this connection, the need to provide transitional housing emerges first to facilitate reintegration with the family. Next comes the requirement, though not well recognized as the first, for permanent housing for the life-long resettlement of persons who cannot be reintegrated because of unavailable family. Therefore, this task is enormous and the same has been acknowledged in the National Mental Health Policy, 2014, where it is recognised that the public sector alone cannot address the housing problem—a collaboration with the nongovernmental sector would be needed. Similarly the health sector alone cannot do full justice

¹Dept. of Psychiatry, Government Medical College, Kollam, Kerala, India. ²School of Public Health and National Suicide Research Foundation, University College, Cork, Ireland.

HOW TO CITE THIS ARTICLE: Ramkumar GS and Sadath A. Residential Rehabilitation Facilities for Persons with Mental Illness: Current Status and Future Directions Based on a Survey from Kollam District of Kerala. *Indian J Psychol Med.* 2022;44(6):598–603

Address for correspondence: Ramkumar G S, Dept. of Psychiatry, Government Medical College Idukki, Painav, Idukki colony, Kollam, Kerala 685602, India. E-mail: ram3481@gmail.com

Submitted: 03 Jun. 2021
Accepted: 29 Oct. 2021
Published Online: 06 Apr. 2022



Copyright © The Author(s) 2022

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution- NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>) which permits non-Commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

ACCESS THIS ARTICLE ONLINE

Website: journals.sagepub.com/home/szj
DOI: 10.1177/02537176211060442

to this intersectoral arena, hence the need for the involvement of the social care and housing sector.

Current Status of Residential Rehabilitation Global and Indian Scenario

In the deinstitutionalization process in developed countries, the downsizing of large psychiatric institutions was intended to create alternative care systems in the community. In its early phase, the dominant model followed was a “linear continuum” approach. Here, people discharged from hospitals gradually progress through a series of less supervised accommodations like halfway houses, hostels, shelters, or group homes before they become ready for independent housing. Later on, dissatisfaction with this approach led to the “housing first” approaches like the “supported housing” model.²

Influenced by the same values to deinstitutionalize, India too took efforts to reform its mental hospitals. However, mental health care facilities—even outpatient facilities outside of the mental hospitals—were slow to develop even as strengthening the general hospitals with psychiatry units and integrating mental health care into primary care continue to be the strategic approaches of the government.^{3,4}

In more recent developments, the National Mental Health Policy, 2014, calls for a “range of community-based rehabilitation services including daycare centers, short-stay facilities, and long-stay facilities,” and the Mental Health Care Act (MHCA), 2017, calls for “less restrictive community-based establishments including halfway homes and group homes.” A recent paper has summarized how public interest litigations, judicial interventions, and evaluations by statutory commissions have energized these reforms.⁵

Parallel developments in the disability sector have played a catalytic role: Disability from mental illnesses was included as one among the seven disabilities earmarked for welfare provisions under the Persons with Disabilities Act (PwD) of 1995. Besides, the National Policy for Persons with Disabilities, released in 2006, acknowledges care homes and residential rehabilitation as the thrust area of action, especially for disabled women.

A recent public interest litigation regarding the plight of cured mentally ill persons languishing in state mental hospitals has led the central government to implement two guidelines: One for discharge of mentally cured persons and the other for setting up of rehabilitation homes for persons living with mental illness (who have been cured, do not need further hospitalization, are homeless, or are not accepted by their families).⁶

There are a few schemes under the central government for building residential care: For example, the Deendayal Disabled Rehabilitation Scheme (Ministry of Social Justice and Empowerment) that provides grant-in-aid for halfway homes for treated and controlled mentally ill persons, and a scheme during the 12th five-year plan under the National Mental Health Program for district-level long-term residential continuing care centers.

Model for Community Placement in India

Parallel to these developments, the Government of India commissioned the Hans Foundation to report on a national strategy for community-based living for persons with mental health issues.⁷ Based on four criteria—disability, clinical status, preferences, and support needs of the persons overstaying in mental hospitals—the report suggests three broad community placement options that are feasible and appropriate.

They are family placement, scatter-site housing with supportive services, and congregate housing with supportive services. The latter two are group housing options when family placement is not possible because of the unavailable family. Scatter-site housing is rented accommodation within ordinary neighborhoods which is shared by a small group of persons who continue to receive onsite or off-site personalized and need-based support. In contrast, congregate housing is clustered group homes where residents receive 24/7 onsite staff support.

The cost implication of such provisioning per person/month has been estimated to be ₹14,000 and ₹20,000 for scatter site and congregate housing, respectively. The recommendations in the report are based on studies demonstrating that supported housing approaches (clustered group homes and independent shared housing)

increased community integration and reduced disability among the participants compared to living in the institutional facility. The studies also show that such models are workable in India.^{7,8}

Kerala Scenario

The state of Kerala has had a dedicated mental health policy since the year 2000 (GO No. (P) 92/2000 H&FWD, dated April 13, 2000), which was revised in 2013 (GO No. (P) 206/2013 H&FWD, dated May 28, 2013). This document recognizes the gap in rehabilitative services for the severely and chronically ill who do not have enough social and familial support and calls for governmental efforts in this direction to be made effective by collaborating with the NGO sector.

Ongoing Efforts to Rehabilitate Homeless Recovered Patients in Mental Hospitals in Kerala

Kerala state utilizes the three state mental hospitals (Mental Health Centers) built during colonial times as the backbone of inpatient psychiatric care. Time and again, many measures have been taken to address the overcrowding in these institutions.

“Discharge adalats” have helped to clear barriers in difficult-to-discharge patients.⁹ Dedicated programs shift residents of mental health centers to rehabilitation centers run by NGOs (order no H4/32605/16, dated November 26, 2016, from the Social Justice Department [SJD]). A program called “Rehabilitation of Cured Mentally ill Prisoners” provides placement for prisoners overstaying in state mental hospitals even after release by the court.¹⁰ Recently, a more intensive effort has been mooted by the state—this interestingly uses health sector funds (under the Arogyakeralam project) for a rehabilitation project—to provide housing for recovered mentally ill from the state mental hospitals. This project called “Snehakkodu” (house of love) is implemented jointly by the departments of health and family welfare, social justice, and the local self-government body with technical support from NGO agency “Banyan.”¹¹ The project is modeled on a tested approach called “home again” wherein a small group of five persons stays in a shared group home in the community.¹² In another measure, the Kerala government’s health and family

welfare department is constructing a vocational rehabilitation center that costs 0.86 crores and is attached to the mental health center at Kozhikode district.¹³

Residential Facilities for Long-stay in Kerala State

Six residential facilities called Asha Bhavans are run directly by the state government, under the SJD, for “mentally cured patients.”¹⁴ The NGO sector has further filled the gap, and as per the list published by the SJD, there are 117 residential centers registered with the government.¹⁵

As part of a larger survey, the authors got an opportunity to visit and interact with the residents and facility managers of all residential facilities ($n = 9$) in one entire district area (Kollam district).¹⁶ Almost all centers ($n = 8$) were registered as homes under the Orphanages and Other Charitable Homes (Supervision and Control) Act, 1960¹⁷ Under this Act, the Orphanages Control Board supervises and controls all homes in the state, whether for the “differently-abled, beggars, women in distress, old age, or mentally ill persons.”

Six of the nine facilities in the district were registered as psychosocial rehabilitation centers (PRC) under the Kerala Registration of Psycho-social Rehabilitation of Mentally-ill Persons Rules, 2012¹⁸ (under PwD Act, 1995). Among the Six PRCs, two had additional registration as Psychiatric Rehabilitation Centre under the Kerala State Mental Health Rules, 2012¹⁹ (under Mental Health Act, 1987 [MHA]). See **Table 1** for more details.

The Norm of Overlapping Regulation and Licensing

It can be seen that the centers in Kollam district are registered with multiple regulatory authorities and thus have overlapping oversight by the Orphanage Control Board, the District Social Welfare Officer, and the State Mental Health Authority. Data also show that most of the centers are registered under the PwD Act than the MHA, and those centers with MHA registration also had PwD registration. It will be pertinent to dwell a bit on how such a situation has evolved.

Until the incident at Erwadi (Tamil Nadu) in 2001, which jolted the nation’s consciousness on the plight of

TABLE 1.

Characteristics of Long-term Residential Facilities ($n = 9$) for Persons with Mental Illness in Kollam District, Kerala.

Ownership of the centers	NGOs run by a religious order ($n=6$) NGO secular ($n=1$) Government: Poor home (beggars) ($n=1$) and Old age home ($n=1$)
Overlapping registration	Under Orphanage Control Board ($n=8$) As Psychosocial rehabilitation center ($n=6$) As Psychiatric rehabilitation center ($n=2$)
Gender of residents	Women only ($n=3$) Both gender ($n=6$)
The floor area of compound	½ to 7 acres
No. of floors	2 to 5
Arrangement of living space	Dormitory ($n=8$) Independent Rooms ($n=5$)
Duration of existence	12 years to 35 years (Poor home: 50 years)
Staff pattern	General nurse ($n=8$) Medical social worker ($n=6$) Pharmacist ($n=3$) In house doctor and psychiatrist ($n=2$) Visiting doctor and psychiatrist ($n=7$) Yoga therapist ($n=2$)
Number of residents with mental illness	7 to 128 (median 37)

n indicates the number of centers.

facilities for the care of persons with mental illness, the issue of licensing and regulation of such facilities had largely gone unattended. It can be noted that the registration of centers in Tamil Nadu was brought under rules made under the PwD Act in 2002²⁰ itself, probably as a reaction to the Erwadi tragedy—the state mental health rules under the MHA in Tamil Nadu coming much later in 2013.²¹

Unlike in Tamil Nadu, such measures progressed much slowly in other states. Matters came to a head in Kerala state in 2012 when all facilities, including rehabilitation homes, were asked to register under the MHA. However the MHA had defined only a “psychiatric hospital” / “psychiatric nursing home” (mentioning also that the definition shall include a “convalescent home”) and the State Mental Health Rules made in 1990 had prescribed standards for psychiatric hospitals/nursing homes only. So, when the government of Kerala sought to finally implement the MHA rules (the draft of the rules made by the state was in circulation from 2005), personnel associated with rehabilitation homes resisted it.

Faced with a governmental notice to either register or close down, rehabilitation sector stakeholders came together to

find a way out. They contested that rehab homes will not come under the purview of MHA, and the same contestation was brought before the High Court, which was deliberating the matter at that time in March 2012 (personal communication). It was asserted that the minimum standards under the MHA (1987) for psychiatric hospitals or psychiatric nursing homes were too demanding, unnecessary, and unaffordable when applied to rehabilitation homes that mostly run on charity mode. The impasse was precipitated by the rules set by the state, which included “psychiatric rehabilitation home” under “convalescent home” (mentioned in MHA).¹⁹ The same inclusion was done by other states, too, like Karnataka and Tamil Nadu, under their respective rules.^{21,22} Following multistakeholder deliberations, a consensus was chalked out, making way for rehabilitation centers for mentally ill persons to be registered under the PwD Act (1995). A special rule called Kerala Registration of Psycho-social Rehabilitation of Mentally-ill Persons Rules, 2012, was created.²³ This rule was modeled on the Tamil Nadu registration of Psychiatric Rehabilitation Centres of Mentally Ill Persons Rules, 2002, which is earlier mentioned in this article.²⁰

Later on, a few of these rehab centers registered under the PwD Act went ahead and took additional registration under the MHA rules. The existence of a “conflict” in the rehabilitation sector because of the requirement for this “simultaneous registration” is mentioned in a study report on psychosocial rehabilitation centers, and it suggested that it will be better if centers can remain under rules made under the PwD Act.²⁴

Norms Anticipated in the MHCA Era

Two new considerations arise as the new iteration in the legislation come into existence in the form of the MHCA:

First, MHCA stipulates that regulations made by the central authority may classify Mental Health Establishments (MHE) into different categories, and the central or state authority can specify different standards for the different categories. Doing so will formalize the flexibility in the types of centers that may come under MHE and the standards that can govern each. But regulations released yet have not delineated these categories and applicable standards. The first state level initiative in this direction has been done by the Government of Delhi through its draft regulations which specify the different categories and applicable standards for MHEs and it does include the category of “long-term psychiatric rehabilitation center.”

Second, the MHCA definition of a MHE includes “any health establishment where persons with mental illness are admitted, reside, or kept in care, treatment, convalescence, **and rehabilitation**” (emphasis added). Thus, MHCA unequivocally includes facilities catering rehabilitation, too, as an MHE requiring registration. However at the same time, it does recognize that facilities can have multiple registrations under different laws, and explains it as follows:

In case a mental health establishment has been registered under the Clinical Establishments (Registration and Regulation) Act, 2010 (23 of 2010), or any other law for the time being in force in a State, such mental health establishment shall submit a copy of the said registration along with an application in such form as may be prescribed to the Authority with an undertaking that the

mental health establishment fulfills the minimum standards, if any, specified by the Authority for the specific category of mental health establishment.

Thus, as far as MHEs are concerned, MHCA has formalized the norm of a diversity of regulation and registration under different laws: The center may be registered under any other law, say the Rights of Persons with Disabilities (RPWD) Act; still, it will need to be registered as an MHE too. This aspect should not now be a problem for the rehabilitation homes as standards would now be tailor-made based on the category of MHE under the MHCA regulations. Therefore, it is to be expected that the long-held resistance from the psychosocial rehabilitation stakeholders to register under mental health care laws may diffuse.

Parallely, it is to be expected that the rules made under the PwD Act, 1995 (Tamil Nadu Registration of Psychiatric Rehabilitation Centers of Mentally Ill Persons Rules, 2002,²⁰ and Kerala Registration of Psycho-social Rehabilitation of Mentally-ill Persons Rules, 2012)²³ will continue or get upgraded under the RPWD Act, 2016. It may also be noted that within the disability sector rules (PwD Act, 1995, state-level rules of Kerala) for welfare homes, while general rules²⁵ govern all other homes, special rules govern homes for psychosocial disability.¹⁸

Nature of the Centers Home Versus Hostel

As is presented in the table, the presence of dormitories is a characteristic of almost all centers. Even as all these facilities are designated as homes (group homes), shared spaces such as dormitories, shared rooms, or common lavatories give them the character of a hostel than home.

A study from Kerala had observed that centers had one room per 13 residents and one toilet per 12 residents.²⁶ The formal rules for psychosocial rehab homes also categorically say that each dormitory can accommodate 25 inmates. Each person can get a living space of 60 square feet, and there shall be one bathroom and one toilet for every eight male and six female inmates.¹⁸ Dormitories are the norm in welfare homes for persons with other disabilities, too, as the rules for such welfare homes say: “Forty square feet of living space to be pro-

vided to each person in dormitory.”²⁵ The MHCA, under the minimum standards for Mental Health Establishments, calls for “sufficient space between each bed.”

Tamil Nadu State Mental Health Rules, 2013, mentions a hostel model for quarter-way homes that will house mentally ill persons who are functional enough to hold on to a job. Hostels are attractive in Western settings too as crisis housing for the homeless, as they can accommodate a larger number of people in lesser space.

A study of 94 psychosocial rehab homes of Kerala in 2014 reported 7165 inmates, of whom 1278 were getting ready to return to their home state as they were from outside the state. There were 2182 admissions and 1201 discharges in that year.²⁴ These figures indicate the flux of movement of residents in the “homes,” giving them the character of transitional housing. Hence, it is not surprising that the infrastructural built-up would take on features of a hostel than a permanent home.

Standards for Long-stay

The new draft standards as prescribed by the state of Delhi²⁷ under MHCA defines long-stay rehabilitation center as a place for stay for more than six months; however, earlier rules under MHA (1987) had not defined it clearly: Kerala and Tamil Nadu State Mental Health rules defined psychiatric rehabilitation homes and long stay as “temporary” without mentioning what the permanent options are, while Karnataka state had defined long stay as “stay for a flexible period of time.” Mental Health Policy (2014) does recognize this aspect in broad terms like “long term institutional care,” “long-stay facilities,” “appropriately transitioned community care,” and “appropriate housing with the necessary support for homeless persons.”

Hence, there is a need to go into specifics when defining minimum standards for a long stay: When a long stay or life-long stay is the goal, hostel-like arrangements need to make way for private rooms or spaces. Incidentally, in the commentary by Baskaran K. from half a century back, it was remarked that it would be better to resettle the overstaying patient in mental hospitals to “community boarding houses” than “hostels” as hostels will be looked down upon as “miniature hospitals.”²¹

In developed countries, whether in the USA, Europe, or Australia, supported permanent housing for a long stay is mostly envisaged as an independent housing unit for each person, even though congregate options exist to a lesser extent. In contrast, supported housing recommended suitable for the Indian setting as mentioned earlier in this article is not independent housing but shared accommodation for groups of people scattered in a regular neighborhood or clustered as congregate housing.⁷

Custodial Versus Recovery Orientation

Although the psychosocial rehabilitation centers surveyed in the Kollam district were smaller and provided a solution for homelessness by providing shelter, food, and medicines, these facilities had a custodial atmosphere characteristic of institutions. They had institutional-level plans than person-centered plans of care, and there appear limited prospects for community integration of the residents. As the centers prioritize the values of custody, care, and protection over recovery values of autonomy, liberty, and community integration, they recreate the trans-institutionalized scenario.

This aspect has been commented on in other articles: one report calls the existing residential models as “micro institutions,”⁷ and another cautions on how “custodial mindset”²⁸ can get replicated in the halfway and long-stay homes, while a report from Kerala warns that civil rights of the residents in rehabilitation centers need protection.²⁴ Notwithstanding, because of the thrust placed on community placement for long-stay patients stranded in psychiatric institutions, governments in many states like Kerala have shifted stabilized long-stay patients from mental hospitals to these available centers. Such shifting presents as a justifiable action as in the absence of alternate models, trans institutionalization becomes the only way out and the choice is made with the value dependencies and limits that it has in bringing about social inclusion.⁷ Therefore, having the newer supported housing models in the country would help state governments make better choices to place homeless persons with mental illness who have no option for family placement.

Also, two of the nine centers, both of which are run by the government, are custodial centers: One is the poor or beggars’ home, and the other is a long-stay home for the elderly. As both the centers were government-owned, onsite mental health services were provided by the visiting team of the District Mental Health Program.

Costing Assessment

The faith-based charitable sector managed most of the psychosocial rehabilitation centers (PRC) in Kerala, and they relied on donations and support from the larger community and philanthropists. Many PRCs received government grants from the SJD, the funding for which is under a “psychosocial program for destitute mentally ill persons.”²⁹

Whenever the state government transfers persons to these centers, an annual maintenance amount of ₹50,600 per person is granted (order no H4/32605/16, dated November 11, 2016). However, a national-level costing analysis in 2019 has set the annual requirement per person for congregate housing at 2.4 lakh and 1.68 lakh for independent shared group homes in the community.⁷ Hence, one may say that governments will need to spend more than what they are currently doing to provide housing services at the recommended level.

The cost of the Home Again supported living program, which included welfare, staffing, capacity-building, and administration costs, has been estimated in the year 2019 at ₹9060/person/month. It has been compared with the cost of government-run psychiatric facilities, which is three times costlier at ₹29,245/person/month.³⁰ Such cost efficiency considerations that seem to be in favour of the newer and desirable models of community placement could make it attractive for governments to adopt them.

Way Forward

The issue of providing residential rehabilitation for the long-term placement and continuing care of persons with mental illnesses has received greater policy attention recently. For persons with mental illness for whom family placement is not possible because of the absent family, supported accommodation in the form of clustered or

segregated homes for small groups of people is the current recommendation.

Our survey of the existing residential rehabilitation centers at Kollam district of Kerala state indicates that even as they provide valuable service toward the custody, care, and protection of homeless persons with mental illness, they maintained a hostel-like institutional ambience and did not prioritize the preservation of civil rights of the residents. The centers need to embrace the newer values of recovery orientation.

The government can aid the NGOs running such centers redesign the hostel-like centers into the desirable congregate group home model. We assert that hotel like provisioning should be replaced with private rooms within institutions or shared homes when people are staying for long durations. For greater community reintegration, smaller centers that are satellite to the existing main centers may be started in the form of shared and rented accommodation scattered within the neighborhood.

With the MHCA, 2017 and the RPWD Act, 2016 set to work in synergy regarding the rehabilitation aspects of persons with mental illness, past differences between the health care and social care sectors concerning registration and regulation of rehabilitation facilities are bound to diffuse. With the feasibility of supported housing options already demonstrated in India, greater uptake of such models will aid state governments in utilizing them for community placement and reintegration of persons with mental illness, thus limiting the current practice of trans-institutionalization. A recent study on residents in government-owned welfare homes in Kerala report that 24% of them owned property, hence in this subset of persons, poverty is not contributing to homelessness. The study calls for utilizing the property for providing shelter and rehabilitation.³¹ Linking such persons who may own land, to general housing schemes like Life Mission in Kerala (a state-central project for housing for all [Pradhan Mantri Awas Yojana]) may open one avenue for creating houses.

Acknowledgement

Saji S. Raghavan MSW, worked as research associate in the survey from which data is presented here.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The data reported is from a project supported by a grant from the State Board of Medical Research, Government of Kerala.

ORCID iD

Ramkumar G.S.  <https://orcid.org/0000-0002-4022-4290>

References

- Bhaskaran K. The unwanted patient'. *Indian J psychiatry* 1970; 12(1): 1-12.
- Barbato A, D'Avanzo B, Harvey C, et al. Editorial: From residential care to supported housing. *Front Psychiatry* 2020 June 12; 11: 1. <https://www.frontiersin.org/article/10.3389/fpsy.2020.00560/full> (cited 2021, March 21).
- Gupta S and Sagar R. National mental health programme-optimism and caution: A narrative review. *Indian J Psychol Med* 2018 November 1; 40(6): 509-516. <http://www.ncbi.nlm.nih.gov/pubmed/30533946> (cited 2021, June 1).
- Daund M, Sonavane S, Shrivastava A, et al. Mental hospitals in India: Reforms for the future. *Indian J Psychiatry* 2018; 60: S239-S247.
- Murthy P and Isaac MK. Five-year plans and once-in-a-decade interventions: Need to move from filling gaps to bridging chasms in mental health care in India. *Indian J Psychiatry* 2016; 58(3): 253.
- Supreme Court order in WP (Civil) no. 412/2016 vide order-dated 22.02.2017. (Gaurav Kumar Bansal vs The State Of Uttar Pradesh). <https://indiankanoon.org/doc/162348665/>
- Narasimhan L, Mehta SM, Tirthalli S, et al. *National strategy for inclusive and community based living for persons with mental health issues*. The Hans Foundation, 2019. <http://thehansfoundation.org/wp-content/uploads/2020/07/THF-National-Mental-Health-Report-Final.pdf> (cited 2021, May 28).
- Padmakar A, de Wit EE, Mary Set al. Supported housing as a recovery option for long-stay patients with severe mental illness in a psychiatric hospital in South India: Learning from an innovative de-hospitalization process. *PLOS ONE* 2020 April 9; 15(4): e0230074. <https://dx.plos.org/10.1371/journal.pone.0230074> (cited 2020, October 3)
- Adalat solves crowding at mental health centre. *The Hindu*. 2016 <https://www.thehindu.com/news/cities/kozhikode/adalat-solves-crowding-at-mental-health-centre/article8186311.ece> (cited 2020, October 3).
- Rehabilitation of cured mentally ill prisoners. Kerala: Social Justice Department. 2019 http://sjd.kerala.gov.in/scheme-info.php?scheme_id=MTY3c1Y4dXFSI3Z5 (cited 2020, October 4)
- These Kerala rehabilitation homes help people with mental illness integrate into society. *The News Minute*. <https://www.thenewsminute.com/article/these-kerala-rehabilitation-homes-help-those-cured-mental-illness-integrate-society-77816> (cited 2020, October 1).
- Narasimhan L. *Homelessness and mental health: Unpacking mental health systems and interventions to promote recovery and social Inclusion*. Vrije Universiteit Amsterdam, 2018.
- Mental health hospitals to get rehabilitation centres. *The Hindu*. <https://www.thehindu.com/news/national/kerala/mental-health-hospitals-to-get-rehabilitation-centres/article35717012.ece> (cited 2021, August 6).
- Asha Bhavan. Kerala: Social Justice Department. http://swd.kerala.gov.in/institutions.php?inst_id=MTJzVjh1cVIjdnk= (cited 2020, October 3).
- List of recognised psychosocial rehabilitation centres (under the Kerala registration of psycho-social rehabilitation of mentally ill person, rules 2012). Social Justice Department, Government of Kerala. <http://sjd.kerala.gov.in/DOCUMENTS/Downloadables/OTHERS/22038.pdf>
- Ramkumar GS, Michael JP, and Sadath A. Clinical and psychosocial profile of persons with mental illness living in non-hospital residential facilities in a district in Kerala, India: A cross-sectional survey. 2021. <https://doi.org/10.1177/00207640211059678>
- The orphanages and other charitable home (supervision and control) Act, 1960. <https://indiankanoon.org/doc/1759043/>
- Kerala registration of psycho-social rehabilitation of mentally ill persons rules. Government of Kerala Social Welfare Department Notification, 2012. <http://swd.kerala.gov.in/DOCUMENTS/Act&Rules/Rules/11454.pdf> (cited 2020, October 3).
- The Kerala state mental health rules. Health and Family Welfare Department, Government of Kerala, 2012. <http://sjd.kerala.gov.in/DOCUMENTS/Act&Rules/Rules/12123.pdf>
- Tamil Nadu registration of psycho-social rehabilitation centres of discharged mentally ill persons' rules. Tamil Nadu government gazette, 2002. <http://www.scd.tn.gov.in/Acts and Rules/Tamilnadu Psychiatric rehabilitation of persons with mental illness rules,2002.pdf>
- Notification by government health and family welfare department Tamil Nadu state mental health rules. Government of Tamil Nadu, 2013.
- Karnataka mental health rules. Health and Family Welfare, 2012. *Karnataka State Gazette, vol 148, 2; Jan 10, 2013.*
- Radhakrishnan VK and Abraham KR. A magna carta in psychosocial rehabilitation: The long road traveled. *Indian J Psychiatry* 2017; 59: 407-410.
- Nazeer E and Prabhakaran A. Scopes and limitations of psychosocial rehabilitation in Kerala, 2016. (unpublished) <https://drive.google.com/file/d/oByYgrmfsGjWhMkVYaW5CSTlfc3JKSG5GQ3ZWNm9LdoItYlcw/view?resourcekey=o-VuTirxxQP6k4EqGXTLhsW>
- Guidelines for registration of welfare institutions for disabled persons. Social Justice. 2013 <http://sjd.kerala.gov.in/DOCUMENTS/Downloadables/Guidelines/13635.pdf> (cited 2020, October 3).
- Anish KR. An evaluation of psychosocial rehabilitation facilities for homeless mentally ill in India. *Artha J Soc Sci* 2013 June 1; 12(2): 1. <https://cujnlm.christuniversity.in/index.php/artha/article/view/405>
- Minimum standards for mental health establishments as per MHA. Delhi State Mental Health Authority (Draft), 2017. <http://smhadelhi.org/admin/pdf/pdf-english/DRAFTMinimum Standards for Psychiatric Hospital and Nursing Homes-23pdf>
- Sivakumar T, Thirthalli J, and Gangadhar B. Rehabilitation of long-stay patients in state mental hospitals: Role for social welfare sector. *Indian J Psychiatry* 2020; 62: 202-206.
- Psycho social programme for destitute mentally ill persons. Kerala: Social Justice. 2012 http://sjd.kerala.gov.in/scheme-info.php?scheme_id=MTQxc1Y4dXFSI3Z5 (cited 2020, October 4).
- World Health Organization. *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. Geneva: World Health Organization, 2021. <https://www.who.int/publications/i/item/9789240025707> (cited 2021 October 19).
- Ravindren RK and Kurian J. Sociodemographic and clinical features of homeless persons with mental illness residing in welfare homes in Kerala, India. *J Psychosoc Rehabil Ment Health* 2020 October 15; 1-6. <https://link.springer.com/article/10.1007/s40737-020-00201-9> (cited 2021, March 27).