Addressing mental health needs in shelter homes: lessons from a case study in Uttarakhand, India

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Citation: Bhupinder Kaur Aulakh. Addressing mental health needs in shelter homes: lessons from a case study in Uttarakhand, India. Indian J Comm Health. 2026;38(3): Page Number 624 - 626 https://doi.org/10.47203/IJCH.2026.v38i03.018

Article cycle: Received:05/05/2026; **Accepted:** 17/06/2026; **Published:** 30/06/2026

Mental health is increasingly seen as a key part of overall well-being. According to the World Health Organization (WHO), nearly one in four people worldwide will face a mental health disorder in their lifetime. In India, around 197 million people are impacted, with the National Mental Health Survey of India (2015-16) reporting that 10.6% of the population suffers from common disorders like depression, anxiety, and substance abuse. Progress in tackling mental health disorders is challenging due to ongoing stigma, neglect in the system, and limited access to services.

Homeless individuals are among those most affected, facing additional challenges. Shelter homes offer safety and respite, but often lack proper care, medical and psychosocial support. Studies show that homelessness and mental health issues are linked in a harmful cycle-mental illness increases the risk of homelessness, and homelessness worsens mental health conditions. In India, 1.77 million people (0.15% of the total population according to the 2011 census) are homeless, for whom shelter homes are the only resort available. In India, only 12% of urban homeless access shelter homes, most inadequately equipped, where scarce resources and untrained staff result in neglected mental health needs and insufficient support services.

This case study details the transformation of a shelter home for women in Uttarakhand, India. It shows how targeted efforts focused on safety, health, nutrition, activities, and reintegration can greatly improve the lives of women with mental health challenges and even help them return to their families and communities. The case study comes from Mahila/Kishori/ Kishor Kalyan Kendra in Kedarpur, Dehradun district. During the assessment in 2016 by the author, 140 women aged 15 to 65 years lived there, of whom 106 had diagnosed or suspected mental health conditions. The living quarters were poorly lit, and beds were unclean and infested with bedbugs. Toilets were broken and unsanitary. The kitchen lacked essential equipment, and there was no organized menu or dining tables. Residents had no access to structured activities or job training. Risks to the women's safety were clear as male sweepers often exploited the mentally challenged residents. Medical care was minimal. For medical care, women had to be sent by auto-rickshaw to Doon Hospital accompanied by women security guards, often resulting in long waiting hours and occasionally returning without having seen a doctor due to long queues. If mental health needs were recognized, they were seldom adequately addressed.

In 2016 and 2017, the Social Welfare Department of Uttarakhand launched a series of reforms to improve the safety, living conditions, health, nutrition, documentation, and overall involvement of women in state shelter homes, some of them were trafficked women who landed up in shelter homes. To boost safety and security, all male staff were replaced with female staff. They installed CCTV cameras and deployed female police home guards. Fire extinguishers were added to handle risks. Living spaces received renovations and fresh paint, windows were repaired, and sanitation was improved with upgraded toilets. They provided essential items like fans, air conditioners, and clean mattresses covered by rexin to avoid soiling of beds and easy cleaning. The kitchen was modernized with a refrigerator, chimney, water purifier, and better dining arrangements. Nutrition standards were improved by raising the daily food allowance from INR 60/day/patient to INR 100/day/patient and by introducing balanced diet weekly menu designed by dietitians.

To ensure the onsite round the clock, 24/7 medical care for the residents, services of a local private hospital were contracted and onsite nurses were deployed with weekly visit by the

doctor. Traditional medicine doctors were deployed onsite on weekly basis to provide traditional therapy to residents. They provided identity cards and legal documents like Aadhaar cards, voter IDs, disability certificates to inmates, and opened individual bank accounts. Engagement activities were introduced included yoga, exercise, music therapy through bhajans played in the morning and evening, and festival celebrations to support psychosocial well-being. In collaboration with the Uttarakhand Skill Development Mission, they introduced vocational training in tailoring, painting, knitting, and beautician skills for those who showed interest in learning. They hired an NGOs that trained mentally disabled women on how to prepare incense sticks from dried flowers and paper plates from old newspapers and paint them. The prepared products were sold online and the money earned was deposited in their bank accounts thus promoting financial independence. Some women living on footpaths in Dehradun were brought to the shelter home where they were provided care and medical services.

Following these reforms, health of residents was monitored using a structured method. Between March 2016 and October 2016, results showed significant improvement among women in the acute phase, characterized by severe psychosis and behavioral problems, which dropped from 28% to 0%. Those in the continuation phase, marked by moderate psychosis and seizure control issues, reduced from 39% to 8%. Meanwhile, women in the maintenance or remission phase, showing minimal or no symptoms and needing only non-drug support, increased from 33% to an impressive 92%. In addition to improvements in mental health, physical rehabilitation showed positive results. Women affected by paralysis regained mobility and independence through regular physiotherapy sessions.

Equally important was the reintegration of women with their families, which became a key part of recovery and social inclusion. Initially, counseling with families focused on women who had been abandoned for non-psychiatric reasons, leading to 43 reunifications. As mental health improved, many women recalled personal details. This, along with staff support, use of translators for native languages, and help from government officials, made it easier to trace families across states and abroad. Social media and administrative networks strengthened these efforts. Over time, 28 women with mental illness were reunited with families across India, some after more than 15 years. Cross-border reunifications were also managed successfully, with six women returning to Bangladesh, Myanmar, and Nepal. So far, more than 450

women have been reunited with their families through this initiative, often with heartfelt gratitude and lasting connections. The families and communities welcomed their "lost members" with open arms.

The experience from Uttarakhand shows that shelter homes, when supported by targeted reforms, can evolve beyond institutional care. They can become transitional spaces that promote recovery, dignity, and reintegration for women with mental health issues. Similar findings are reported worldwide. In the United States, supportive housing models that combine psychiatric care with housing have led to better stability and fewer hospitalizations among homeless individuals with severe mental illness. In low- and middle-income countries (LMICs), community-based rehabilitation and the inclusion of mental health in primary care have effectively improved outcomes for marginalized groups. In India, pilot programs that connect livelihood opportunities with mental health care have positively affected social functioning and community acceptance. These methods align with the Uttarakhand model, where skills training, improved care including medical care, and family reunification create pathways for long-term recovery. Global frameworks, like WHO's Comprehensive Mental Health Action Plan 2013-2030, stress the need for deinstitutionalization, community reintegration, and approaches that respect human rights. The Uttarakhand experience fits well with these principles, which shows that even in areas with limited resources, relatively low-cost but dedicated interventions can lead to significant changes. Expanding these models across India will require careful investment, collaboration across sectors (such as hospitals, NGOs, and government agencies), and integration with existing national programs such as the District Mental Health Programme and Skill India Mission. This could help shelter

homes transform into rehabilitative platforms instead of merely serving as institutional spaces. These outcomes reaffirm that structured and comprehensive interventions can change lives, even in areas with limited resources. With efforts to find the where abouts of the homeless residents of shelter homes, their families can be traced and they can be reunited with their families. Thus, shelter homes should serve as transitional spaces. They should support recovery, restore dignity, and help reintegrate individuals with their families, not keep them in long-term care. Improvements in safety, nutrition, psychosocial engagement, and skills training can all contribute to recovery and empowerment. Focused family tracing and community reintegration efforts pointed out sustainable options to institutional care. This emphasizes the urgent need for policy changes that incorporate rehabilitation and reintegration into shelter home systems.

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