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Psychosocial Interventions and Gendered Mental Health Vulnerabilities Among Homeless Adults: A Case Study of Hastings, Kolkata

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Abstract

Homelessness is deeply intertwined with structural marginalization, poverty, and gendered vulnerabilities that significantly shape mental health outcomes. In Hastings, Kolkata - an area characterized by dense urban precarity and limited access to welfare services - homeless adults experience heightened psychosocial stressors, compounded by inadequate institutional support. This study, titled "Psychosocial Interventions and Gendered Mental Health Vulnerabilities Among Homeless Adults: A Case Study of Hastings, Kolkata," adopts an embedded case study design to examine the intersection of mental health distress, social support deficits, and psychosocial intervention practices within a defined urban context.

Using a mixed-methods approach, data were collected from 133 homeless adults through standardized instruments, including the General Health Questionnaire (GHQ-12) and the Multidimensional Scale of Perceived Social Support (MSPSS). To capture lived experiences and gendered dimensions of vulnerability, semi-structured interviews were conducted with 20 homeless participants (men and women) and 5 professionals involved in intervention delivery, including social workers and mental health practitioners. Quantitative data were analysed using SPSS, while qualitative data were examined through thematic analysis to identify patterns related to distress, coping, and service access.

Findings indicate that nearly 70% of participants exhibited significant psychological distress, with women reporting higher levels of emotional strain, safety-related anxiety, and social isolation compared to men. Perceived social support was consistently low across familial, peer, and community networks. However, individuals who accessed psychosocial interventions - such as individual counselling, peer support groups, crisis referrals, and community outreach - reported improvements in emotional regulation, coping capacity, and perceived social connectedness. Qualitative insights further revealed that gender-sensitive outreach, sustained trust-building, and integrated service delivery were critical in facilitating engagement, particularly among women experiencing compounded vulnerabilities.

The study underscores the urgent need for structured, gender-responsive, and community-based psychosocial services tailored to the complex realities of urban homelessness. By situating mental health within broader social and gendered contexts, this case study contributes to a deeper understanding of how targeted psychosocial interventions can mitigate vulnerability and promote sustainable pathways toward well-being and social reintegration.

Keywords: Homelessness, Psychosocial Intervention, Mental Health, Social Support

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Introduction

Homelessness remains one of the most visible manifestations of structural inequality in contemporary urban societies. Beyond the absence of shelter, homelessness represents a condition of chronic insecurity, material deprivation, and social exclusion that profoundly shapes mental health outcomes. A growing body of research demonstrates that individuals experiencing homelessness face disproportionately high levels of psychological distress, trauma exposure, substance dependence, and restricted access to mental

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health services (Roy et al., 2024). These vulnerabilities are not merely individual pathologies but are deeply embedded within broader structural conditions that constrain agency and access to care.

In the Indian context, homelessness must be understood against the backdrop of rapid urbanisation, precarious informal labour markets, internal migration, and insufficient public welfare infrastructure (Bhattacharya, 2024). Urban poverty in cities such as Kolkata is spatially concentrated within micro-localities marked by overcrowding, informal housing arrangements, and limited service delivery. Hastings, a dense urban area in Kolkata, presents one such micro-context where homelessness intersects with economic marginality, infrastructural neglect, and fragmented outreach systems. These localized configurations shape how mental health vulnerabilities are produced, experienced, and addressed. Yet, empirical scholarship in India has seldom examined homelessness and psychosocial interventions within specific urban micro-settings, instead privileging institutional or shelter-based populations.

The bidirectional relationship between homelessness and mental illness further complicates this terrain. Mental health conditions may predispose individuals to housing instability, while prolonged exposure to homelessness - characterised by insecurity, stigma, violence, and uncertainty - can exacerbate or precipitate psychological disorders (Raman et al., 2025). This cyclical dynamic reflects what may be conceptualised as structural vulnerability: a condition in which individuals' health risks are patterned by socio-economic hierarchies, policy failures, and institutional exclusions rather than solely by personal characteristics. Structural vulnerability shifts analytical attention from individual deficits to the systemic arrangements that generate risk, including labour precarity, inadequate social protection, and the criminalisation or invisibilisation of homelessness.

Within this structurally constrained environment, gender emerges as a critical axis shaping mental health vulnerability. Homeless women frequently encounter heightened exposure to sexual violence, exploitation, reproductive health risks, caregiving burdens, and intensified stigma, all of which compound psychological distress. Men, conversely, may experience pressures associated with normative expectations of masculinity, substance use, and reluctance to seek help. These differentiated experiences underscore the necessity of a gender lens that recognises how mental health risks and coping strategies are mediated by socially constructed roles and power relations. Despite these realities, research in India has rarely integrated gender analysis into studies of psychosocial interventions among street-based homeless adults.

Psychosocial interventions - encompassing individual counselling, peer support groups, outreach-based screening, crisis referral, and case management - have been identified as promising strategies for addressing both emotional distress and social isolation among homeless populations (Roy et al., 2024). In India, civil society organisations such as The Banyan have demonstrated the potential of community-oriented and rehabilitative models that integrate clinical care with social reintegration (Bhattacharya, 2024; The Banyan Case Study, 2019). However, the transferability and contextual functioning of such interventions within specific urban localities remain insufficiently examined. Global reviews similarly emphasise the need for contextually adapted, gender-responsive programmes that address both mental health and social determinants (Evidence Map Review, 2014).

Understanding how psychosocial interventions operate within a particular locality requires methodological approaches capable of capturing complexity, context, and lived experience. Case study research is especially suited for investigating phenomena embedded within real-life settings where boundaries between context and process are indistinct (Yin, 2014). Rather than isolating variables from their socio-spatial environment, a case study approach enables holistic exploration of how structural vulnerability, gendered experiences, and service delivery mechanisms intersect within a bounded system. By focusing on Hastings as a defined urban micro-context, the present study seeks to illuminate how psychosocial interventions are implemented, experienced, and mediated by local conditions.

Framing Hastings as a case allows for analytical depth that extends beyond descriptive prevalence estimates. It facilitates examination of how structural constraints - such as insecure livelihoods, limited documentation, stigma, and service fragmentation - shape access to care. Simultaneously, it enables exploration of how gendered experiences influence both vulnerability and engagement with interventions. Through this theoretically informed case study, homelessness is treated not merely as a demographic category but as a socially produced condition embedded within intersecting systems of inequality.

Accordingly, this study investigates psychosocial interventions and gendered mental health vulnerabilities among homeless adults in Hastings, Kolkata. By

integrating quantitative assessments of psychological distress and perceived social support with qualitative insights from homeless individuals and service providers, the research aims to deepen understanding of how community-based interventions function within a structurally constrained urban environment. In doing so, it contributes to scholarship that foregrounds context, structural determinants, and gendered power relations in the design of mental health strategies for marginalised populations. Ultimately, situating psychosocial intervention within a case study framework provides a pathway for generating analytically grounded insights that can inform more inclusive, responsive, and sustainable urban mental health policies.

Literature Review and Research Gaps

Homelessness is widely recognised as a critical social and public health concern, with profound implications for mental health outcomes. International evidence consistently demonstrates that individuals experiencing homelessness exhibit significantly higher rates of depression, anxiety disorders, post-traumatic stress disorder (PTSD), psychosis, and substance-use disorders compared to the general population (Fazel et al., 2014). These elevated rates are closely linked to precarious living conditions, chronic insecurity, exposure to violence, disrupted social networks, and restricted access to health and welfare services. Homelessness thus represents not only a housing crisis but also a condition of sustained psychosocial stress embedded within structural inequality.

In low- and middle-income countries such as India, homelessness is shaped by rapid urbanisation, circular migration, informal labour precarity, and fragmented welfare systems (Srinivasan & Kumar, 2017). Empirical studies conducted in Indian urban settings have reported high prevalence rates of depression, severe psychological distress, and trauma-related symptoms among homeless adults (Srinivasan & Kumar, 2017). Structural barriers - including lack of identity documentation, stigma, bureaucratic exclusion, and limited integration of mental health services into primary care - further constrain access to treatment and rehabilitation. These patterns resonate with the concept of structural vulnerability, which posits that health risks are patterned by social hierarchies and institutional arrangements rather than solely by individual characteristics (Quesada et al., 2011). From this perspective, homelessness produces mental health vulnerability through systemic exclusion and marginalisation.

Although the burden of mental illness among homeless populations has been documented, research in India has largely remained generalised at the city or institutional level. Few studies examine how psychosocial vulnerability operates within specific urban micro-contexts, where service availability, policing practices, environmental conditions, and community interactions vary considerably. A locality-specific approach is therefore necessary to capture the socio-spatial realities of homelessness within defined settings such as neighbourhood clusters in Kolkata.

Gender further shapes mental health vulnerability within homeless populations. Research indicates that homeless women experience disproportionate exposure to gender-based violence, exploitation, caregiving burdens, and social stigma, all of which intensify psychological distress (Padgett et al., 2006). Men, conversely, may exhibit higher rates of substance dependence and reduced help-seeking behaviour, influenced by socially constructed norms surrounding masculinity. Despite these differentiated experiences, gender-responsive analyses remain limited in Indian homelessness research. The absence of a gender lens restricts understanding of how intervention access, participation, and outcomes may vary between women and men in street-based contexts.

Social support has consistently been identified as a protective factor mitigating the adverse mental health effects of homelessness. Perceived social support from family, friends, and community networks is inversely associated with depression, anxiety, and stress levels (Zimet et al., 1988). However, homelessness often disrupts familial ties and weakens social capital, resulting in isolation and diminished coping resources (Caton et al., 2005). Studies in Kolkata have reported fragile or absent family connections and limited community integration among homeless individuals, exacerbating vulnerability to mental distress (Chatterjee, 2019). These findings underscore the importance of integrating multidimensional social support frameworks into psychosocial interventions.

Psychosocial interventions - including individual counselling, peer support groups, case management, outreach screening, and referral services - have demonstrated effectiveness in enhancing coping strategies, emotional regulation, and social connectedness among homeless populations (Roy et al., 2024). In India, organisations such as The Banyan have pioneered integrated models combining mental health care, housing assistance, and livelihood rehabilitation (The Banyan, 2019). These initiatives

illustrate the potential of community-based approaches tailored to local realities. Nevertheless, systematic evaluations of psychosocial interventions within specific neighbourhood contexts remain scarce. Much of the existing evidence derives from high-income countries or institutional settings, limiting applicability to street-based urban populations in India.

Methodologically, the literature reveals additional gaps. Few studies employ mixed-methods designs that integrate quantitative assessments of psychological distress with qualitative insights into lived experience and service engagement. Moreover, limited research has examined how multiple dimensions of perceived social support - familial, peer, and community - interact with psychosocial intervention outcomes in Indian urban settings.

These gaps justify the need for a contextually grounded case study approach. Case study methodology is particularly suited for examining complex social phenomena within real-life settings where contextual variables are integral to understanding outcomes (Yin, 2014). By focusing on a defined urban locality, such as Hastings in Kolkata, research can capture how structural vulnerability, gendered experiences, mental health distress, and psychosocial interventions intersect within a bounded socio-spatial environment. Such an approach facilitates analytical generalisation by linking empirical findings to broader theoretical insights regarding homelessness, structural inequality, and gendered mental health risk.

Objectives of the Study

To assess the mental health status and levels of perceived social support among homeless adults in Hastings, Kolkata, situating these within a framework of structural vulnerability and gendered marginalization.

To evaluate the effectiveness of community-based psychosocial interventions in enhancing emotional well-being, coping capacities, and social connectedness among the homeless population in the selected case study setting.

To explore the lived experiences and perspectives of homeless adults, along with professionals involved in intervention delivery, regarding the accessibility, implementation, and impact of psychosocial services in Hastings.

To develop context-specific recommendations for strengthening structured, gender-sensitive, community-based psychosocial programs tailored to the needs of homeless adults in Hastings, Kolkata.

Research Methodology

This study employed a mixed-methods research design to comprehensively examine mental health status, perceived social support, and the effectiveness of psychosocial interventions among homeless adults in Hastings, Kolkata. The mixed-methods approach was chosen to capture both quantitative outcomes and qualitative insights, providing a nuanced understanding of the participants' experiences and the impact of interventions.

Study Setting and Participants

The research was conducted in Hastings, a densely populated urban locality in Kolkata known for high levels of homelessness and urban poverty. A total of 133 homeless adults participated in the quantitative phase, selected through purposive and convenience sampling based on their accessibility and willingness to participate. For the qualitative phase, 20 homeless participants and 5 professionals - including social workers and mental health practitioners involved in delivering psychosocial interventions - were purposively selected to provide in-depth perspectives on the interventions and social support mechanisms.

Data Collection Instruments

Quantitative data were collected using standardized and validated instruments. The General Health Questionnaire (GHQ-12) was used to assess psychological distress and general mental health status, while the Multidimensional Scale of Perceived Social Support (MSPSS) evaluated perceived support across three domains: family, friends, and significant others (Zimet, Dahlem, Zimet, & Farley, 1988). Demographic and socioeconomic information was also collected to contextualize the findings.

Qualitative data were gathered through semi-structured interviews with both participants and professionals. The interviews explored participants' lived experiences, coping strategies, access to social support, and perceptions of psychosocial interventions. Professionals were interviewed to understand intervention design, delivery challenges, and observations on participant engagement and outcomes.

Psychosocial Interventions

The study focused on structured community-based psychosocial interventions available to homeless adults in Hastings, including individual counselling, peer support groups, and referral services to healthcare

and social welfare agencies. These interventions were designed to improve emotional well-being, strengthen coping skills, and enhance social connectedness.

Data Analysis

Quantitative data were analysed using SPSS software (version 26). Descriptive statistics summarized demographic characteristics, mental health status, and perceived social support scores. Inferential statistics, including correlations and t-tests, were applied to explore relationships between mental health outcomes, social support, and engagement with psychosocial interventions. Qualitative data were analysed using thematic analysis, following Braun and Clarke's (2006) framework. Interviews were transcribed verbatim, coded, and organized into themes that captured participants' experiences, perceived benefits of interventions, barriers to engagement, and the role of social support networks. Triangulation of quantitative and qualitative findings was performed to strengthen validity and provide a comprehensive understanding of the study objectives.

Ethical Considerations

The study adhered to ethical guidelines for research with vulnerable populations. Ethical approval was obtained from the institutional review board, and informed consent was secured from all participants. Participants' anonymity and confidentiality were strictly maintained, and support services were made available for individuals experiencing distress during the study.

Overall, this methodology allowed for a holistic assessment of mental health, social support, and the effectiveness of psychosocial interventions, providing both numerical evidence and rich contextual insights into the lives of homeless adults in Hastings, Kolkata.

Results and Discussion

In accordance with the four research objectives, this case study integrates quantitative findings with qualitative narratives to situate mental health within the structural and gendered realities of homelessness in Hastings, Kolkata. By examining psychological distress, perceived social support, intervention outcomes, and lived experiences within a bounded urban locality, the findings illuminate how structural marginalization shapes mental health vulnerabilities and how community-based psychosocial interventions mediate these risks.

The quantitative findings revealed that 70% of participants (n = 93) scored above the GHQ-12 threshold, indicating significant psychological distress. This high prevalence underscores the magnitude of mental health vulnerability among homeless adults in Hastings. However, within a structural vulnerability framework, distress cannot be interpreted as merely individual pathology. Rather, it reflects chronic exposure to precarious living conditions, insecurity, poverty, and institutional neglect.

Participants' narratives vividly illustrated this structural embedding of distress. One male participant (P7, Male, 45 years) stated:

"Every night I sleep with fear - fear of rain, fear of police eviction, fear that someone will take my belongings. The mind never rests."

Similarly, a female participant (P12, Female, 38 years) shared:

"We are always alert. Even while sleeping, we are listening. For women, the street is never safe."

These accounts reveal that psychological distress is intimately tied to spatial insecurity and gendered exposure to risk. Women participants reported heightened anxiety related to harassment, sexual violence, and lack of privacy, suggesting that homelessness produces differentiated mental health burdens across gender lines. Thus, mental illness in this context emerges as both socially produced and structurally sustained.

The MSPSS scores indicated low perceived social support across family (M = 2.4), friends (M = 2.1), and community (M = 2.3) domains on a 7-point scale. These findings reflect profound relational isolation and fractured social networks. Structural vulnerability theory helps explain how displacement, migration, and poverty erode traditional support systems.

Several participants described estrangement from families due to economic hardship, marital breakdown, or social stigma. One woman (P19, Female, 41 years) noted:

"When I left home, they told me not to return. Here, I have no one. I survive by myself."

Another male participant (P3, Male, 52 years) reflected:

"On the street, everyone struggles for food and space. Friendship is difficult when survival comes first."

These narratives suggest that low perceived support is not simply subjective loneliness but a consequence of disrupted kinship ties and weakened community integration. Women's accounts frequently referenced domestic violence or abandonment as pathways into homelessness, underscoring the gendered nature of relational rupture. Thus, the erosion of social capital

operates as both a precursor to and consequence of homelessness, compounding psychological distress.

Participants who engaged in structured psychosocial interventions - including counselling, peer support groups, and referral services - reported improvements in emotional well-being estimated at 25–30%. Additionally, over 60% reported feeling more socially connected following participation. These improvements indicate that community-based psychosocial engagement can mitigate distress even within structurally constrained settings.

Qualitative narratives provide deeper insight into how these gains were experienced. One participant (P11, Male, 36 years) expressed:

"Before counselling, I kept everything inside. Now, when I speak, I feel lighter. At least someone listens."

Similarly, a woman participant (P22, Female, 34 years) noted:

"In the women's group, we share our problems openly. Outside, we cannot talk freely. Here, we feel safe."

These accounts suggest that psychosocial interventions function not only as therapeutic mechanisms but also as spaces for reconstructing relational belonging. Peer groups fostered collective recognition of shared suffering, reducing isolation and enhancing coping capacities. For women in particular, gender-sensitive spaces facilitated psychological safety and empowerment.

The findings demonstrate that improvements in GHQ-12 and perceived support measures are reinforced by relational validation and social reconnection. Thus, psychosocial interventions operate simultaneously at psychological and social levels, addressing both symptom reduction and social reintegration.

Thematic analysis highlighted trust-building and consistent outreach as critical to successful engagement. Given participants' histories of eviction drives, institutional neglect, and broken promises, initial scepticism toward intervention providers was common. One participant (P5, Male, 48 years) remarked:

"At first, we thought they would also disappear. Many people come, take information, and never return."

A mental health practitioner (Professional 2, Female, NGO Counsellor) reflected:

"Trust was built slowly. We had to come regularly and show that we were not here just for a survey."

This emphasis on continuity underscores that psychosocial effectiveness depends not only on intervention content but also on relational credibility and institutional consistency. Inter-organizational collaboration among NGOs and outreach workers further enhanced referral systems and continuity of care.

Taken together, the findings confirm that mental health vulnerabilities among homeless adults in Hastings are deeply embedded within structural and gendered inequalities. High psychological distress and low perceived social support reflect systemic marginalization rather than isolated pathology. At the same time, the measurable and experiential gains observed through community-based psychosocial interventions demonstrate the transformative potential of localized, relationally grounded programming.

Importantly, this case study reveals that intervention effectiveness is mediated by trust, gender-sensitive spaces, and sustained outreach. Mental health recovery in this context requires not only counselling but also the reconstruction of social bonds and recognition of gendered risk.

By situating quantitative outcomes within lived narratives, this case study contributes contextually embedded evidence for strengthening structured, gender-responsive psychosocial programmes for homeless populations in urban India. It highlights that sustainable mental health improvement must address both individual distress and the structural conditions that produce it.

Policy Recommendations and Way Forward

Grounded in the findings of this case study on psychosocial interventions and gendered mental health vulnerabilities among homeless adults in Hastings, Kolkata, the following policy recommendations aim to translate empirical insights into actionable, context-sensitive strategies. The recommendations emphasize structural vulnerability, gender responsiveness, and the importance of locally embedded service delivery models.

Strengthening Community-Based Psychosocial Services

The high prevalence of psychological distress and low perceived social support identified in this study underscores the urgent need to institutionalize structured, community-based psychosocial services within urban homelessness policy frameworks. Municipal authorities, in partnership with non-governmental organizations (NGOs), should prioritize the establishment of decentralized mental health outreach units embedded within homeless clusters and informal settlements.

Rather than relying solely on hospital-based or institutional care models, policies should promote neighbourhood-level counselling hubs, peer-support collectives, and structured psychosocial engagement spaces that are accessible to street-dwelling populations. Given the mobility, irregular routines, and lack of formal documentation among homeless individuals, services must be flexible, outreach-oriented, and documentation-light. Simplified intake processes, evening and early-morning service hours, and street-based engagement models can significantly improve access.

Furthermore, regular monitoring and evaluation mechanisms should be integrated into program design. Participatory feedback systems - where beneficiaries can share experiences and suggest improvements - should inform iterative program refinement. Structured outcome tracking using validated tools (such as GHQ-12 and MSPSS) can help assess emotional well-being and social connectedness over time, ensuring accountability and adaptive service delivery.

Enhancing Social Support Networks and Social Reintegration

This study demonstrates that low perceived social support across family, peer, and community domains significantly contributes to psychological distress. Policy interventions must therefore move beyond clinical mental health treatment to include relational and community-level strategies that rebuild social capital.

Structured peer support groups should be formally recognized and funded as core components of homeless welfare programs. These groups can foster mutual aid, collective coping, and solidarity, particularly for women who experience heightened vulnerability on the streets. Gender-specific peer spaces should be institutionalized to create psychologically safe environments for disclosure and empowerment.

Where feasible and safe, family mediation and reunification initiatives may be explored, especially in cases involving non-violent estrangement. However, such efforts must be trauma-informed and voluntary, recognizing that family reintegration is not always appropriate or desirable. Alternative social network-building strategies - such as community volunteering, skill-building workshops, and recreational engagement programs - can facilitate inclusion and rebuild trust within broader society.

Municipal social welfare departments should also consider introducing structured social mentorship programs that pair trained community volunteers with homeless individuals, fostering sustained relational support and guidance toward reintegration pathways.

Facilitating Accessible and Trauma-Informed Mental Health Care

Homeless populations face structural barriers to accessing mental health care, including stigma, lack of identification documents, financial constraints, and mistrust of institutions. Policy frameworks should therefore support mobile mental health clinics, outreach-based counselling services, and decentralized referral systems tailored specifically to street-based populations.

Integrating mental health services into existing urban homelessness outreach initiatives can reduce fragmentation and improve continuity of care. Frontline workers - including outreach staff, shelter coordinators, and peer leaders - should receive structured training in mental health literacy, crisis de-escalation, suicide prevention, and trauma-informed care. Such training enhances early identification of distress and strengthens referral pathways.

Policies should also formalize referral linkages between community-based programs and public hospitals, primary health centres, and psychiatric rehabilitation services. Establishing clear referral protocols, fast-track consultation systems, and documentation assistance services can reduce service

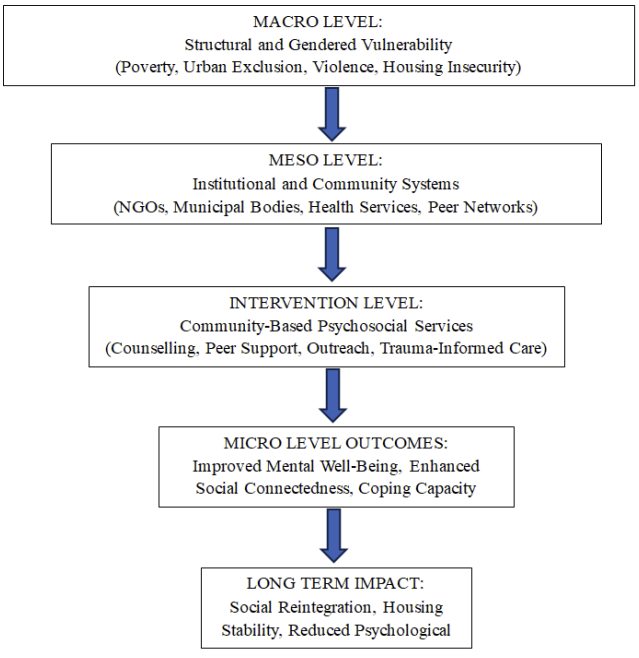

Fig 1: Multi-Layered Systems Model – Psychosocial Interventions for Homeless Adults (Case Study: Hastings, Kolkata)

gaps. Additionally, mental health insurance portability and simplified enrolment procedures under public health schemes should be strengthened to ensure financial protection.

Promoting Gender-Responsive and Safety-Centred Programming

Given the gender-differentiated vulnerabilities identified in this case study, policy must incorporate a gender lens into all homelessness and mental health interventions. Women experiencing homelessness face disproportionate risks of harassment, sexual exploitation, and stigma. Programs must therefore ensure safe physical spaces, female outreach workers, confidential counselling environments, and mechanisms for reporting abuse.

Dedicated women-only support groups, reproductive health integration, and partnerships with women's protection services should be institutionalized. Mental health programming must explicitly address trauma related to domestic violence, marital abandonment, and gender-based discrimination.

Gender-responsive budgeting within municipal homelessness policies can ensure sustained funding for these tailored interventions.

Institutionalizing Intersectoral Collaboration:

Homelessness is a multidimensional issue that intersects with housing insecurity, employment instability, mental health, and social exclusion. Effective policy requires coordinated intersectoral collaboration across departments of health, social welfare, housing, urban development, and labor.

Municipal homelessness task forces or joint coordination committees should be established to facilitate integrated planning and accountability. These bodies can coordinate resource allocation, avoid duplication of services, and ensure complementary delivery of mental health, housing assistance, vocational training, and social protection schemes.

Public-private partnerships may also be leveraged to enhance vocational rehabilitation and livelihood integration, addressing structural determinants of homelessness and mental distress simultaneously.

Expanding Housing-Linked Mental Health Interventions

Given the bidirectional relationship between homelessness and psychological distress, policy must recognize stable housing as a foundational mental health intervention. Transitional housing programs integrated with psychosocial support services can provide safer environments conducive to recovery.

Adopting a "Housing First–informed" adaptation suitable to the Indian urban context - where housing stability is prioritized alongside voluntary psychosocial engagement - may significantly enhance long-term mental health outcomes. Such programs should include case management, employment counselling, and peer support to facilitate sustainable reintegration.

Strengthening Documentation and Social Protection Access

Lack of identification documents emerged as a practical barrier to service access. Municipal authorities should initiate documentation facilitation drives to help homeless individuals obtain Aadhaar cards, voter IDs, or other necessary documents. Simplified address verification mechanisms and mobile enrolment units can support this process.

Linking homeless populations to social protection schemes - including food security programs, health insurance, and disability benefits - can reduce financial stressors that exacerbate mental distress.

Advancing Research and Evidence-Based Policy Development

This case study highlights the importance of localized, evidence-driven policymaking. Policymakers should prioritize funding for longitudinal and mixed-methods research that tracks mental health outcomes, social support trajectories, and intervention effectiveness over time.

Community-based participatory research models can further enhance contextual sensitivity and ensure that policy reflects lived realities. Scaling successful pilot interventions should be accompanied by rigorous evaluation frameworks to assess sustainability and replicability across urban settings.

The findings from Hastings, Kolkata, demonstrate that psychological distress among homeless adults is not solely an individual clinical issue but a manifestation of structural vulnerability and gendered marginalization. Effective policy must therefore move beyond episodic service provision toward integrated, community-anchored, gender-responsive systems that simultaneously address mental health, relational disconnection, housing insecurity, and social exclusion.

By embedding psychosocial services within local urban ecosystems, strengthening social support networks, enhancing access to trauma-informed care, and institutionalizing intersectoral collaboration,

policymakers can create sustainable pathways toward mental well-being and social reintegration for homeless populations in urban India.

A multi-layered systems model can be developed as follows –

Conclusion

This case study of homeless adults living in Hastings, Kolkata offers an in-depth understanding of how psychological distress and social isolation intersect within the lived realities of urban homelessness. The findings reveal a strikingly high prevalence of mental distress, with nearly seventy percent of participants experiencing significant psychological challenges. At the same time, perceived social support from family, friends, and the wider community was consistently low. Taken together, these patterns illuminate a dual and mutually reinforcing burden: mental health vulnerabilities are intensified by social isolation, while weak relational networks limit coping capacities and pathways out of homelessness. In the context of Hastings, where insecurity, economic precarity, and marginalization are part of daily life, distress is not episodic but structurally embedded in everyday survival.

Beyond documenting vulnerability, the study also foregrounds resilience and the transformative potential of structured psychosocial engagement. Participants who engaged in counselling, peer support groups, and referral services reported noticeable improvements in emotional regulation, coping confidence, and social connectedness. The qualitative narratives deepen this understanding, revealing that meaningful change was not merely a product of service provision but of relational processes - trust-building, empathetic listening, and sustained outreach in a context marked by instability and mistrust. Collaboration between NGOs and mental health professionals emerged as a critical enabling factor, ensuring that care was not fragmented but responsive to complex and overlapping needs. These insights reinforce the importance of interventions that are community-based, culturally attuned, and flexible enough to adapt to the rhythms of street-based life.

As a case study rooted in a specific urban locality, this research highlights how homelessness must be understood not simply as the absence of shelter but as a multidimensional condition shaped by psychological strain, relational disconnection, and structural exclusion. The evidence suggests that interventions are most effective when they address these dimensions simultaneously - strengthening mental health support while rebuilding social networks and fostering inclusion.

From a broader policy and practice perspective, the study underscores the need for integrated, evidence-based strategies that bridge mental health services with social support systems. Holistic programs that prioritize accessibility, continuity of care, and stakeholder collaboration can move beyond crisis management toward sustained rehabilitation. Ultimately, addressing homelessness in urban India requires more than temporary relief; it demands comprehensive, community-anchored responses that promote dignity, resilience, and long-term social reintegration. By offering empirical insights from Hastings, Kolkata, this study contributes to the design of sustainable psychosocial frameworks capable of improving well-being and advancing social inclusion among some of the city's most vulnerable residents.

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