सत्यमेव जयते

The Gazette of Meghalaya

PUBLISHED BY AUTHORITY

No. 3 **Shillong, Thursday, January 19, 2023** **29th Pausa, 1944 (S. E.)**

Separate paging is given on this part in order that it may be filed as a separate compilation.

PART-IIA

GOVERNMENT OF MEGHALAYA

NOTIFICATIONS

The 4th January, 2023.

No.Health.180/2017/312. - The Governor of Meghalaya is pleased to notify The Meghalaya Mental Health and Social Care Policy-Promoting equitable mental health and social care through collaborative engagement with all concerning Departments/Agencies and communities. The Policy will come into effect from the date of publication and is hereby published for general information.

SAMPATH KUMAR,
Principal Secretary to the Govt. of Meghalaya,
Health & Family Welfare Department.

Executive Summary

Meghalaya is a state unique in its socio-cultural fabric, connection to nature, affiliation to collectivist practices, and the essential values of loyalty (to one's tribe and the state) and preservation of traditional, ancestral rituals. However, the state also has complex and deep-rooted development challenges that manifest in a high prevalence of substance use, high rates of non-communicable diseases, and low health-seeking behaviours, all of which contribute to broader health concerns and reduce life expectancy. According to the Health of the Nation's States report, **depressive and anxiety disorders** feature in the top 15 causes of YLDs (years of healthy life lost due to disability) in Meghalaya. Meghalaya reported **226 deaths by suicide in 2021**, *i.e.* nearly six for every 10,000 people (National Crime Records Bureau, 2022). There has also been a significant rise in **substance use** in Meghalaya over the last decade, which has reached three times the national average due to the increased availability of substances. In light of this, the state has seen the need to develop a policy and strategy to improve mental health and well-being, as well as the social supports that enable full human flourishing.

The Meghalaya Mental Health and Social Care Policy aims to promote overall mental health and well-being and facilitate appropriate access and care pathways for every member of society. It aims to reduce the extent of disability, morbidity, mortality, and social suffering. It seeks to do this by addressing the social determinants of mental ill-health and ensuring cultural security and collaborative engagement with communities in promoting equitable mental health and social care for all. The policy has been steered by a certain set of **values** including, **equity**, **justice**, **fairness and respect**, **empathy, responsiveness,** and **respect for individual autonomy.**

Mental Health Policy Framework:

The vision and values highlighted call for a holistic and people-centred approach to mental health care. This requires a substantial reorientation of the system to better identify mental health issues and provide sensitive care.

Mental Health Policy Framework **Dimensions**	
1. Sensitive Public Health Care Approach	3. Care Pathways
2. Community Awareness & Engagement	4. Support for Vulnerable Groups

1. Sensitive Public Health Care Approach

There are numerous challenges associated with mental health including cultural alienation faced by individuals & communities along with the limited focus placed on well-being and management of stress. Several strategies are proposed to overcome these challenges.

- **Pursue a capabilities and person-centred approach** geared to help those using mental health services to attain states of health and well-being, regardless of the extent of disability. The 'healthiest' communities are those which have retained their language, culture, and rituals centred on their collective identity, as **culturally sensitive care** lead to lower rates of addiction and suicide (Linklater, 2014).
- It is imperative to develop a new **collaborative approach** including training indigenous community health workers (CHWs) for cultural biomedical knowledge thereby enhancing well-being within cultural institutions and with traditional healers.
- **The community will be engaged** to legitimise and develop positive and empathic attitudes that will cultivate enabling environments conducive to healing.
- Establish pathways that **address social determinants of mental health, especially for vulnerable groups** through participatory and locally embedded community mobilisers.

2. Community Awareness & Engagement

- **Culturally-adapted IEC campaigns to destigmatize mental health**: Integration of culturally-relevant IEC as part of basic mental health literacy campaigns to increase awareness of the impacts of mental health on well-being and physical health, and to destigmatize mental health.
- **Build capacity of subcenters and VHCs as platforms for information dissemination, sensitization and peer support systems:** This involves linking communities to service points through the existing 460 Sub-centers and more than 6500 + Village Health Councils (VHCs). These platforms may be used to sensitise communities and play a key role in facilitating social entitlements to focus on community inclusion. These platforms can also serve as a means for leveraging community practices and local traditions to develop culturally congruent public mental health systems.

3. Care Pathways

- **Initiation of a Helpline, First Responders' Team, Crisis Teams and Psychological First Aid:** A helpline and/or other tech-enabled interventions may help support distressed persons and care providers. By matching the need with the service at the first point of contact, first responders and crisis support teams may then respond depending on the kind of support needed.
- **Screening of all individuals by trained personnel:** The presence of local trained personnel who are meticulous, empathic and thorough with assessment plans and identification pathways in primary settings is integral to effective public mental health. Not only will this reduce the burden of disease and disability, but it will also help address the strain on caregivers, reduce overall social suffering and improve well-being.
- **Triaging, referral systems, and contact with services:** The links between community health workers, first responders, and clinicians will be strengthened, with an emphasis on early screening and detection.

- **Inpatient care - the importance of social architecture:** To provide supportive inpatient care, the policy will strengthen provision of private or shared spaces based on patients' needs, the use of collaborative care planning, cultivating a climate of safety, restorative care and trust, and various therapeutic and counselling approaches (e.g., CBT, narrative therapy, compassion-focused therapy, Open Dialogue, etc.).
- **Post-discharge self-management using Assertive Community Care (ACT):** Most people are likely to experience a recurrence of a psychotic episode or ill-health and options such as Assertive Community Care (ACT) or Meghalaya ACT (M-ACT), which combine aspects of ACT adapted to the needs of the relevant population, have been shown to reduce repeated hospitalisations, increase housing stability and improve participation in the labour force. Such measures will be expanded and strengthened.
- **Long-term inclusive care options:** For persons with high support needs with moderate to severe psycho-social disability long-term care facilities in the community may be provided that are also sensitive to independence, choice and agency, such as half-way homes and supported housing options.
- **Disasters and exceptional circumstances:** Training in psychological first aid will be used to strengthen the state's response in special circumstances involving public health implications and by extension, mental health consequences, including pandemics such as Covid-19.

4. Support for Vulnerable Groups

Focus on supporting and providing access to vulnerable groups**,** including women, youth, GBTQIA+ community, elderly, persons with substance addiction, persons living below the poverty line, and caregivers working with persons with mental illness.

- **Women:** The policy aims to **improve Maternal Mental Health** and treatment for postpartum depression by leveraging community health workers and women's collective to offer support and guidance. Expand **economic empowerment** by providing opportunities for women to boost women's self esteem for Mental Well-Being.
- **Political empowerment for action** can enable women to draw attention and take action on mental health challenges faced by women. The reservation policy for women in village employment councils (VEC) needs to be complemented with initiatives to build agency and leadership among women.
- **Positive children, adolescent & youth development:** An effective mental healthcare system needs a continuum of care that starts at early childhood and provides age-appropriate care and support through adolescence and youth.
    - **Effective Early Childhood Care** through the Integrated Child Development Scheme (ICDS), Anganwadis and the ECD Mission to ensure that young children have access to socio-emotional care, protection and opportunities for early learning.
    - CHC staff will be equipped to provide first-level **support for children** at schools & facilities.
    - Engage and **support adolescents & youth** on the central importance of life skills in intimate relationships, sexual decision-making, and substance use.
- Professionals across all health care institutions will be trained in appropriate mental health care provision for **elderly care**, **support for persons with intellectual disabilities, support for LGBTQIA+ community, migrants,** and **support for persons with substance-use concerns.**

Implementation Strategy

To effectively execute the policy framework described above, there is need for a particular focus on implementation, and attention to potential barriers to achievement of the Mental Health Policy goals. This policy identifies five enabling dimensions that can help ensure successful implementation. As a first step, the state

must work to strengthen **Human Resources**, both through building the capabilities of existing government officials, medical staff and community members, and through recruitment for new roles. Specifically, the policy envisions:

- Building up human resources in 3 core professional arenas: psychiatry, nursing, social work and psychology; Managing demand through better staff-client ratios;
- Aligning service delivery standards and standard treatment guidelines;
- Aligning the curriculum and professional training with the development of ecological perspectives and skills to engage in social understanding of mental distress and associated interventions to address structural barriers that affect mental health.

Beyond human resources, the implementation approach will also aim to strengthen the medical **Infrastructure** for addressing mental health needs through extending the provision of medication and equipment to more local areas, prioritising high-use PHCs/CHCs and Sub-Centres. In addition, the policy will address important access barriers through provision of **Financial Support**, by increasing take-up of MHIS and strengthening community support systems.

For all of the above measures to succeed, the state will focus on strengthening state capability to address the complex challenge of mental health. A key element of this will be ensuring **Inter Department Collaboration & Policy Convergence**. The state will address this by:

- Aligning all departments through the Meghalaya Human Development Council
- Integrating Public Mental Health (PMH) within the Comprehensive Primary Health Care (CPHC) approach of the state.
- Establishment of a *Policy Implementation Unit within the State Mental Health Authority.* In keeping with the mandate of the Mental Healthcare Act, 2017 (MHCA) and the NMHP mandating mental healthcare as a basic right, the State Mental Health Authority (SMHA), will ensure the integration of all mental healthcare services. A policy implementation unit can be created under the SMHA that will oversee and develop an implementation plan to ensure the advancement of the policy.
- Establishment of District Convergence and Implementation Committee to implement mental health policy will be anchored by the DC along with Health (DMHP), Social Welfare (ICPS, ICDS) and Education Dept Officials.

While the state aims to improve coordination and convergence across all relevant departments, attention will also be paid to mobilising and empowering **Community Institutions**. Community engagement is an integral part of Meghalaya's mental health policy and approach, as it is the bedrock for prevention, early detection & long term social support.

- *Village Health Councils* will serve as the nodal community agency for disseminating information, reducing stigma and providing local social support to those with mental illness and their families.
- *Village Headmen* are often the first point of contact for distressed families and will be proactively engaged in early identification, as well as in assisting families in addressing social and economic factors behind illness

Other *trusted community leaders,* such as *teachers, religious leaders & traditional healers,* will be engaged through community health workers & VHCs, to assist in reducing stigma, raising awareness of the importance of mental health, and early detection of mental health disorders and illness.

Key Outcomes

Through the Mental Health and Social Care Policy the state will bring focused energy to implementation of the following key inputs, to achieve the essential outcomes and impacts for transformational change of the mental health landscape.

Inputs	Outcomes	Impact
→ Increase in mental health human resources such as psychiatrists, psychologists and nurses → All medical officers and community health workers trained on assessing and addressing mental health issues → Streamlining of referral process → Co-ordination across departments & policies under Human Development Council → Expansion of mental health helpline → Creation of support groups under VHCs, guided by community health workers	→ Monthly IEC campaigns in all communities on mental health issues → Annual school and community-based screening for mental health for every citizen → Faster & cheaper referral process, with reduced out of pocket expenditure → Increased access of schemes & programs by the mentally ill → Increased number of initiatives targeted at preventive measures such as addressing stress among vulnerable groups → Community support groups meeting for regular discussion & activities	→ Higher rates of identification of mental health disorders → Reduced wait times and costs for treatment → Lower percentage of suicidal thoughts reported by adolescents → High rates of care seeking among population → Lower prevalence of substance use → Lower rates of mental health disorders due to preventive programs → Reduced stigma and greater social integration for those suffering from mental illness

Abbreviations and Acronyms

ACT - Assertive Community Treatment
ADHD - Attention-Deficit/Hyperactivity Disorder
ANM - Auxiliary Nurse Midwifery
ASHA - Accredited Social Health Activist
AYUSH - Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
CBO - Community-Based Organisation
CBR - Community-Based Rehabilitation
CBT - Cognitive Behaviour Therapy
CBT (P) - Cognitive Behaviour Therapy for Psychosis
CHC - Community Health Centre
CMD - Common Mental Disorder
CMNND - Communicable Malnutrition Maternal Newborn Disease
C-PTSD - Complex Post-Traumatic Stress Disorder
CSA- Child Sexual Abuse
CSO - Civil Society Organisation
DALYs - Disability-Adjusted Life Years
DBT - Dialectical Behaviour Therapy
DMHP - District Mental Health Programme
GAD - Generalised Anxiety Disorder
GBG - Good Behaviour Game
GDP - Gross Domestic Product
GP - General Practitioner
IPD - Inpatient Department
IPV - Intimate Partner Violence
LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual
LTC - Long-Term Care
MDD - Major Depressive Disorder
MHC - Mental Health Commission
MHRB - Mental Health Review Board
MIMHANS - Meghalaya Institute of Mental Health and Neuroscience
MOTHER - Measurable Outcomes in Transforming Health sector through a holistic approach with focus on women's Empowerment - Meghalaya State Health Policy
NGO - Non-government organisation
NMHP - National Mental Health Policy
NMHS - National Mental Health Survey
OPD - Outpatient Department
PDS - Public Distribution System
PHC - Primary Health Centre
PND - Postnatal Depression
PPD - Postpartum Depression
POCSO - Protection of Child from Sexual Offences
PTSD - Post-Traumatic Stress Disorder
PWLE - Persons with Lived Experience
PwMI - Persons with Mental Illness
RKSK - Rashtriya Kishor Swasthya Karyakram
SAMVAD - Support, Advocacy & Mental health interventions for children in Vulnerable circumstances and Distress
SDG - Sustainable Development Goal
SHG - Self Help Group
SMD - Severe Mental Disorder
SMHA - State Mental Health Authority
SUD - Substance Use Disorder
UNCRPD - United Nations Convention on the Rights of Persons with Disabilities
UDHR - Universal Declaration of Human Rights
WHO - World Health Organization
YLDs - Years of healthy life lost due to disability

Section 1. Vision, Values, Statement of Intent & Compliance with Norms

1.1 Vision

The Meghalaya Mental Health Policy aims to promote overall mental health and well-being and facilitate appropriate access and care pathways for common and severe mental health concerns. It aims to reduce the extent of disability, morbidity, mortality, and social suffering. It seeks to do this by addressing the social determinants of mental ill-health and ensure cultural security and collaborative engagement with the communities it intends to serve in promoting equitable mental health and social care for all. Its values are those of social justice, life satisfaction, personal recovery and community inclusion and participation.

1.2 Values

1.2.1 ***Equity***

Health equity works towards ensuring that all persons may achieve their fullest potential by adequately addressing the social and biological determinants that affect ill-health, regardless of class, marginality or status.

1.2.2 ***Justice***

Frameworks of justice are designed to ensure that exclusion based on historical segregation or bias is addressed and that access to public goods and rights and a dignified life is denied to none, and enabled for all, irrespective of privilege or status. This addresses historical injustices, especially in the context of vulnerable communities, so that healing processes also address intergenerational trauma. Concepts of social justice in mental health also regard intersectionality framings as central to care and recovery.

1.2.3 ***Fairness and respect***

As an extension of social justice frameworks and in line with the Universal Declaration of Human Rights (UDHR), equal standards of care should be made accessible to all. The UDHR has helped establish a moral grounding for improved standards of care based on our mutual responsibilities as equal members of 'humanity'.

1.2.4 ***Empathy***

Cognitive empathy and radical empathy concern the ability to distinguish between one's own and others' feelings, emotions and perspectives, resulting in nurturing a greater sense of trust, compassion and interpersonal connectedness. Within health systems, the use of empathy as a value and framework leads to the service users' (or patients') greater engagement and the ability to cultivate an environment that stimulates pro-social behaviour. It is relatively easy to empathise with those who share our values, belief systems, and moral compass (Riess, 2017). When there is fundamental disagreement, or prolonged periods of caregiving, especially for people experiencing chronic conditions of ill-health, this may lead to compassion fatigue and apathy or indifference. Radical empathy and cognitive empathy (intellectually encouraging people to actively consider another person's point of view) can be fostered among health providers to encourage safe conversations, support patients to remain engaged in care, use creative methods to address concerns collaboratively, while also ensuring their own emotional health. This is particularly useful in serving marginalised communities.

1.2.5 Responsiveness

WHO defines responsiveness as meeting people's non-medical expectations when they interact with a health system, including how and in what environment they are treated by health workers. Many governments recognise that appropriate health services depend on being able to respond to public expectations and sustain public confidence. Quality of care, appropriate provision, dignity, autonomy and confidentiality make for a responsive mental health system (Roberts et al., 2008).

1.2.5 Respect for individual autonomy

The rights of those who have recourse to mental health services are at the centre of their process of recovery. Loss of agency and self-determination may negatively influence the outcomes. Therefore, providing treatment without an adult patient's explicit consent (or that of parents or guardians in the case of minors) should occur only in exceptional circumstances to prevent irreversible harm, death, exacerbating ill-health and unbearable suffering, and help promote well-being in the longer term. For this reason, it is essential to provide calm environments and treatment, or healing centres that are unrestrictive and staffed by engaged and responsive care teams.

1.3 Statement of Intent

Well-being is a basic and essential right for all citizens and the state will therefore seek to promote a sense of life satisfaction and flourishing and encourage hope, all of which have a positive and mutually reinforcing impact on mental health.

1.3.1 Need for a Transdisciplinary Approach

Alongside biological factors, social determinants such as scarcity, poverty, intimate partner violence (IPV), domestic violence, adverse life events, malnutrition, childhood distress and disorders, limited or inadequate access to decent standards of living, trauma, unresolved conflict, grief, loneliness and social isolation, pressures of acculturation (in the tribal context) and unique cultural belief systems may influence mental health. We therefore adopt a transdisciplinary approach in drawing from the wisdom of multi-sectoral entities and actors to develop a comprehensive, dynamic and adaptive mental health system that attempts to address the many dimensions of well-being and ill health. The Government of Meghalaya aims to ensure that all sectors cooperate to alleviate distress, improve mental health and well-being and reduce disability arising from common and severe mental disorders across the lifespan of each person living in the state.

1.3.2 People-Centred Care

Cultural specificity, diversity and a wide range of needs have been taken into consideration in framing our guidance for action, validating people's subjective notions of well-being and their historical traditions and rituals and integrating these into healing systems. We need to facilitate early and appropriate access to locally based care and person-centred approaches that support those who need mental health services to pursue personal recovery goals and remain engaged with the service (Campion, 2018).

1.3.3 Acting Early

A related aim is to achieve information symmetry as part of health-promotion activities to foster better help-seeking behaviour. The emphasis on early access to mental health and social care in the case of common and severe mental disorders seeks to pre-empt any rise in their prevalence, a decline in the incidence of disability, and promote effective community inclusion.

1.3.4 Supporting Vulnerable Groups

An equally important consideration is the focus on responding to the particular needs of vulnerable groups such as women in distress, children with experiences of adverse life events, persons experiencing multidimensional poverty or homelessness or those exposed to oppressive practices and enduring stress that may exacerbate mental ill-health. The state's unique demographic, cultural, and geographical context are situated at the heart of this guidance, which therefore combines a wide imagination and pragmatic approaches in a policy that is both aspirational and people centred.

1.3.5 Capabilities-based approach

Transformative changes in mental health may be attained if the ability to pursue freedoms that enhance 'functionings and capabilities', as defined by Martha Nussbaum, in a context that expands opportunities for all service users. This may be through appropriate social programmes and architecture in the design of mental health systems, alongside help with housing and livelihoods or expanding their support network, or other means to foster capabilities and nurture well-being.

1.3.6 Cultural and geographical specificity:

Tribal peoples constitute 86% of the population in Meghalaya, and have their own unique customs, rituals and practices (Chandramouli, C., & General, R., 2011). It is essential to adopt seamless approaches to care that integrate biomedical-codified structures with traditional practices. Cultural dissonance may result in deleterious effects; collaborative care planning is therefore essential at individual and community levels. At the same time, a high degree of participation and community engagement in promoting collective health may also affect perceptions, attitudes and help-seeking behaviour in a wider sense.

1.3.7 Participation and community inclusion

Linked to capabilities (principle 40) are the goals of participation and community inclusion that allow for valued social roles and identities to be pursued. Socio-cultural and political participation are associated with rights that persons living with mental illnesses (PLWMI) should be able to enjoy. Barriers - cultural, political or social - must be resolutely addressed to encourage social mixing, which may help reduce the social distance between communities and individuals.

1.3.8 Peer-led participatory movements and action

Restorative Justice, co-creation of knowledge and collective liberation: To foster change based on social justice, the development sector has begun to adopt the concept of proximal leadership. Simply put, this enables individuals and communities with first-hand experience of inequality and oppression to take theleadinguiding principles forchangeand participate in its implementation. Proximal leaders facilitate agency and autonomy, focus on individual strengths and assets in a non-judgemental manner, and create opportunities for sharing and access to support networks and safety nets. This function also includes grassroots organisations that have the data, knowledge and meaningful relationships with their community to develop measurable and sustainable programmes. A combination of the two, with grassroots organisations also acting as intermediaries as appropriate, can use a community's strengths and assets to bring about change.

1.4 Alignment with National & Global Norms

The Policy complies with rights-based inclusive frameworks such as the **Convention on the Rights of Persons with Disabilities (UNCRPD)**, which highlights the fundamental human rights and freedoms to which persons with disabilities are entitled in areas such as health, education, access to justice and independent

living (United Nations Department of Economic and Social Affairs, 2006). The Policy is also aware of the obligation to pursue the **Sustainable Development Goals (SDGs)** to ensure equitable standards of living for all, resulting in well-being for all. In alignment with the SDGs, this Policy makes its recommendations in the belief that every action to further health and well-being will result in a reduction of poverty, improvement in overall health indicators, greater gender parity, better linkages between physical and mental health, improvement in access to community living, and the reduction of inequalities, intergenerational distress, among others.

The **social justice framework** of mental health is a key motivator and reference point in the conceptualisation of the Policy. While it is essential to ensure early identification pathways and address morbidity, disability and mortality, it is equally important to address the structural and systemic barriers that exacerbate distress and permit negative life events and power relations that perpetuate personal suffering and prevent people from developing their own life, thus continuing insidious and historical forms of discrimination and a vicious cycle of hopelessness, intergenerational precarity, poor health and sub-optimal living standards and therefore ontological insecurity. The Policy therefore views recovery not as a destination, but as a personal, social and political journey, dependent on many factors that frame perspectives and individual goals; this is the basis for developing care plans and addressing individual mental health concerns.

The Policy is aligned with approaches to **neurodiversity** that are based on differences rather than deficits. The proposed framework of personal recovery and capabilities acknowledges that 'recovery' is influenced by the ecosystem and therefore is a dynamic state of being and 'becoming' (Morrow & Weisser, 2012). Finally, effective health and social care systems are central to enabling states of well-being espoused in justice and value-based frameworks that promote integrated and person-centred care. In this respect, the Policy is guided by the **World Health Organization's (WHO) Global Strategy** on integrated people-centred health services, which outlines the critical importance of intersectoral coordination, good governance and the role of the community in creating enabling environments (Service Organizations and Integration, n.d.; World Health Organization, 2021).

The Policy is also shaped by the **National Mental Health Policy (Ministry of Health and Family Welfare, 2014)**, which recommends the integration of care within public mental health and health systems, with a focus on community living, special attention to vulnerable groups, and coordination and convergence between health and social sectors to appropriately address the social determinants that affect mental ill-health; and adequate training of the necessary personnel to provide comprehensive care and build robust mental health and social care systems (Ministry of Health and Family Welfare, 2014). Access to mental health is a basic right as outlined in the NMHP and is therefore reflected in the Meghalaya State Mental Health Policy.

The World Mental Health Report: Transforming Mental Health for All (WHO, 2022) suggests three crucial paths to transformation - strengthen mental health care, reshape environments and deepen value and commitment. The recommendations outlined in this policy may be effectively understood through the lens of this approach, as categorised below.

Strengthen Mental Healthcare	Reshape Environments	Deepen Value and Commitment
• Focus on flourishing and well-being. • Promote sub-centres as nodal points of mental health promotion. • Promote community education to aid in early identification of stress, distress, address social	• Build accessible dissemination platforms for health information (through folklore, street theatre, role plays etc). • Work closely with village headmen and village councils, to use culturally resonant and enabling rituals to manage stress, prevent escalation to	• Commitment to values of social justice and capabilities-based approaches, recognition of public mental health as a basic right. • Recognition that the onus of 'recovery' lies equally with the community, due to social precipitators and structures

determinants and identify CMDs and SMDs. • Initiate a helpline and first responders team - to address distress and social crises. • Use contextualised mental health triage approaches outlining roles from the sub-centre level to tertiary hospitals, integrated with village health councils. • Strengthen therapeutic offerings at in-patient settings. • Develop continuity of care protocols, promote self - management post discharge, using Assertive Community Care (ACCT- an adaptation of ACT) and treatment options with accessible and integrated follow up options. • Offer long-term inclusive care options, including - halfway homes, Home Again, Housing First etc. • Build Human Potential, focus on task shifting - train non-specialists to offer promotion, prevention and rehabilitation-focused interventions. • Build multidisciplinary teams including - psychiatrists, social workers, psychologists, nurse-practitioners, tribal leaders and social prescribers - in association with village councils, tribal leaders, ASHA workers and peer advocates; Upgrade service facilities such as MIMHANS and Tura Civil Hospital to teaching and research institutions in collaboration with local and global institutions of eminence.	CMDs and SMDs, and spur hope and resilience. • Promote peer-led knowledge-creation programmes. • Promote self-help groups (SHGs), safe spaces, support groups and distress helplines. • Use models such as Good Behaviour Game (GBG) for children, Experience Corps-based programmes for elderly. • Facilitate employment, basic income-type interventions and other social security schemes through multi-sectoral convergence to address social determinants of mental health.	also being embedded in the community. • Commitment to the National Mental Health Policy (2014) and the Mental Healthcare Act (2017) including protocols on admissions to hospitals, and roles of the Mental Health Review Board. • Adopt reflexive monitoring & evaluation, and transdisciplinary research frameworks - in view of the policy being a living document, build adaptive systems based on user feedback loops. • Set up a local sub-group - a Mental Health Commission to build an implementation plan in line with recommendations of the policy, based on socio-cultural formulations of mental health and ill health, and contextualise programmes to the culture of different tribes. • Ensure adequate budget allocations to achieve the outlined priorities.

Table 1: Highlights of the strategic priorities detailed in the policy, categorised based on the ‘paths to transformation’ framework (WHO, 2022).

1.4.1 Compliance with the Mental Health Care Act (MHCA):

The MHCA recognises that the determination of mental illness and authorisation of admissions in mental health establishments is a clinical decision (The Mental Healthcare Act, 2017, n.d.). This means that a person may be admitted to a mental health facility only if this is authorised by the designated mental health professional (MHP) or the medical officer (MO), and that judicial magistrates no longer have any powers in respect of admissions and discharge.

There are two ways in which a person with mental illness may be admitted - independent admission and supported admission.

1. Independent admission is when a person voluntarily requests to be admitted to the mental health establishment for treatment. The MHP/MO reviews the request based on the legal criteria and decides whether admission is appropriate. In this kind of admission, the patient can ask to be discharged at any time and must be informed of this right at the time of their admission.

2. A supported admission is when the NR requests admission of the person with mental illness (the patient's consent is not required).

Supported admissions are authorised in exceptional circumstances when the individual lacks the capacity to make treatment decisions and/or requires very high support and any one of the following situations are met:

1. recently threatened/attempted or is threatening/attempting to commit self-harm.
2. has behaved/is behaving in an aggressive manner towards another person or causing them to fear bodily harm.
3. they are at risk to their own well-being as they are unable to take care of themselves.

MHPs are required to independently examine the individual based on the criteria in the Act for supported admission and certify whether the person should be admitted. Supported admission is initially for up to 30 days, but can be extended to 90 days, 120 days and eventually 180 days by repeating the admission process at each stage. The patient's capacity has to be assessed frequently, at least on a weekly basis. On regaining capacity, the patient can seek to be discharged or continue admission as an independent patient. When the police bring a homeless person with mental illness to a mental health establishment, the same criteria for admission and assessment apply. Under the MHCA, the mental health establishments can refuse admission if the criteria are not met, although they are obliged to protect the rights of persons with mental illness and thus provide appropriate health care and treatment.

In keeping with these mandates of the MHCA and the NMHP mandating mental healthcare as a basic right, the State Mental Health Authority (SMHA) will ensure integration of community mental healthcare services (aimed at improving quality of life and community inclusion), and services delivered through multiple points, ranging from sub-centres and CHCs to tertiary hospitals (as elaborated in the section on health and social care systems), and ensure human resource availability with an informed and pragmatic approach.

All homeless and wandering persons with mental illness have the same rights as others mentioned in the MHCA, which include: (i) right to equality and non-discrimination; (ii) right to medical insurance; (iii) right to community living; (iv) right to protection from cruel, inhuman and degrading treatment; (v) right to information; (vi) right to confidentiality; (vii) right to access medical records; (viii) right to personal contacts and communication; (ix) right to legal aid; and (x) right to make complaints about deficiencies in services.

The State Mental Health Authority (SMHA) will also protect the rights of persons with mental illness and ensure proper implementation of the MHCA. If any person's rights have been violated or they wish to challenge any decision of the mental health establishment or law-enforcement official, a complaint can be submitted to the Mental Health Review Board (MHRB) for redressal of their grievances. The MHRB will conduct a review and after hearing both authorities will pass a binding order (Tamil Nadu Mental Health Care Policy & Implementation Framework, 2019). The MHRB is also authorised to register advance directives and appoint/revoke/modify a nominated representative.

Section 2. Mental Health Issues in Meghalaya

2.1 Meghalaya: A Socio-demographic Overview

Covering an area of 22,429 km2 and divided into 12 districts, Meghalaya has a population of 29,66,889 (Chandramouli, C., & General, R., 2011), of whom 79.9% live in rural areas, and the remaining 20.1% constitute the urban population. In 2011, the adult literacy rate was 74.4%, with male and female rates of 76% and 73%, respectively. The state is predominantly mountainous, with plains and flood-prone areas in the foothills. It is bounded by the Brahmaputra valley of Assam in the north and northwest, the Cachar area of Assam in the east, and the Surma valley (Bangladesh) in the south and partly in the southwest. Meghalaya shares a 443 km border with Bangladesh.

The population is predominantly tribal, the main tribes being the Khasi, the Jaintia and the Garo, as well as the Koch, Rabha and Bodo. The Garo, Khasi and Jaintia have a matrilineal system, whereby property rights are passed on to the youngest daughter of the family. This also extends to a matrilocal system, wherein the youngest daughter's spouse, children and parents all reside at the home inherited by her. Each tribe has its own language, but many also speak English. According to the 2011 census, around 75% of the population is Christian, and Hindus are the largest minority. Meghalaya is mainly an agrarian economy with about 80% of the population depending entirely on agriculture (Meghalaya State Legal Services Authority, 2015). Meghalaya is also an important centre for trading with Bangladesh.

2.2 Situational Analysis: Methodology

A situational analysis was conducted as a background to developing this policy. This was based on key informant interviews and focus group discussions (FGDs) with key stakeholders including service users, caregivers and service providers across primary, secondary and tertiary facilities (CHCs, civil hospitals, psychiatric hospitals, DMHP teams and grassroot workers), village headmen, religious leaders, traditional healers, representatives of non-government organisations (NGOs), members of educational institutions, and various government departments, as well as consultations with members of different tribes, in combination with secondary data (reviews of academic literature and government reports).

2.3 Mental Health: National and Local Context

The National Mental Health Survey (Murthy, 2017) conducted by the National Institute of Mental Health and Neurosciences, India, indicates that around 150 million Indians require active mental health interventions. The overall prevalence of mental illness was estimated to be 10.6% among adults and 7.3% among adolescents. Common mental disorders (CMDs), including depression, anxiety disorders and substance-use disorders were found to affect nearly 10% of the population, and severe mental disorders (SMDs) around 0.8%. The survey indicated that the prevalence rates for most of the disorders peaked in the 40-49 age group, and evidence suggests that another peak may occur after the age of 60, particularly linked to depressive disorders. This may either be a recurrence of an earlier episode or a first episode (Lodha & De Sousa, 2018).

The survey also found that 83% of the population has no access to mental health services. Specifically, the treatment gap was found to be 85% for CMDs, 73.6% for SMDs, and nearly 90% for substance-use disorders. This was owing to range of factors, including a low perceived need to access services because of limited awareness of their existence; socio-cultural beliefs, values and stigma; insufficient, inequitably distributed, and inefficiently used resources; high out-of-pocket expenses; and the poor quality of care associated with mental health services. It was observed that many people with mental health concerns usually opt first for other sources of treatment such as faith healing before having recourse to hospital care.

For Meghalaya, Roy (2021) mapped the prevalence of each type of disability based on the 2011 Census. In general, the data across all districts indicated that some north-eastern states like Nagaland, Manipur and

Meghalaya have the least prevalence, but specifically with regard to mental illness, the highest disability prevalence was recorded in the western parts of Gujarat and Kerala, followed by Meghalaya and Mizoram. The Global Burden of Disease Study 1990-2017 also offers some insight into the estimated prevalence of mental disorders in Meghalaya, from 1990 to 2017 (Sagar et al., 2020).

Disorders	**Prevalence of mental disorders** *(per 100,000; 95% uncertainty interval)*
Idiopathic developmental intellectual disability	**4,755** (3,170-6,331)
Depressive disorders	**3,340** (3,089-3,649)
Anxiety disorders	**3,117** (2,846-3,439)
Conduct disorders	**961** (754-1,202)
Bipolar disorders	**527** (447-624)
Attention-deficit/hyperactivity disorders (ADHD)	**441** (361-534)
Autism spectrum disorders	**354** (315-396)
Schizophrenia	**220** (191-254)
Eating disorders	**171** (135-215)
Other mental disorders (personality disorders)	**1,544** (1,316-1,760)

Table 2: Prevalence of mental disorders in the state of Meghalaya, estimated by the Global Burden of Disease Study 1990-2017.

The highest prevalence in the country for the conduct disorder was observed in Jharkhand, Bihar, and Uttar Pradesh, and in the north-eastern states of Meghalaya, Nagaland, and Arunachal Pradesh. The highest prevalence of ADHD was in Maharashtra, Meghalaya, Arunachal Pradesh, and Bihar. As such, Meghalaya has been identified as one of the states with high prevalence of such disorders. According to the Health of the Nation's States report, depressive and anxiety disorders feature in the top 15 causes of YLDs (years of healthy life lost due to disability) in Meghalaya (in 6th and 9th positions respectively) (Hay et al., 2017). Meghalaya reported 226 deaths by suicide in 2021, i.e., nearly six for every 10,000 people (National Crime Records Bureau, 2022), of which 172 were male and 54 were female. The most common reasons for suicide were marriage-related issues, family problems and illness.

The literature also suggests a high prevalence of concerns related to substance use. The National Survey of Substance Use conducted in 2019 by the Ministry of Social Justice and Empowerment and the National Drug De Addiction Centre, AIIMS, Delhi reported that 6.34% of the population of Meghalaya uses opiates and that 2% needs urgent help about it (Ambekar et al., 2019). These numbers are three times the national average. Overall, the reviews of current statistics reveal that Meghalaya has a high prevalence of mental disorders and related issues such as substance abuse.

2.4 Findings from Field Reports

Frequently reported concerns at outpatient clinics (PHCs, CHCs and district hospitals) include major depressive disorders (MDD), generalised anxiety disorder (GAD), bipolar affective disorder, seizure disorder, schizophrenia and substance-use disorder. Most hospitalised patients are diagnosed with schizophrenia (and

psychoses), bipolar affective disorder and substance-use disorder, often with comorbid conditions. Among children, commonly reported concerns include intellectual disability, seizure disorder, ADHD, autism, conduct disorder and specific learning difficulties. Less commonly reported are tic disorders, selective mutism and, rarely, psychosis. Across age groups, a common observation is the prevalence of somatisation, meaning that mental distress is experienced and reported in terms of physical concerns.

Disorders	**Number of reported cases (2021-2022)**
Depression	1,684
Anxiety disorders (GAD, panic disorder, phobias etc)	1,315
Bipolar Affective Disorder	1,151
Schizophrenia	2,822
Psychosis - Others (delusional disorder, psychosis NOS etc)	1,769
Somatoform disorders	325
Epilepsy	1,510
Substance-use disorder	
Alcohol	1,919
Opioids	308
Cannabis	134
Tobacco	13
Multi-substance use	255
Child-specific concerns	
Intellectual disability	911
ADHD	43
Autism	31
Conduct disorder	2
Mood and anxiety disorders	1,315

Table 3: Prevalence of mental health concerns reported at DMHP clinics (2021–2022) There are some differences between the literature and field reports in the observed prevalence of mental health concerns, particularly in the case of SMDs (higher in the DMHP data than in the GBD findings), and child-related concerns (ADHD and conduct disorder, found to be higher in the GBD findings). As DMHP operations began in 2019, it is possible that increased access has enabled greater identification and therefore higher prevalence rates of SMDs. In the case of ADHD and conduct disorders, field reports suggest that while children might be diagnosed with these conditions, they are seldom brought into clinics/hospitals unless the conditions are associated with academic concerns. Hence, there may be gaps in reported numbers.

In all settings, care teams perceive substance-use disorder to be the predominant and most challenging concern, particularly in relation to alcohol and heroin, along with cannabis, yaba tablets, 'brown sugar' and 'white sugar' (opiates). Consumption of areca/betel nut is also very common and linked to socio-cultural customs and practices in the state. According to Athukorala (2021), betel nut contains both addictive and carcinogenic properties. Overall, health professionals note a change in the substance-use patterns in Meghalaya over the last decade, mainly due to the increased availability of substances. This means that many start using substances from or even before the age 20. Care providers also note an associated increase in crime as substances can cost up to INR 2,000–3,000 a day. Moreover, interpersonal conflict (with family, friends, at the workplace), loss of employment, financial pressure, land disputes, peer pressure and exam-related stress are seen as important psychosocial stressors, triggering mental distress.

2.5 Mental Health, Health and Social Determinants

2.5.1 Physical Health and Mental Health: A Two-Way Relationship

Meghalaya Health Policy (2021) highlights the need for a holistic approach to health and well-being, which also entails understanding the deep links between physical and mental health. It is possible to make progress on health and well-being only if both physical and mental health initiatives are integrated.

For instance, Meghalaya has a large burden of non-communicable diseases (NCD). Ischaemic (coronary) heart disease, asthma and chronic obstructive pulmonary disease (COPD) account for 56.3% of all DALYs in the state. The 2020 Cancer Statistics Report from the National Cancer Registry Programme highlights that the East Khasi District has the country's highest proportion of cancers associated with the use of tobacco (70.4% for males and 46.5% for females) (Mathur et al., 2020). The number of new cancer cases per 1,00,000 population in Meghalaya was 227.9 among males and 118.6 among females (ICMR-NCDIR, 2021). And behavioural factors such as smoking and alcohol consumption are identified as major risk factors for NCDs. As such, the burden of NCDs cannot be addressed without simultaneously inducing behavioural change.

Mental and physical health are in a two-way relationship, as chronic mental stress and disorders can heighten vulnerability to a range of physical health concerns and lifestyle-related issues (such as hypertension, heart disease, obesity, type-2 diabetes, etc). A meta-analysis by Vancampfort et al. (2015) found that the prevalence of metabolic syndrome was 58% higher in psychiatric patients than in the general population. Those with mental health concerns are also less likely to receive proper care at an early stage, which in turn exacerbates their co-morbidities. Meghalaya also has 11,420 injectable substance users which is an extremely high proportion of the population and carries the risk of spreading HIV and Hepatitis C, imposing a significant extra burden on health care.

A meta-review by Chesney et al. (2014) suggested that the life expectancy of patients with major psychiatric disorders may be reduced by up to 24 years. Similarly, many persons with chronic or terminal physical health concerns may develop mental disorders (e.g., depression, anxiety, suicidal ideation). Hence, the integration of physical and mental health services in the state is essential to improving the quality of life.

2.5.2 Poverty & Other Social Determinants

Various forms of social disadvantage (including poverty, hierarchies among tribal communities, etc) often co-occur with mental ill-health and heighten the vulnerability of persons with mental health issues. Being already marginalised and experiencing mental ill-health hinders access to basic needs like clean water, sanitation, food, clothing, shelter, physical safety, education, employment, health care and social security. Deprivation of these needs further exacerbates mental health conditions, in a vicious cycle.

The Meghalaya State Legal Services Authority (2015) suggested that one-third of the state's population is living below the **poverty** line, and that rural poverty is almost twice as high as in urban areas. The report

suggested that poverty has worsened in the interior due to stagnant agricultural production, soil erosion and a lack of new economic opportunities. According to NITI Aayog's Multidimensional Poverty Indicator (MPI) estimates (a metric that factors in nutrition and health, availability of clean drinking water, gas, electricity, education etc.), 32.7% of the state's population lives in multidimensional poverty - among the top five multidimensionally poor states in India.

Communities across Meghalaya highlight the strengths of the **tribal cultures** and the state's unique socio-cultural fabric, including a strong connection to nature, affiliation to collectivist practices, and the essential values of loyalty (to one's tribe and the state) and preservation of traditional, ancestral rituals. Simultaneously, also linked to deep-rooted, intergenerational practices, there are complex challenges, such as the widespread use of substances, home births, fragmented medical help-seeking patterns, and low demand for the termination of pregnancies (linked to religious values), all of which contribute to the health concerns raised in this section (development concerns, poorer health outcomes for women, cancers and a generally lower life expectancy). Hence, harnessing cultural strengths, while also addressing the associated challenges collaboratively with the population, is critical to strengthening culturally grounded, acceptable and sustainable physical and mental health outcomes.

Section 3. Situational Analysis of Mental Health Care System

3.1 Existing Infrastructure

Public mental health services tend to be provided at PHCs and CHCs (through the DMHP), at district hospitals (through outpatient and inpatient Psychiatry Departments) and at NIMHANS, a 150-bed state-run mental health hospital in Shillong (with outpatient and inpatient care). In addition, there are 10 psychiatric beds at the Tura Civil Hospital.

Facility	Number	Services
Sub-Centres	463	Sub-centres are the most peripheral contact point between the Primary Health Care System and the community. It is staffed by one auxiliary nurse midwifery (ANM) and a Chowkidar.
Primary Health Centres (PHCs)	110	A PHC is the first contact point between a village and the Medical Officer and has 10 beds for inpatients.
Community Health Centres (CHCs)	30	A CHC serves as a referral centre for four PHCs. It is ideally staffed by four specialists, *i.e.,* surgeon, physician, gynaecologist and paediatrician as well as medical officers and a dental surgeon. It has 30 beds for inpatients, an operating theatre, X-ray, delivery room and laboratory facilities.
General Hospitals	10	100-bed facilities in most districts, and offering a range of services, including a psychiatry outpatient and inpatient department.
Specialty Hospitals	4	Include – ● TB-focused –1 ● Maternal and child health – 3
Mental Hospital	1	State-run mental hospital in Shillong with an outpatient clinic and a 150-bed inpatient facility.

Table 4: Public health services in Meghalaya. Source: Department of Health and Family Welfare, Government of Meghalaya

3.2 District Mental Health Programme (DMHP)

The District Mental Health Programme (DMHP) is operational in 11 districts of Meghalaya, with PHCs as the basic unit. Through a combination of word-of-mouth referrals and those identified by Accredited Social Health Activists (ASHAs), persons with mental health concerns can get identified and referred to the nearest health facility. Monthly DMHP outpatient clinics are run at these centres (though frequency varies across districts), MIMHANS and the Tura Civil Hospital.

Two of the 11 district teams have a psychiatrist, who treats common and severe mental disorders.

In the other nine districts, medical officers are trained by psychiatrists to offer treatment, along with tele-consultations conducted by psychiatrists. In such cases, medical officers may treat issues that do not require a hospital admission. Patients who are referred to MIMHANS or Tura Civil Hospital for SMDs are usually the ones who require more specialised treatment.

In addition to health services, there are also outreach activities, which are planned by the Clinical Psychologist, Psychiatric Social Worker, Psychiatric Nurse, and Monitoring and Evaluation Officer, with the approval of the District Nodal Officer. In 2021, four halfway homes were established in the state to move long-stay patients

from MIMHANS and civil hospitals and offer long-term services focused on rehabilitation, long-term care and incorporation in the community.

It was found that medication was not always available, particularly at PHCs, meaning that patients may need to obtain medication from a CHC or tertiary hospital. Sometimes, staff availability permitting, patients may also be offered brief counselling sessions with a psychologist. ASHAs do not offer counselling as they are trained only to identify distress and facilitate referrals.

3.3 Role of AYUSH

AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy) aims to integrate 'traditional medicine' into the state's healthcare system. Albert et al. (2015) found that in Meghalaya there is little awareness of or recourse to AYUSH among rural communities. Almost all were aware of biomedicine, and 91% had at some point visited a public health facility for medication. Most respondents indicated biomedicine and tribal medicine as their top choices, while none cited any of the AYUSH streams as a preference for any particular ailment. Field observations are in line with these findings, as mental health professionals at CHCs and tertiary-level centres report unfamiliarity with AYUSH interventions, both among themselves and the communities with which they work. As such, resources dedicated towards AYUSH are likely underutilised for both physical and mental health needs.

3.4 Role of Non-State Actors

Following are some important non-state actors who are directly or indirectly involved in various mental health-related services and initiatives.

- **Traditional healers**: People across the state go to traditional healers for a range of ailments, such as injuries, fractures, skin diseases, insect bites, high blood pressure and so on. In the case of mental health issues, many first go to traditional healers, sometimes for years before going to formal health institutions. Health professionals observe that in some cases, people also may ask to be discharged from hospital to seek help from a healer instead. In general, health professionals do not work with healers and are therefore unsure about how they might approach a mental health issue. Some healers make it clear that they do not treat mental health issues, and refer such clients to community health centres (Bio-Resources Development Centre, 2017)

- **Village headman**: Headmen, part of the village governance system, play a crucial role in the community. SAMVAD (2022) highlights that in relation to child protection, they are a vital source of information regarding what is happening in the village. For instance, if the doctor at the CHC suspects that a child's injuries may be the result of abuse, they contact a headman to better understand the child's context and the background of the injuries. When a person experiences mental health issues, it is often the headmen who write a note to refer the person to a hospital such as MIMHANS. In some cases, persons with mental illness who are allowed to return home after treatment may also require the headman's approval. There have been challenges in such cases as community members may not be able to obtain timely care if the headman does not agree to refer them to a hospital. A headman may also need to give their approval to organise activities such as awareness camps, which could delay implementation.

- **Non-profit organisations**: In many communities, non-profit organisations offer important physical and mental health related services. Various non-profit organisations also focus on specific issues, such as education, livelihoods and health, in which they offer programmes. Religious institutions (such as missionary organisations) also play a vital role in establishing and running services such as shelters for the elderly, persons homeless, de-addiction and rehabilitation centres.

Section 4. Mental Health Policy Framework

The vision and values highlighted in Section 1 call for a holistic and people-centred approach to mental health care. This requires a substantial reorientation of the system to better identify mental health issues and provide sensitive care. Moreover, there are several efforts that are being made by multiple actors but there is a strong need to establish a common policy framework that can help guide these efforts and enable greater level of coordination. This mental health policy, thus, seeks to establish a coherent system that can provide end-to-end care for the people of Meghalaya. The Mental Health Policy has outlined a framework that has four dimensions. These dimensions represent key aspects of mental healthcare that the state needs to reimagine in order to achieve the vision outlined in the first section.

Mental Health Policy Framework **Dimensions**	
1. Sensitive Public Health Care Approach	3. Care Pathways
2. Community Awareness & Engagement	4. Support for Vulnerable Groups

Table 5: Dimensions of Mental Health Policy Framework

The following sections discuss each dimension of this framework by first presenting key challenges and then outlining some strategies to strengthen mental health care.

4.1 Sensitive Public Health Care Approach

Challenges

- **Cultural Alienation:** Many studies have indicated higher rates of poverty and land alienation, as well as lower rates of access to health care, safe drinking water, and adequate nutrition among tribal communities (Guha, 2007; Kannan, 2018). Given the strong correlation between psycho-social precarity and higher rates of CMDs (Patel & Kleinman, 2003; Morgan, McKenzie & Fearon, 2008) it is important consider the historical and persisting iniquities that have contributed to precarity among tribal communities in the state, which translate into psycho-social stress. These stressors are exacerbated by a widening gap opened by a decline in traditional cultural resources (Willford, 2022a; 2022b) coupled with inadequate biomedical systems. In addition, the latter are often alienating and dehumanising to indigenous peoples when they seek health care. Cultural stigmas and prejudices against tribal cultures have contributed to various forms of structural violence, particularly when health interventions have further pathologized them (categorising their behaviours as deviant, or as mental disorders). (King, Smith, & Gracey, 2009; Linklater, 2014).

- **Individuals & Communities:** The current mental health care approaches in the state attempt to address challenges faced by individuals but are not able to sufficiently tackle issues that operate at a community level. This manifests as low involvement of community institutions and muted public dialogues on mental health issues. Moreover, an individual-centric approach can make it harder to tackle stigma, which is more of a collective issue and requires changing social norms across a range of stakeholders. The failure to grapple with these factors is twofold: it has led to inward-looking and individualised blame and stigma within indigenous communities for historical iniquities and social transformations that were collective in nature; and it has made indigenous experiences of biomedical care systems, especially in relation to mental health, alienating, stigmatising, and pathologizing.

- **Limited focus on flourishing and well-being and on management of stress:** Well-being is often articulated as states of ‘feeling that their life is valued’, being free of ‘excessive worries and anxieties’,

'feeling positive about oneself', feeling a sense of being rid 'of a depressed mood', 'being able to bounce back when things go wrong', 'being optimistic about the future', feeling 'calm and peaceful', and 'having a sense of accomplishment'. Life satisfaction (how people perceive their quality of life) is essential, as it shapes health outcomes, instils hope and influences a person's relationship and connectedness with the larger community. The impact of loneliness and isolation on the development of cardiovascular diseases, poor quality of life and mortality is well documented. Social connections and feeling that 'people care' also contribute significantly to thriving, feeling hopeful and well (Burns et al., 2022; Snyder, 1994). However, cultivating an enabling environment for well-being has been often deprioritised in mental health care, which is very much limited to treatment for those suffering serious disorders. A simplistic understanding of good mental health as the absence of ill-health may impede health assistants and providers from identifying distress in its initial stages and address those at risk of developing more serious mental health or psycho-social issues in later life. The expansion from curative care to holistic well-being needs setting higher-order goals for the system.

Strategy

- **Pursue a capabilities and person-centred approach:** Acknowledging that unequal power represented by the emphasis on a dominant and singular type of recovery associated with neurotypical persons and pursuits, and its impact on individual health and social perception, person-centred approaches are geared to helping those using mental health services to attain states of health and well-being, regardless of the extent of disability; and embrace ideas of neurodiversity that effectively support individuals and their participation both in the care process and in socio-cultural and political life. This calls for a paradigm shift in care approaches, vocabulary and ethics that enables personal recovery in congruence with the capabilities approach – where connectedness, hope, identity, empowerment and meaning in life (CHIME) 'matter as much as remission of symptoms and functionality reduced impairment' (Leamy et al., 2011).

- **Culturally Sensitive Care:** Comparative studies of indigenous peoples suggest that the 'healthiest' communities are those which have retained their language, culture, and rituals centred on their collective identity, leading to lower rates of addiction and suicide (Linklater, 2014). A resilient identity is critical to a sense of well-being, especially for indigenous cultures, where community and identity are more critically intertwined, and where beliefs and the rituals maintain a sense of wholeness through relationships both with the living and with ancestors, local landscapes and the natural world (Bird-David, 2017). Care providers need sensitization on working effectively with communities to be able to provide care and support that accounts for cultural and social norms. This can help build trust between the citizens and state systems. The focus is more on preventive and promotive healthcare.

- **Need for Collective Approach**: It is imperative to develop new intervention strategies of a more collaborative and participatory nature, including training indigenous community health workers (CHWs) not only to translate biomedical knowledge in ways that are culturally meaningful, and hence enhance well-being, but also to work within cultural institutions, beliefs, and partner with traditional healers to consolidate sources of resilience and generate hope. For example, rather than focusing care for individual substance abusers, or chronically depressed, which treats the individual and indigenous community as inherently problematic, more focus on collective restorative justice and group rituals would acknowledge shared painful experiences (Linklater, 2014). If historical traumas were collective, a sense of justice and healing may also mean less focus on individual health issues, and more on a sense of collective wholeness that is central to notions of relationality in indigenous worldviews (Bird-David, 2016; Linklater, 2014). Given the deep attachment to ancestral landscapes, sacred groves, and traditional foods that are linked cosmologically through rituals, their disruption by socioeconomic transformations, land seizures, and dietary changes has contributed to feelings of cosmic and bodily disequilibrium, and to being vulnerable to illness, often framed in supernatural or culturally defined symptoms (Kakar, 1982; Demmer, 2016; Willford, 2022; 2023). In designing mental health interventions and policies tailored to the tribal communities in the state, it is important to be aware of

indigenous worldviews that consider scale, and embodied notions of relationality, sometimes referred to as 'substantialism' in the South Asian context, in which food, bodies, and environments commingle with ancestors and environments (West & Zimmerman, 1987). This has two implications. First, collaboration and partnership with each tribal community is paramount to bridge the divides between biomedical and traditional forms of care to attain well-being in a holistic sense. Second, focusing on the collective, as opposed to the individual who is unwell (in a general sense, obviously not if there is an acute need for care), acknowledges the traumatic ruptures and forms of structural violence that have particularly affected indigenous communities, given their scale, precarity, and powerlessness, coupled with the emphasis on relationality in their worldviews.

- **Engage the community in the recovery process:** It should be highlighted that in systems characterised by injustices, the onus of 'recovery' lies equally with the community. This is because social precipitators – such as identity, poor social capital, lost connections, poor interpersonal relationships and kinship ties, limited social networks, a history of trauma, isolation and grief, constant exposure to oppressive practices, hegemonic governance and social structures – are also embedded in the community. This approach will have to be integrated and reinforced in public awareness campaigns so that it is legitimised and used in training programmes for all service providers. Not only will these value-based strategies affect individual health outcomes, but they may also contribute to developing positive attitudes and behaviour that are non-stigmatising and empathic and therefore help cultivate enabling environments conducive to healing.

- **Address stress:** As in the case of physical health, the state needs a stronger emphasis on preventive care. It is important to acknowledge the role of stress in influencing mental health. While certain levels of stress i.e., eustress can be beneficial and promote health and well-being, prolonged periods of psycho-social stress can impact pathology, adaptability, neuroplasticity and overall well-being. (Radley et al., 2011). Hence, it is critical to address stress through effective interventions, to promote life-satisfaction and prevent escalation to CMDs and SMDs. The mental healthcare system should support initiatives that proactively reach out to communities to discuss risk factors such as chronic stress, which can translate into severe mental health disorders.

- **Address social determinants of mental health, especially for vulnerable groups:** It is imperative to establish pathways that identify and address the needs of those with experience of discrimination, segregation, disadvantage and oppression, keeping in mind the cultural factors that particularly affect the lives of women and children in Meghalaya. This may be achieved by using participatory methods involving diverse but locally embedded community mobilisers, teachers, auxiliary health staff such as ASHA workers, community-based rehabilitation workers and traditional healers, using techniques such as community mapping.

4.2 Community Awareness & Engagement

Challenges

- **Low awareness of connection between mental and physical health:** Many people do not see this aspect of health as a significant priority, further exacerbating distress and perpetuating a cycle of poor social health. The association between physical and mental health are inadequately addressed, such as the linkages between substance-use disorders and cancers and/or other NCDs, or home births and a possibly higher prevalence of postnatal complications including the probability of death, seizures, postpartum depression, IPV and its impact on physical injuries and emotional ill-health etc.

- **Negative stigma:** There is a need to address stigma and negative perceptions about mental illness, to improve help seeking behaviours. Shame often intimidates people from expressing feelings of distress that they may experience; the focus on collective healing and the responsibility of tackling shame as a deterrent to promoting health has to be reinforced among care teams and communities.

- **Knowledge asymmetry and mental health literacy:** Adequate and culturally relevant forms of knowledge transfer and dissemination platforms that inform the population about the impacts of mental health on well-being and physical health, and the bi-directional relationship between both are currently unavailable.

- **Accessible and comprehensive mental health services at primary, secondary and tertiary levels:** Mental health access and coverage in Meghalaya is currently somewhat uneven. Among other factors, low population density (132 persons per km2) makes it particularly difficult to provide services as part of comprehensive primary care, resulting in large gaps in health and social care and significant implementation challenges.

Strategy

- **Culturally-adapted IEC campaigns to destigmatize mental health**: Awareness and knowledge-transfer initiatives and effective dissemination platforms are essential to promote better help-seeking behaviour, address asymmetric knowledge and improve population-level health outcomes. It is important to make use of local culture, folklore, street theatre, role plays, and local and powerful advocates such as representatives from women's groups, child and youth leaders, healers and tribal leaders, as well as teachers, auxiliary health staff, and mental health and social care teams as part of a concerted effort to encourage individuals and communities to focus on their mental health and identify early signs of distress. Rather than build false dichotomies by focusing exclusively either on contemporary or on traditional approaches to addressing mental health needs, awareness approaches by all groups should seek to integrate these for maximum gains. The use of newer approaches, particularly those that engage communities, such as theatre and community dialogue, may be relevant in this context, giving a space to community voices and lived experiences to help shape local narratives on mental health and healing. Edutainment - short for entertainment education - has also proven to be successful in addressing complex challenges, particularly those that have stigma associated with them. Community radio with relevant content and helpline services may also help promote messaging on social health and mental health in engaging ways that break down stigma. In the context of mental health and the critical importance of early, appropriate, barrier-free and non-stigmatising identification pathways, the benefits of timely access to care may need to be underlined by a range of influencers such as those suggested above, and also political and social leaders who have a positive public image.

- **Helpline:** The state can leverage existing helplines such as 1098, Tele-MANAS and other initiatives to improve access to support through first-line responders. The helpline may be expanded to proactively reach out to citizens for mental health support.

- **Developing an application that disseminates information in indigenous and other languages** on mental health literacy, mental health risks and mitigation, self-care, help-seeking strategies, referral resource directories, and interactive tools such as graphic grounding techniques, and Q&A portals can help engage younger people. Existing apps, such as the 'Manas App' created by NIMHANS, could be specifically tailored to the context of Meghalaya.

- **Build capacity of subcenters and VHCs as platforms for information dissemination, sensitization and peer support systems:**

    - **Linking community to service points:** This involves creating awareness through the existing 460 Sub-centers and more than 6500 + Village Health Councils (VHCs), with a focus on facilitating enabling environments to help identify persons at high risk or with experience of vulnerabilities or distress at the earliest and link them with a service point.

    - **Community sensitization:** These platforms may be used to sensitise communities and play a key role in facilitating social entitlements to focus on community inclusion, eg. promoting

access to job opportunities through social cooperatives and home-based entrepreneurial efforts, and stronger support structures through affinity groups or SHGs. Sub-centres can operate as information kiosks information on stress (linked to themes ranging from exams, peer pressure and bullying, to gender roles, poverty traps, natural calamities, unemployment, demographic shifts, violence, existential concerns etc), stress management measures (coping techniques, community engagement tools such as support groups and circles, and escalation pathways to counsellors), general well-being (e.g. nutrition and healthy eating, positive youth development and parenting, prenatal and postnatal care, mental health care, social health etc) and problem solving, acting as the nodal point for mental health promotion.

- ***Community practices and local traditions to be leveraged*** to develop culturally congruent public mental health systems, making the most of preexisting structures and customs to foster integrated approaches to enhance health and well-being gains that draw from the deep sense of community.

- **Community-level mobilisation and connectedness:** Healing could be viewed as both a personal and collective process in tribal and minoritized communities that are often affected by intergenerational trauma, in a way that is largely supportive of the individual in distress or emotional pain. In this context, it is important to support community ties and build social cohesion, where existing rituals help form bonds and connections and strengthen affiliations (Yu et al., 2020). Rituals, whether small or elaborate, have the potential to forge cooperation, help members of the group better deal with conflict and crises, stimulate generosity, increase trust and 'think and act as groups' (Watson-Jones & Legare, 2016). These protective functions of certain existing rituals may help challenge stigma and help individuals in distressing predicaments gain from collectivism and related practices, in addition to personal agency. It is recommended to encourage rituals with healing properties to build solidarity, group cohesion, reduce anxiety and 'othering' among the most vulnerable, especially for those living with mental health concerns. Singing and dancing, often accompanying or being the main component of traditional rituals, have other therapeutic gains in relation to mental health in stimulating movement, feelings of connectedness and hope, and encouraging engagement in social activities, and may be explored further.

- **Peer-support groups:** Work with community members, especially village health councils, to encourage the establishment of peer support groups, in which individuals suffering from mental illness and their families, can meet others who have been through similar struggles. Individuals with experience of mental, social, economic and psychological distress are often isolated due to stigma, limited access to effective and appropriate health care, support structures and social systems that are ill-equipped to respond to complex and diverse needs, especially exacerbated among vulnerable groups. In the process, the extent and range of personal goals diminish, limiting individuals' ability to pursue capabilities that allow them to thrive or flourish, remain hopeful and participate in community and social life, especially against the backdrop of disempowering structural barriers. It is recommended that all individuals and groups – ranging from those who experience loneliness to those with experience of depression or psychoses – are served in a way that helps foster feelings of trust, safety and collaboration with primary care providers in the community. In the case of those living with serious mental health concerns, care plans have to address unique needs, adopt a holistic approach and therefore engage a range of health professionals, healers and other support networks from local communities, to offer services based on individual needs. Loss of control over treatment options and systems that place greater emphasis on medication and formal treatment rather than on models that integrate social justice and disability may discourage health-seeking behaviour.

- **Promote peer-led knowledge-creation programmes for healing:** The key aim is to create spaces of collective processing through group work, art and play, reclaiming indigenous identities through oral histories, documenting people's own experiences and preparing toolkits in local languages. Testimonials of change, and of navigating personal and systemic challenges, have universally inspired greater participation in people's recovery process and encouraged hope and energy, inspiring others to become community role models. These services would be most authentic as in-person sharing, but tech-assisted platforms may also be used to reach diverse populations in public health and education settings.

- **Facilitate grief circles:** Acknowledging that communities with generational and ongoing trauma experience multiple forms of cultural, personal, financial, structural, and environmental loss is central to establishing therapeutic alliances. Programmes aimed at creating spaces for individual and collective support through grief circles and responsive programmes to help people who are experiencing bereavement may resonate locally. Further, using rituals that are accepted and established in the Meghalaya context, and adapting them collaboratively in ways that are both therapeutic from an evidence-based practice perspective, and familiar and relatable from a cultural perspective, may effectively support the healing process.

- **Edutainment for Reducing Stigma**: short for entertainment-education, edutainment has proven to be successful in addressing complex challenges, particularly vulnerable groups that have stigma associated with them.

4.3 Care Pathways

Challenges

- **Delayed identification of mental health concerns:** Limitations associated with access to every household, such as door-to-door screening and assessment mechanisms, identifying persons in distress in a timely manner, combined with overburdened personnel and poor alignment with culturally meaningful forms of care, frustrate the attainment of public mental health goals. Further, stigma and information asymmetry and/or poor mental health literacy inhibits people from self-reporting concerns, especially given the limited provision of locally accessible care.

- **Inadequate (local) access to emergency and acute care centres:** Apart from effective identification of and referral pathways for all CMDs and SMDs, there is no access to acute and emergency care and teams that can ensure consistent and coordinated care in times of emergencies or mental health crises. The delays, in combination with poor continuity, pose significant barriers to treatment. MIMHANS and Tura hospitals have historically over-extended themselves owing to limited bed capacity. It is recommended to increase the number of beds in primary and secondary health centres across districts, leading to more local and better integrated care.

- **Helplines and Safe Spaces in Meghalaya:** Currently, there are few helpline services or safe spaces available for citizens of Meghalaya. Helplines provide prudent and non-judgemental emotional support for persons in distress. In addition, safe spaces provide a non-judgemental location, and allow people to feel supported and respected. This is particularly beneficial for minoritized communities such as the socially disadvantaged or the LGBTQIA+ community (India CSR, 2021). Non-clinical suicide-prevention interventions in Australia indicate that peer-led safe spaces provide non-judgemental support to those in need. They can often be customised or modified to each cultural context. According to the WHO guidelines, distancing or prohibiting access to substances that could cause harm, such as pesticides, helps reduce the incidence of suicide. Support groups and access to individual coaching, building resilience supported by active listening, and Cognitive Therapy for Suicide Prevention (CTSP) have shown significant gains in terms of saving lives and sustaining good outcomes for a period of time (Slesnick et al., 2020).

- **Limited focus on care coordination and continuity of care:** Protocols and tiers of care and treatment are not well defined, resulting in poor commitment to protocols that are unclear in terms of the nature of service, type of service provider, provision of training, and location of provision. This leads to poor coordination within and across departmental care teams, which affects the continuity and consistency of care and the outcomes of interventions that are intended to reduce disability and improve community inclusion. Referral pathways are discrete and unclear, with virtually no convergence with social care that provides social security to individuals who experience other hardships arising from systemic barriers. In addition, referral pathways often ignore issues such as out-of-pocket costs, requiring families to travel great distances repeatedly in order to access care.

- **Poor integration of care pathways:** Limited integration of mental health care within the public health system, and between mental health and social care systems and culturally acceptable traditional approaches or AYUSH, results in a disjointed system with disparate pathways, largely focused on biomedical approaches.

- **Lack of exit pathways and other supportive institutions:** Patients who are admitted to hospital often remain in the institution for longer than necessary owing to a lack of exit pathways (families/homes to which to return). A study by Hans Foundation in 2019 suggests that in MIMHANS, 50 out of the 116 patients who were in the inpatient ward (at the time of the study, in 2019) were long-stay patients (*i.e.,* had remained in hospital for over a year) (Narasimhan et al., 2019). The study also indicated that only seven of these 50 patients had severe levels of disability, while the remainder had mild to moderate disability. This suggests that several of the long-stay patients could have adapted well to and benefited from being discharged, and from living in a community. Health professionals at NIMHANS estimate that as of August 2022, 50–60 patients were ready to be discharged but were unable to leave. Further, due to challenges in tracing families and facilitating reintegration, many patients in the halfway homes move from one institution to another but remain stuck without options for community-based living.

Strategy

- **Initiation of a Helpline, First Responders' Team, Crisis Teams and Psychological First Aid:** A helpline and/or other tech-enabled interventions may help support distressed persons and care providers. By matching the need with the service at the first point of contact, first responders and crisis support teams may then respond depending on the kind of support needed. If the person is homeless, lives alone or has an elderly or child caregiver as their primary support and similar circumstances, in the event of extreme social distress intersecting with negligible support networks the first responders would be trained to refer them appropriately to a service that is best placed to respond to their needs. First responders would be drawn from existing mental health and social care support staff and associated professionals or community-based rehabilitation workers, peer advocates, community members and volunteers engaged in outreach work. The police may intervene in the case of extreme vulnerabilities or limited social capital to provide help, or where care is provided without explicit consent. First responders may access ambulatory care when needed, which the state will provide, since transport is expensive and impedes speedy access to care. Crisis and co-crisis teams (*e.g.,* the police and the mental health team or peer advocate co-led team) are usually trained to make initial clinical and needs assessments, use reflective listening, reduce distress, prioritise needs and match care pathways, stabilise (if possible and required), and triage. These crisis teams are trained in de-escalation, community interface and verbal and non-verbal communication techniques that are supportive, culturally appropriate and embedded in a culture of empathy and responsiveness.

- **Screening of all individuals by trained personnel:** The presence of local trained personnel who are meticulous, empathic and thorough with assessment plans and identification pathways in primary settings is integral to effective public mental health, a basic right for all. Not only will this reduce the burden of disease and disability, but it will also help address the strain on caregivers, reduce overall

social suffering and improve well-being. Healthcare workers can be trained on early identification of mental health disorders, particularly among vulnerable populations. There can be annual screenings that have combined assessment of physical and mental health.

- **Pathways for early identification of diverse, intersecting vulnerabilities and provision of appropriate social care to alleviate distress:** Various types of distress and vulnerabilities may be identified at school, in the family and by community mobilisers such as the ASHA workers, traditional healers and teachers, in order to prevent the experience of feeling blocked, and the loss of resilience among children, adolescents, young adults, single women, pregnant women, working men and women and the elderly (Nead, 2016). Early identification of social vulnerabilities has the potential to arrest the descent of these individuals into states of emptiness and alienation, and ultimately depression and self-harm. The state may leverage specialised early-intervention strategies that have been developed for a range of conditions including psychosis, bipolar disorder, major depression, trauma-related conditions and personality disorders.

- **Triaging, referral systems, and contact with services:** A first responder would use contextualised and adapted mental health triage, the clinician would assess a referral based on the nature of the need and its severity or urgency. In the case of acute, emergency and urgent needs, the patient would be treated in a tertiary hospital, with specialist care focusing on stabilisation, assisting recovery and restitution of biological, psychological and social functioning. In general, inpatient care would range from one to eight weeks, and longer if necessary. Acute care could be provided across tertiary hospitals, MIMHANS and, with adequate training and personnel, also integrated into sub-centres, PHCs, upgraded PHCs, and block-level CHCs. Sub-centres will help in early identification of mental health concerns and facilitate referrals to PHCs, CHCs or tertiary hospitals based on the need. They will also house first responder units and offer crisis support and psychological first aid (explained above) when required. These units will also double up as a safe space in the context of intimate partner violence and/ or other forms of distress in the context of children as well. This would establish many accessible units across the state, while ensuring that mental health teams may maintain contact with their patients over a period of time. Besides rapport, trust building and a focus on care throughout a person's life, this also achieves continuity in the therapeutic alliance and with the mental health and social care team. In addition, convergence will be promoted between the public mental health systems, private actors and activities of the village health councils.

- **More beds in primary care:** It is recommended that every PHC or CHC assign 2/10 and 3/30 beds and that every tertiary care centre or District Hospital assign 15/100 beds for mental health care. Increasing the number of beds for emergencies or acute need would lead to more beds overall, which could also be used to provide respite care. Addressing suicidal ideation or attempted suicide and preventing suicide would also benefit from the greater number of beds offering specialised services, including a suicide watch protocol, to support a person through a period of crisis.

- **Inpatient care- the importance of social architecture:** It is vitally important that inpatient care is supportive. In pursuit of this, the provision of private or shared spaces based on patients' needs, the use of collaborative care planning, cultivating a climate of safety, restorative care and trust, and various therapeutic and counselling approaches (*e.g.,* CBT, CBT(P), DBT, narrative therapy, dance and movement therapy, mindfulness techniques, expressive arts-based therapies, psychodrama, compassion-focused therapy and Open Dialogue) may be introduced. Open Dialogue also involves support networks in a non-hierarchical patient–therapist interaction. Other approaches such as solution-focused therapy, motivational interviewing, behaviour activation etc. may also be helpful. Peer advocates involved in care inspire hope and offer expert advice based on their lived experience, nuancing care plans based on context, diagnosis, social stressors and the environment, and offer real-life inputs – although these by definition do not lend themselves to being standardised – underlining their essential role in supporting meaning-making exercises in a person's unique emotional landscape. It is also essential that social care specialists, social workers or social prescribers work alongside

psychologists and other interdisciplinary mental health professionals to address social determinants of health pre and post discharge to prevent recurrence of distress, offer appropriate solutions that may help manage stress and distress, create healing environments in IP set ups, clarify concerns, provide consistent support and focus on building personal recovery plans that involves care coordination between departments so as to offer non clinical support such as housing, income security, spiritual support, access to activities that induce 'flow states' etc. Increase in the number of nurses, nurse-practitioners and psychiatrists is required (with mentorship chains for escalation support) for continued care.

- **Post-discharge self-management using Assertive Community Care (ACT):** Following discharge, as far as possible it is recommended that patients periodically seek follow-up care with the same mental health team, although there should be mandatory access to medication in all PHCS (Johnson et al., 2018). Most people are likely to experience a recurrence of a psychotic episode or ill-health and options such as Assertive Community Care (ACT) or Meghalaya ACT (M-ACT), which combine aspects of ACT adapted to the needs of the relevant population. Overall, ACT has been shown to reduce repeated hospitalisations, increase housing stability and participation in the labour force. Similarly, peer-led after-care options also seem to have equal and additional benefits through periods of crisis (Johnson et al., 2018). Either or both options could be adopted to respond swiftly to prevent ill-health and often, as a result, exposure to scarcity in a context of disadvantage, and even homelessness. How long such support continues will be determined by the mental health and social care teams but could typically go on for up to three years. An integrated care plan such as this that reduces secondary deficits by early treatment of the onset and recurrence of illness and encourages engagement with care services for each person identified with a mental health concern. With a population of about 3 million, there are likely to be around 1,000 new cases of psychoses each year and planning responses for this 'high-risk and high-need' group could help define a range of services which would benefit from the spin-off expertise. From first symptoms to long-term care, digital technology could also enable virtual tours of 'wards' in the absence of nearby services and personnel. Every patient gets to 'consult and see' an assigned Mental Health and Social Care team.

- **Long-term inclusive care options:** For persons with high support needs with moderate to severe psycho-social disability long-term care facilities in the community may be provided that are also sensitive to independence, choice and agency. Services in community settings, using local resources and making mental health care management cost effective, focus on the continuum of care. Provisions that may be made with community participation and ownership are:

    - **Halfway homes** that provide safe shelters and serve as rehabilitation centres to prepare gradual readiness for people to re-adjust to their communities (Sahu, 2014).

    - **Supported housing options** where accommodation alongside supervised support is offered to enable socially inclusive living. Housing First (Homeless Hub, 2012) is based on flexibility, person-centred support, and autonomy. Formal professional support offers continuity of care and referral services when required.

    - **Home Again**, a flagship model of The Banyan, is recognised by WHO as a sustainable model of community living for persons with psychosocial disabilities with restricted exit pathways from institutional care (Padmakar et al., 2020). It aims to form family kinship, recovery at an individual pace, social mixing, livelihood choices and thus progress towards social inclusion and community membership and participation.

    - **Respite bed programmes** are for persons moving out of acute care – an interim place to stay for a couple of weeks before moving into other living options. Respite care services offer occasional respite for caregivers, whether for an evening or weekend, usually called 'breakaway or friendship schemes' that provide a service geared to individual needs.

- **Independent Living options** encourage peoples' choices to manage their disability, select forms of treatment, exercise work choices, and live independently in the community with very minimal organisational support, and using affordable service options, *e.g.,* outpatient clinics, tele-psychiatry, counselling services. Interdependence among community members for mutual support is vital, enabling problem solving, addressing crises, alleviating distress and active help-seeking behaviour.

- **Hostels**: with board and lodging paid, subsidised and sometimes free, may be used by adults with mental health concerns in the absence of home-based care and similar safe alternatives. These seem economical as these are dormitory-like services with basic amenities, interim spaces that prevent them from living on the street and become vulnerable (Ramkumar G. S. & Sadath, 2022).

- **Disasters and exceptional circumstances:** Special circumstances involving public health implications and by extension, mental health consequences, including pandemics such as Covid-19 also require intervention protocols. Broadly, training in psychological first aid must be offered to different cadres of the community, including - healthcare professionals and village health councils, police forces, teachers and academics engaging with students, and peer leaders. Mental health must be identified as a key priority during such situations, and therefore, continued access to care pathways must be ensured through appropriate context-specific forms (such as helplines, as mentioned above), and health communication strategies must include messaging around mental health, to reduce anxieties and promote confidence, a sense of control, and stronger responses to the situation.

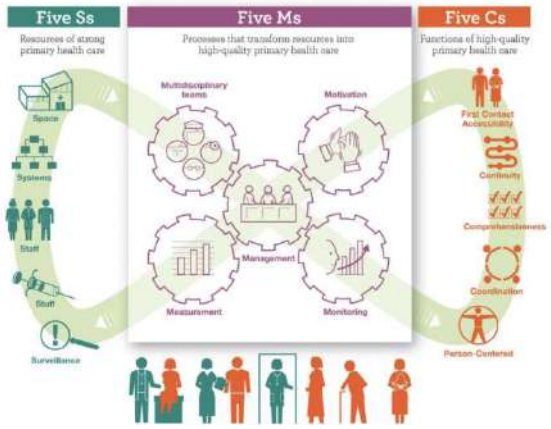

Figure 1: The 5S-5M-5C schematic - Key Components of Primary Care. (Bitton et al., 2018).

- **Grievance-redressal systems:** Grievance-redressal units may be set up alongside well-being or mental health and social care kiosks located in wellbeing clinics to respond to urgent needs. The facilitation of swift and effective grievance redressal mechanisms in combination with other justice-oriented, responsive support systems and care pathways, such as safe spaces for women in distress, immediate galvanising of legal aid support in the case of inter-community conflict or other perceived vulnerability-based oppression, a distress helpline for children, women and older people in distress or for those seeking information about health and social care access etc., are critical to building trust, an essential step to espousing the values of community-level social cohesion.

- **Use of trauma-informed interventions:** Trauma may arise from adverse childhood experiences, intergenerational distress and historical segregation, or socio-political contexts that discriminate against minoritized groups. Intergenerational collective trauma may also be transmitted over many years. Trauma-focused interventions understand the pervasive nature of trauma or negative life events

and promote environments of healing and recovery, avoiding services that could potentially re-traumatise an individual. While trauma-focused mental health services include prolonged exposure therapy, eye movement desensitisation and reprocessing, trauma-focused CBT provided by trained professionals, incorporating a comprehensive trauma-informed approach, goes beyond mental health services. It involves bringing structural, organisational and clinical changes to facilitate the individual's recovery and empowerment, increase participation and enhance social inclusion. At a clinical level, using culturally and clinically appropriate trauma-screening tools will aid personalised treatment and decisions to improve health and social outcomes. It is crucial to understand the role of the community in not only contributing to trauma but also in the treatment process and facilitating recovery. Engaging with community-based and culturally sensitive organisations, early referrals and working with multiple stakeholders in the patient's environment can aid sustained recovery. At an organisational level, there will be a need for continuous efforts to sensitise clinical and non-clinical staff and senior management and to identify resources. Safe spaces that facilitate opportunities for traumatised individuals to occupy leadership positions and use their voice in decision-making processes should be provided to enable confidence and trust. In relation to prevention, gatekeepers and various stakeholders in a person's environment need to be trained to provide a safe and secure setting, build positive social relationships, identify signs of mental and physical distress caused by potentially traumatic experiences, and refer to resources without delay. Awareness and sensitisation programmes may help limit the occurrence of trauma or offer the opportunity for early redressal, preventing long-term impact.

4.4 Support for Vulnerable Groups

Challenges

- **Children and Adolescents:** Children and adolescents are amongst the most vulnerable sections of the society as their experiences can have long-term impacts on their physical and mental development. Some of the most pressing issues experienced by young people in the state including the following:
    - **Intellectual disabilities:** Families of children with intellectual disabilities experience stigma and discrimination, particularly in rural areas. Further, there is a general lack of inclusive education frameworks.
    - **Substance use:** Owing to factors like stress, easy access to substances, and exposure to adults consuming substances, children and adolescents develop substance-use habits from a young age. By extension, delinquency and aggression are commonly observed among young people using substances.
    - **Teenage pregnancies:** Health professionals note that although Meghalaya is largely a matrilineal society, patriarchal beliefs regarding reproductive health and the women's roles contribute to the early marriage and motherhood for young girls. It is also culturally unacceptable to seek a medical termination, which particularly affects adolescents. As a result of early and frequent pregnancies, some women, particularly in rural areas, may have up to ten children by the age of 30.
    - **Child sexual abuse:** An issue reported across districts is the prevalence of child sexual abuse (CSA), usually perpetrated by an adult relative. Children by previous marriages have been identified as being at particular risk of being sexually abused by stepfathers when mothers remarry; POCSO cases have been on the rise, which are also linked to high rates of teenage pregnancy. While their families may accept underage pregnancy, the mandatory reporting if the case reaches a hospital brings the adolescent father to the Juvenile Justice Board. Studies suggest a positive correlation between adverse life events in childhood, particularly child sexual abuse (CSA), and higher levels of psychopathology in later life (Mullen et al., 1993).
    - **Child labour:** Many rural children are sent to be domestic servants in urban households. These arrangements tend to be kept private as the employers are wary of these children being

identified by the relevant authorities. Often, these children also attend school, which then brings them within the ambit of the legal exception to child labour, i.e., family-related vocations.

- **COVID-19 impact:** School teachers in Meghalaya indicate that children showed signs of stress, anxiety and depression during COVID-19 lockdowns and found it hard to adjust when schools reopened (due to long school hours, and their attention span affected by online education).

- **Women:** The situational analysis found that, the matrilineal structure notwithstanding, patriarchal structures have an overarching influence. Therefore, alongside the economic independence associated with property rights are women's gendered social responsibilities, such as providing most of the care for their immediate and extended family, which in combination with gender biases, and IPV or domestic abuse, disempower women. These patterns and events have a negative impact on physical and emotional health and often precipitate and perpetuate episodes of depression and anxiety and even suicidal ideation. For many women, these responsibilities result in high pressure and emotional distress. In addition, women face a number of other challenges and vulnerabilities:

  - **Single Mothers:** There are many single mother-headed households in the state, which means that many mothers end up shouldering the entire responsibility of raising their children and supporting the family. This can be a source of stress for many women.

  - **Domestic violence:** According to the National Family Health Survey-5 (2019–20) data for Meghalaya, 16% of ever-married women between the ages of 15 and 49 have reported spousal violence (23.2% of rural women and 14.2% of urban women). Intimate partner violence (IPV), which includes physical, psychological and sexual violence, contributes to women's poor general health, mental health conditions, and suicide (International Institute for Population Sciences & ICF, 2021). IPV and domestic abuse affect psychological health in various ways, including the propensity to develop anxiety, depression, post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD) and Substance Use Disorder (SUD). Health professionals also note that the problems experienced by mothers also affect their children. As a result of early exposure to domestic violence and substance use, or the lack of consistent parenting, children from these families may be more likely to use substances from an early age.

  - **Childbirth practices:** Home births, as opposed to institutional deliveries, could have an impact on maternal and infant mortality, and may also increase the greater likelihood of the child developing neurological challenges, in the context of high-risk pregnancies and unskilled care at birth.

  - **Lack of Medically Terminated Pregnancies (MTPs):** In the case of sexual abuse or the mother's lack of agency to make her own decisions, few women and girls exercise the right of access to abortion in Meghalaya, which has a negative impact both on health outcomes and the realisation of reproductive rights. The balance between respect for cultural and religious affiliation and the unmet need for a medical termination needs to be addressed in a collaborative spirit of working towards better health outcomes for all. If the principal criterion is a person's agency, based on the values that guide this policy, the choice should rest with those who need this service, which means giving priority to access. This would also be in accordance with the recent Supreme Court mandate that women, irrespective of their marital status, have the right to seek a medical termination of their pregnancy as an expression of autonomy and control over their own body.

- **Elderly Population:** The elderly adults, in many households, often experience several mental health concerns, including loneliness, depression and anxiety. These can often go undetected and unaddressed. Moreover, elderly population may also have other health conditions such as hypertension, diabetes and dementia, which can exacerbate mental health challenges.

- **Persons Living in Poverty**: Poverty, lack of basic amenities and a low standard of living may affect emotional and social health, and also expose individuals, communities and populations to structural violence and related trauma. People from poor households are at a heightened risk of experiencing chronic health-related physical and psychological, and social needs, which also places them in a fragmented social care structure. For example, a 2018 survey on urban homelessness in Meghalaya found that 37.5% of homeless individuals had general ailments, 31.25% were experiencing mental distress, two had been injured, and one was suffering from TB; 10.42% also had health issues (Completion report submission of systematic survey for identification of urban Homeless in 6 ULBs of Meghalaya). In addition, the intersection of poverty with high unemployment, mental ill health, and out-of-pocket expenditure, is linked to poor health access.
- **Migrants and Identity Crises:** About one million people from the north-east migrate to other states in India, seeking employment and a better standard of living. There is anecdotal evidence that these migrants face racial microaggression in other parts of the country. In other marginalised communities across the world there are clear links between racism, microaggression and depressive illnesses. Embracing one's cultural identity and actively addressing problems in response to stigma and discrimination, rather than passively accepting them, tends to yield more long-term benefits because it gives a sense of control over the situation (Loyd et al., 2022). Attention to issues of identity and cultural influences should therefore be prominent in mental health care.

Strategy

- **Strengthen Women's Support and Affinity groups**: As detailed in MOTHER, a focus on women's rights and health is of utmost importance. The policy aims to build a deeper understanding of specific challenges faced by women and implement ways to mitigate these challenges.
    - **Improving Maternal Mental Health:** Given limited exposure and deficient post-natal care, postpartum depression can often go undiagnosed. Community health workers such as ASHAs and women's collective can offer support and guidance around nutrition, health, stress management, conflict resolution and negotiation, and screen for mental distress/PPD around health access points. The health system also needs to be sensitised to prevent obstetric violence at health facilities. This can also promote information symmetry around body/reproductive rights and basic rights as a health service user.
    - **Economic Empowerment for Mental Well-Being:** Economic empowerment can lead to higher levels of self-esteem and can translate into enhanced physical and mental well-being. Economic opportunities can foster social mobility, autonomy on expenditure, and increased social capital. As such, it is recommended that economic opportunities for women be continually expanded at all levels. At the household level, schemes such as Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) can provide paid employment. At the group level, self-help groups (SHGs) can function as peer-support groups that strengthen individual resilience and collective belonging among members (Alemu et al., 2013). SHGs both enable access to finance, and foster emotional connectedness, an opportunity to share feelings and to form affinity groups. Finally, there is a need for more investment in skilling and job creation for women to play a more active role in economic growth of the state.
    - **Political Empowerment for Action**: Another key dimension of action is political empowerment, which can enable women to draw attention to mental health challenges faced by women and take action to address these challenges. The state has already taken an important step in this direction by bringing a reservation policy for women in village employment councils (VEC). This needs to be complemented with initiatives to build agency and leadership among women.
- **Positive Children, Adolescent & Youth Development:** An effective mental healthcare system needs a continuum of care that starts at early childhood and provides age-appropriate care and support through adolescence and youth. This is the period of greatest mental plasticity in that strong exposure

to toxic stress can have lifelong effects. Following are some key strategies for putting children on a positive growth trajectory.

- **Effective Early Childhood Care:** The state aims to use the Integrated Child Development Scheme (ICDS) and the Anganwadis to ensure that young children have access to socio-emotional care, protection and opportunities for early learning. The state has already launched the Early Childhood Development or ECD Mission for this purpose. Under the mission, the state will provide training and sensitization on ECD practices such as positive parenting, joyful learning and healthy nutrition. These practices can significantly reduce exposure to stress and neglect that can cause mental health challenges. The frontline workers and community cadres will also be trained on standardised assessments, child interviewing and case-management skills and recognition of child-protection issues (such as violence, abuse and neglect) to better support parents and communities on effective childcare.
- **Support for Children at Schools & Facilities:** The state will ensure that CHC staff are equipped to provide first-level support to vulnerable children via assessment and referral services. Care teams will be trained to carefully examine distress and behavioural concerns before offering diagnoses such as ADHD and conduct disorder, as these labels carry stigma and can lead to children feeling alienated and also cause them to disengage from services. As human resources are strengthened, counsellors will be made available at schools and colleges (through clustering methods, in the case of resource constraints), along with strong parent-teacher-counsellor coalitions.
- **Support for Adolescents & Youth**: The state will seek to engage adolescents on the central importance of life skills in intimate relationships, sexual decision-making, and substance use. Investing in de-addiction services and resources for the rehabilitation of children and adolescents is an important secondary prevention measure, with training in harm reduction approaches for care teams. Keeping in mind the impact of substance-abuse issues, the state will identify and scale up interventions that are sensitive to childhood adversity and related vulnerabilities. Evidence-based techniques of meditative practice and anger management, tools of DBT and the use of storytelling, folklore and arts-based, movement-based therapeutic modalities through support circles (based on local cultural practices) are recommended to promote a stronger sense of affiliation to one's community and to build therapeutic gains. Promotion and dissemination campaigns will also include a focus on parenting skills in relation to children with behavioural concerns. Further, the use of the Good Behaviour Game initiated in accessible and child and youth-friendly ways, integrating cultural safety considering the mental health disparities in tribal populations may also support positive outcomes in the longer term (Kellam et al., 2011). Health messaging that supports healthy intellectual development and emotional health should be shared widely and in accessible and engaging ways.

- **Elderly Care & Support:** Given the range of mental health concerns experienced by elderly adults (including loneliness, depression, and anxiety), it is recommended that professionals across primary, secondary, tertiary levels as well as shelter/ elderly homes should be trained in geriatric mental health care. Further, professional training in specific approaches such as Cognitive Stimulation Therapy (CST) is recommended. This is an evidence-based therapeutic model developed in the UK by Spector et al., currently being adapted to the Indian context by the Schizophrenia Research Foundation (SCARF). From a promotion and prevention perspective, community-based activities and engagement can be critical in improving the quality of life, instilling a sense of hope, and aiding meaning-making processes. The adoption of models such as 'Experience Corps' (developed by AARP Foundation) – a volunteer-tutoring programme that engages people from the age of 50 as tutors for struggling /students – may foster participation and intergenerational connectedness. Elderly adults may also be prone to suicidal ideation and depression. Group care, meeting circles and fellowship opportunities may be encouraged in formal and informal structures.

- **Persons with Substance-Use Concerns**: Currently there are no public rehabilitation facilities although there are four Oral Substitution (OST) centres (Civil Hospital Shillong, Jowai, Tura and V.H.A.M centre, Nongmynsong) where counsellors are available. In addition, there are about ten private de-addiction centres in towns and cities. However, these are too few and far between for the size and terrain of the state because the drugs used for OST are restricted and issued for only two or three days or a week at a time, requiring very frequent visits to hospital outpatient clinics. The DMHP component of the NMHP has a presence in all 11 districts but is staffed by psychiatrists only in two. The state should aim to:
    - Establish awareness programmes at the community level to be run by schools, local governance bodies and local leaders.
    - Train medical officers at the district level to manage detox treatment for alcohol and opioids during admissions of a few days.
    - Train professional counsellors and school teachers in both awareness and intervention counselling.
    - Institute OST treatment for long-term maintenance at the sub-district level along with establishing a regulatory framework for dispensing these drugs.
    - Offer facilities for professional and lay counselling, and potential liaison with religious leaders in this effort.
    - Train psychologists, social workers and other professionals at primary, secondary and tertiary healthcare facilities in harm reduction approaches.
    - Upgrade the DMHP to include testing for HIV and Hepatitis-C and refer those testing positive to the nearest public medical college for treatment and advice on how to limit its spread.
- **Caregivers**: Caregivers themselves often face mental health concerns and require additional support, particularly elderly, young and lone parents. Adverse social and mental health impacts have often been associated with child and young caregivers in adult life (Ballal et al., 2019). The provisions related to family caregivers in the National Mental Health Policy 2014 will be adopted and implemented. Similarly, the provisions in the Mental Healthcare Act 2017 which provide financial or non-financial relief to the family caregivers will also be swiftly implemented. The state will streamline these procedures to avoid undue delays in issuing disability certificates to the persons with benchmark mental illness. The state will also draw up a scheme to provide financial help to low-income families who are compelled to admit their family members with severe mental disorders in private mental health establishments. The state needs to make arrangements for public employees who are required to be caregivers of a family member, such as staggered working hours, time off in emergencies, compassionate leave, exceptional paid or unpaid leave, or relaxation in transfers. Newer and diverse approaches to care may help parents address the many insecurities and feelings of inadequacy and anxiety that they may face owing to their ill-health, while Open Dialogue Therapy may support strengthening ties and building stronger connectedness despite the strain associated with caregiving, enabling them to better cope with disruptions as the child grows up, corresponding to different states on the spectrum of health and well-being that the parent may experience.
- **Persons homeless with mental issues:**. According to the Law of Administration of Justice, Meghalaya, Sardars, Laskars, Nokmas can bring ‘vagrants’ or ‘suspicious characters’ to jurisdictional police stations for further investigation. As indicated in the section on first responders, the police need to be trained in identifying and referring persons homeless with mental health issues to the appropriate care services. There are no precise numbers of persons homeless, but once that data is consolidated, including police data on the number of referrals of mentally ill persons from this ‘vagrant’ population, the system can accurately determine the need for specialised services for persons homeless and mentally ill. In areas where such people are more concentrated, such as border districts, it is recommended that the state train and equip district hospitals for short-term emergency and acute care,

and crisis support. This helps mainstream the distress of HPMI, and complies with the Mental Health Care Act, which stipulates that care has to be accessible to all. These facilities should also be made available for the larger non-clinical homeless population as well to access medical and psychological care as needed. Availability of care at the earliest in the case of homeless persons prevents abuse, development of comorbidities such as substance use, grave injuries, nutritional deficits; exacerbation of distress, separation from loved ones, ability to remain connected to one's place of origin and therefore access to continued mental health and social care locally. Additionally, a missing persons database may also be created to enable cross sectoral and cross regional coordination, particularly in the case of homeless persons who are young, elderly, living with mental health conditions, dementia, Alzheimer's disease or intellectual disability.

- **Persons with intellectual disabilities**: As indicated by field reports, intellectual disability (ID) is a commonly reported concern in Meghalaya. While services for ID are offered by various institutions (including PHCs, district early-intervention centres, non-profit organisations etc), it is essential to further strengthen these services and address causal factors ranging from environmental toxins to maternal health and unsafe birthing practices.
    - ***For children and adolescents***, this includes offering comprehensive training to identify ID, supporting families in caring for a member with ID, reviewing educational policies and school curriculums to integrate inclusive education, and developing specific care guidelines and protocols for childcare institutions (based on rights-based frameworks, including sexual and reproductive rights). ○ ***Older people*** with ID are more prone to health-related conditions than others of a similar age, owing to a combination of genetic and lifestyle factors, which could accumulate over a person's lifetime and have a greater impact as they age (Bauer et al., 2019). Regular screening for health-related issues and monitoring of nutrition and diet are essential, particularly in institutional / shelter-based settings. Being involved in age-appropriate work (such as vocational training activities typically used for persons with ID) may offer a level of physical and mental stimulation.
- **LGBTQIA+ community:** Members of the LGBTQIA+ community face several unique stressors arising from their identities (Ranade, K et al., 2022). They tend to face a range of challenges, including prejudice, discrimination and internalised homophobia (Meyer, 1995), and may experience low self-esteem, anxiety, self-doubt, and an inability to lead a meaningful, fulfilled life (Ranade, K et al., 2022). In line with the National Legal Services Authority (NALSA) judgement in 2014 (affirming the right to gender self-identification), the repeal of Section 377 (decriminalising homosexuality), and the Mental Health Care Act (2017), people who access mental health services should not face discrimination based on their gender and sexual identity. Mental health professionals will not recommend practices such as so-called 'conversion therapy', nor pathologize queer identities. Further, in line with the National Medical Commission (2022) directive to all State Medical Councils, inaccurate and outdated content on the LGBTQIA+ spectrum needs to be removed in all medical subjects including psychiatry and replaced with revised content. It is recommended that health professionals across primary, secondary and tertiary levels undergo training in – understanding concepts related to gender and sexual identities / orientations and heteronormativity, along with using queer-affirmative therapeutic practices as well as family systems approaches. Collaborations may be explored with NGOs and persons with lived experiences to strengthen peer-led movements and safe spaces for the community. Medical and surgical gender affirmation procedures must be made available. IEC materials (highlighting that LGBTQIA+ identities are not disorders) will be a key part of larger health promotion and dissemination campaigns, as elaborated under Section 1b (under Guidance for Action).
- **Migration and related distress:** It is essential to extend health services and social welfare schemes to migrants coming to the state to seek work. Schemes such as the 'guest worker' approach (offering residential camps, medical services and counselling support) implemented by the state of Kerala may be considered. Migrants who are experiencing severe mental illnesses and homelessness are generally taken to MIMHANS by the police, in compliance with the MHCA. It is therefore important to develop strong training protocols for the police to ensure sensitive care from the first point of contact.

Section 5. Implementation Strategy

To effectively execute the policy framework described above, there is need for a particular focus on implementation, and attention to potential barriers to achievement of the Mental Health Policy goals. This policy identifies four enabling dimensions that can help ensure successful implementation.

1. Convergence Across Departments & Policies		
2. Strengthening Human Resources	**2. Community Institutions**	**4. Financial Support & Infrastructure**

Table 6: Key Aspects of the Implementation Strategy

5.1 Convergence Across Departments & Policies

Challenges

- **Lack of comprehensive care approach:** Comprehensive care calls for multi-stakeholder collaboration and the participation of health, social and education sectors. The mental health sector is rife with stories of individuals who have left the health system and reverted to ill-health and isolation in the absence of social and community networks that help sustain well-being by creating access to resources such as jobs, livelihood seed grants, social cooperatives, supported employment programmes, housing in thriving communities (or whatever the individual prefers), disability allowances, basic income, scholarships for children, support groups, religious and cultural activities, crisis prevention/intervention centres or programmes, civic and political participation, including being able to vote, or campaign for office. Each person's process of recovery is unique, and there may be several ups and downs. Stability through these networks also builds trust in the system, and one's place within it (Salzer, 2021).
- **Missed opportunities to ensure economic & social inclusion of those with mental illness:** Wolfensberger et al. (1972) hypothesised that those who do not participate in valued social roles – such as work, school, religion, or family – were at risk of being diminished and devalued by society, leading to abuse, neglect, isolation (e.g., institutionalisation), and even premature death. He discussed the need for the 'creation, support, and defence of valued social roles for people at risk for devaluation'. The social model of disability places the onus not on the individual but on a society that fails to provide an environment in which all individuals, each with their own strengths and challenges, can participate and thrive. An inclusive society both allows for the integration of persons with disabilities in mainstream society and welcomes their participation and inputs, enabling them to choose how best to reach their own goals, without being forced into limited roles in the absence of rights-based systems, programmes and policies.
- **Mental illness not treated as a disability:** The Rights of Persons with Disabilities Act, 2016 recognised Mental Illness as one of 21 disabilities. The Government of Meghalaya also developed a State Policy for the Empowerment of Persons with Disabilities in 2019 and The Meghalaya Rights of Persons with Disabilities Rules, 2017. These entail offering access to benefits in areas including education, livelihoods and independent living. In reality, however, persons with mental illness have not always been able to access such benefits. The Ministry of Social Justice and Empowerment, Government of India (2022) reported that the Meghalaya State Government has issued 22,244 persons with disability certificates and 23,805 with e-UDID cards. According to the Social Welfare

Department, Government of Meghalaya, 14,237 people with disabilities are accessing the Chief Minister's Social Assistance Scheme (offering Rs 500 per month). However, according to the department, these disability allowances are not currently being offered to persons with mental illness, indicating a gap in health and social care provisions. Recognition of mental illnesses as disabilities, not just by health professionals but also by the various government departments, is crucial to ensuring effective care and recovery pathways.

Strategy

- **Align all departments and agencies through the Meghalaya Human Development Council:** The Human Development Council will spearhead the convergence between the mental health policy, targeted missions on substance abuse, MPOWER and other relevant initiatives. In addition to policy convergence, the Human Development Council will serve as the body through which departments can align implementation plans, review progress, and adapt policy as needed, given any new challenges or developments on the ground.
- **Integrate Public Mental Health (PMH) within the Comprehensive Primary Health Care (CPHC) approach of the state:** Orient state's Comprehensive Primary Health Care approach away from any single or linear definition of "good mental health," but rather, towards the purpose of enabling all individuals to reach a state of well-being that supports their goals.
- **Establishment of a Policy Implementation Unit within the State Mental Health Authority and District Convergence and Implementation Committee** . In keeping with the mandate of the Mental Healthcare Act, 2017 (MHCA) and the NMHP mandating mental healthcare as a basic right, the State Mental Health Authority (SMHA), will ensure the integration of all mental healthcare services. A policy implementation unit can be created under the SMHA that will oversee and develop an implementation plan to ensure the advancement of the policy. Similarly, the district committee will coordinate actions at the district level. The PIU and district committee will incorporate representatives from the key stakeholder departments and agencies, eg. Social Welfare Department, Health & Family Welfare Department, and the State Health Resource Centre (SHRC), among others. Some activities that can be facilitated:
    - Defining the problem statement and the priority mental health issues that concern the state, especially issues that are persistent, complex, and affect a large number of people across demographics (Badgett, 2022).
    - Define metrics that will measure not just the impact of each stakeholder, but the impact of cross-sectoral collaborations, and which can inform implementation, eg. by tracking the most effective forms of outreach, screening, etc.
    - Identify teams that will come together periodically to review progress and implementation challenges, developing recommendations for improvements.
- **Connect mental health with socio-economic inclusion:** Departments of social welfare and justice, disability, women, child and tribal welfare can facilitate employment, basic income-type interventions and other social security schemes to prevent individuals from descending into a state of poverty and destitution. To enable recovery and enhance care, and a supportive environment for persons with mental illness, their caregivers and family members, a priority system can be introduced in various schemes and services (e.g., health care, housing, education, livelihoods, allowance/pension, travel concessions, or legal aid). Village health councils can play a key role in facilitating social entitlements, with a focus on community inclusion, promoting access to job opportunities through social cooperatives and home-based entrepreneurial efforts; and stronger support structures through affinity groups or SHGs. This priority access system will be monitored annually by preparing statistical reports and being able to identify and address any bottlenecks for specific groups or regions.
    - **Basic Income pilots:** Benefits associated with social security, such as the introduction of basic income and access to finance, have been highlighted in the context of high-income

countries (Albert et al., 2017). The main benefits include significant improvements in mental health, general health and well-being, as well as a marginal increase in participation in the labour force, indicating an association between stability, agency and constructive behaviours that affect the quality of life. Unequal or inequitable access to resources and health care can affect vulnerable populations in devastating ways. It is therefore recommended that those who are ultra-poor or acutely socially disadvantaged obtain access to cash transfers that are unconditional to gain a level of social capital that may not only enable them to overcome poverty but also have a ripple effect in other social spheres. Lone women-headed households, the elderly, vulnerable caregivers, pregnant women in distress and those living with disabilities (including psycho-social disabilities) may be prioritised.

5.2 Strengthening Human Resources

Challenges

- **Lack of trained personnel:** The main difficulty in all settings is a lack of trained personnel. Mental health professionals take on a large workload because there are so few trained professionals in the state. As a result, care teams are often exhausted, particularly when facilities are working at full, or even exceed, bed capacity. The division of labour is also unclear, such as the specific roles of community mobilisers, traditional healers, peer advocates, local leaders and lay counsellors. This is also true of the DMHP. While the programme works across all districts, it is not uniformly staffed owing to budgetary and personnel constraints. This also increases patients' and families' out-of-pocket expenditure, as those experiencing SMDs have to travel to MIMHANS or Tura Civil Hospital.
- **Limited training opportunities focused on integrated care approaches:** There is limited provision of training that would facilitate effective mental health and social care at various levels, ranging from early identification of distress to appropriate referral and continued or long-term care. Nor are there any integrated cross-sectoral and cross-cultural training structures. Further, there is negligible training in public mental health and domain-specific approaches (for instance, women-centred services, child and adolescent counselling, de-addiction services, the use of trauma-informed approaches etc) that may affect people over the course of their life. There are no options in psychiatry and related fields in medical training, and the role of psychiatric nurses is unclear.

Strategy

- **Expand Human Resources**: The state will work towards expanding the number of human resources in at least three core professional arenas: psychiatry, nursing, social work and psychology. These human resources will provide specialised care, particularly for severe cases. Expansion of mental health care professionals should help alleviate the burden on other medical staff on mental care provision and would lead to better referral systems from community health workers to specialised staff.
- **Curriculum Development**: The state will develop contextually-tailored curriculum for mental health care that takes into account the specific local drivers of mental health issues. The curriculum would have modules that are customised for different care providers such as community health workers, medical officers, mental health care professionals and even community leaders. The curriculum would also be developed for targeting mental health disorders for different age groups and vulnerable groups.
- **Training of Existing Staff & Community Health Workers:** All medical officers, support staff and community workers such as ASHAs and AWWs will be trained on updated mental health curriculum. Moreover, all the care providers would undergo periodic refresher sessions. Community workers will be supported and supervised by medical officers who liaise with DMHP specialist mental health teams comprising social workers and psychologists, or MIMHANS, for expert guidance using tele-based psychiatric consultations and other technology-based methods.
- **Human resource development in the mental health and social sectors:** There are very few mental health professionals (psychiatrists, nurses, social workers and psychologists) in the state and require urgent investment to boost the number of trained professionals. With the growing gap in human

resources, there is an immediate need to also re-examine the different roles performed by the current personnel. The tasks related to mental well-being and the promotion of mental health care, preventive approaches with at-risk populations and social/vocational rehabilitation measures will be moved to non-specialists who will undergo short-term training and offered in both institutional and community settings supervised by social care specialists and teams. Community members will also be trained to offer such services in collaboration with the DMHP, hospitals and MIMHANS. It is also essential that this workforce is incentivised accordingly, as their workload increases.

- **Standard Assessment & Treatment Guidelines:** The state will develop standard guidelines for assessment/screening and treatment in line with the best practices. These will be incorporated as part of the shift towards comprehensive primary health care (CPHC). The guidelines will help ensure a basic standard of care is provided across the state. Moreover, the guidelines will be made available to care providers on a technology platform that makes it easy to search and access all the material.

5.3 Community Institutions

Challenges

- **Low involvement of communities**: As discussed earlier, there is limited involvement of communities in addressing mental health care challenges. Without community involvement, the state can't make progress on reducing stigma on mental health challenges and increasing demand for health services.
- **Lack of coordination toward community involvement**: Different state departments often hold parallel initiatives for community engagement but don't often coordinate activities. This also manifests as a high number of community committees that have overlapping mandates. As such, there is a strong need for a nodal community institution that can address all health, nutrition and mental well-being issues.

Strategy

- While the state aims to improve coordination and convergence across all relevant departments, attention will also be paid to mobilising and empowering **Community Institutions**. Community engagement is an integral part of Meghalaya's mental health policy and approach, as it is the bedrock for prevention, early detection & long term social support. While all members of society will be engaged through awareness-raising, outreach and other initiatives, the following institutions will be a primary focus of the policy:
    - ***Village Health Councils*** will serve as the nodal community agency for disseminating information, reducing stigma and providing local social support to those with mental illness and their families.
    - ***Village Headmen*** are often the first point of contact for distressed families and will be proactively engaged in early identification, as well as in assisting families in addressing social and economic factors behind illness.
    - **Other *trusted community leaders***, such as *teachers, religious leaders & traditional healers*, will be engaged through community health workers & VHCs, to assist in reducing stigma, raising awareness of the importance of mental health, and early detection of mental health disorders and illness.

5.4 Financial Support & Infrastructure

5.5 *Challenges*

- **Low overall funding for mental health:** While the health budget is aimed to be 2.5% of the GDP (MOTHER, 2021) funds towards mental health have been insufficient, and as a result, public mental health, especially investment in personnel and capacity building, may be inadequate.

- **Access challenges:** Poor referral systems often result in high out-of-pocket expenditure on travel and also loss of wages, which impede access to mental health care. Providing medication, social support and mental health services closer to home requires more attention.
- **Out-of-Pocket Expenses:** In addition to exacerbating mental health conditions, poverty and social disadvantage also further heighten the treatment gap. Many patients and their families incur high out-of-pocket expenses (Murthy, 2017). On average, Rs 1,500 was spent on treatment and care of persons affected with alcohol-use disorder, and Rs 2,000 per month for bipolar affective disorder. For any category of mental disorder Rs 1,000 (median) and above had to be spent on care and treatment. In Meghalaya, while there is no available data on out-of-pocket expenditure specific to mental health treatment, the Health Dossier 2021 report estimated the overall expenditure incurred in accessing health services (Health Dossier 2021: Reflections on Key Health Indicators – Meghalaya, 2021) (see Table 7). High out-of-pocket expenditure (particularly the rural–public and urban–private expenditure, which is significantly higher than the national average) can dissuade people from accessing care services and consequently exacerbate their health conditions.

Out-of-pocket expenditure (OOP) (in INR)	Meghalaya		India	
	Rural	Urban	Rural	Urban
OPD – Per non-hospitalised patient in last 15 days – Public	1,073	0	472	486
OPD – Per non-hospitalised patient in last 15 days – Private	647	2,275	845	915
IPD – Per hospitalised case – Public	2,201	8,219	5,729	5,939
IPD – Per hospitalised case – Private	15,591	29,618	28,816	34,122
IPD – diagnostics as a percentage of inpatient medical expenditure – Public	10	11	18	17
IPD – drugs as a percentage of inpatient medical expenditure – Public	62	55	53	43

Out-of-pocket expenditure estimated by NHSRC using unit level data of NSSO 2017-18 (where OOPE = [Total Medical Expenditure + Transport Cost] – Reimbursement). Source: Health Dossier 2021: Reflections on Key Health Indicators – Meghalaya.

Table 7: Out of Pocket Expenditures in Meghalaya

Strategy

- **Extend provision of medication and infrastructure to more local areas, prioritising high-use PHCs/CHCs and Sub-Centres:** Essentials such as infrastructure and access to medication are already available in the state but need to be provided locally; Sub-centres could be deployed for this purpose. This will reduce expenditure, travel difficulties, and delays in seeking care.
- **Increasing take-up of MHIS**: Megha Health Insurance Scheme (MHIS), a universal health insurance scheme (UHIS) in the State of Meghalaya, provides health insurance to everyone living in the state,

excluding state and central government employees. The scheme was launched to provide financial aid to all citizens at the point of hospitalisation and reduce out-of-pocket expenses. Megha Health Insurance Scheme – Phase IV works in convergence with Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana. The state will work to increase take-up of MHIS to ensure that cost does not dissuade families from seeking treatment. Community institutions can help raise awareness on provisions available under MHIS. In addition to offering insurance for general health concerns, all public and private hospitals offering inpatient psychiatric services will be empanelled under the scheme, to extend financial aid to those with mental health concerns requiring inpatient care, thereby enabling universal access to care services.

- **Increasing the budget for mental health in the state:** Of the direct budget allocated for mental health under the MoHFW, most of it, ₹557.44 crores (93%), is allocated toward two centrally funded mental health institutions with the remaining ₹40 crores (7%) allocated to the National Mental Health Programme (NMHP). The state will consider how best to supplement this budget, as well as how best to leverage existing resources. For example, a "collective pool" system of resources across relevant departments may be considered for convergence initiatives.

Section 6. Quality Standards, Monitoring & Evaluation, and Key Outcomes

6.1 Ensuring Quality Standards

Quality standards in mental health seek to provide assurance of equitable, just and effective services and protection of human rights in institutional and outpatient settings, integrating health and social care. While seeking to build accountability in service delivery, they consider and seek to address the broader exclusionary environment facing people with psycho-social disabilities. Quality standards need to continually seek to incorporate best practices in the context to ensure that the highest possible form of care is available at the appropriate time, place and form. To build a dynamic quality of care framework, the state will:

1. Develop specific and measurable quality standards for services across the continuum of care to ensure the provision of high-quality services for those using or experiencing them, adherence to service-user safety and optimisation of clinical effectiveness.

2. Derive user-generated quality expectations and associated standards including but not limited to the following domains:

    a. Meet minimum staffing requirements, including adequate diverse representation, knowledge, perspectives and skills for service delivery.

    b. Meet minimum standards of infrastructure and access to food, clothing and other essentials in inpatient services.

    c. Timely, appropriate and comprehensive access to care that minimises fragmented services.

    d. Culturally sensitive assessment and admission.

    e. Information and access to personal records.

    f. Capacity and consent processes for evaluating care options, participatory care planning and opting in/out of services.

    g. Discharge options, including access to a range of self-directed community entry pathways.

    h. Oversight for human rights assurance and escalation for violations.

i. Learning environment: changes in the mental health system aligned with user feedback and new contextual realities.

3. Establish mechanisms for continually updating quality standards based on user feedback and emerging evidence in a given context.

4. Align quality standards with the WHO Quality Assurance Toolkit and the major themes of the UNCRPD:

   a. Right to adequate standard of living and social protection.

   b. Right to enjoyment of the highest attainable standard of physical and mental health.

   c. Right to exercise legal capacity and the right to personal liberty and the security of person.

   d. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse.

   e. Right to live independently and be included in the community.

5. Establish dedicated assessment committees with service user–carer representation to continually monitor, assess and take the necessary action to adhere to quality standards in inpatient and outpatient settings.

6. Conduct a comprehensive assessment of facilities and services against quality standards and follow up with commissioned plans and necessary financial resources to improve from the established baseline.

7. Create a system for monitoring, reporting and addressing human rights violations in inpatient and outpatient settings.

8. Align service monitoring and evaluation (M&E) indicators that assess clinical effectiveness, service-user outcomes encompassing quality of life and well-being measures, service-user experience and safety.

9. Establish practices and processes, such as open days, a grievance cell, visitors' access, services such as a café allowing engagement with the wider world, to promote transparency and accountability across inpatient and outpatient services.

10. Establish a mental health service accreditation body with processes and procedures for reviewing quality standards and associated licensing and rating mechanisms.

Develop state rules and oversight processes to ensure compliance with the Mental Health care Act 2017, in particular procedures for admissions and discharge, setting up of Mental Health Review Boards (MHRBs) and use of advance directives. Access local Mental Health Review Boards to seek support to address violations, grievances and expressed needs.

6.2 Monitoring & Evaluation

The implementation of the Meghalaya State Mental Health Policy encompasses fundamental changes in thinking and acting at different levels, as well as in organisational networks and governance structures. This challenging task can be assisted by accompanying research and M&E efforts, provided these are closely aligned with the aim of the policy, involve relevant stakeholders – including (potential) clients/patients – and support mutual learning and reflection.

Reflexive monitoring and evaluation

- ***Establish meaningful measurements*:** Given the high and far-reaching ambitions of the policy, progress and impact indicators will be manifold and varied. They may refer to outcomes in terms of prevalence of disorders (e.g., substance use, common mental disorders), but may also refer to governance innovations (e.g., convergence between health and social sectors, integration of cultural specificity in services), or to inputs (available resources, trained staff). Establishing a set of indicators related to the stated policy goals and objectives will be done with (potential) service users, providers and programme staff to ensure that the agreed measurements are meaningful from multiple perspectives (e.g., clients/patients, service providers, policymakers) at the same time. Meaningful measurements should encompass the strategic priorities and the quality standards (see previous section).

- ***Periodic, collaborative audits**:* As per the **Meghalaya Community Participation and Public Services Social Audit Act (2017**), audits of the stated policy goals and objectives (translated into meaningful measurements) will be conducted by an independent party in close collaboration with actors across the mental health/social care system, including (potential) clients/patients. Auditors will adopt a monitoring and evaluation methodology (e.g., Reflexive Monitoring in Action, Appreciative Inquiry) that allows for continuous reflection on (systemic) barriers and opportunities and at the same time builds and strengthens (existing) capacities to co-create more inclusive and integrated services, programmes and policies. It is preferable to adopt a mixed-methods approach (quantitative, qualitative, transformative). The annual collaborative audits will allow for a periodic assessment of the stated policy goals and objectives, and facilitate any necessary adaptations and improvements. These periodic reviews will inform the policy updates in a changing context. The policy will undergo a review initially two years after implementation and every four years thereafter.

Transdisciplinary research

- While the continuous, reflexive M&E framework is particularly helpful in understanding and supporting efforts to address mental health challenges in Meghalaya, separate research is needed to deepen the understanding of patterns underlying the current situation and examine the long-term efficacy of the piloted approaches. Transdisciplinary research starts from real-life problems, is conducted alongside the relevant stakeholders, and aims to contribute to addressing problems as part of the research process. It takes the problems as people define and experience them (especially the most vulnerable) as a starting point. The research agenda should be co-created with relevant stakeholders and is expected to comprise research topics across all layers of the socio-ecological model, ranging from research on stressors and protective factors for well-being and people's mental health to research on integrated health and social care systems, while integrating research on social, cultural, and temporal patterns in relation to these. Because of its transdisciplinary character, the research agenda covers the current and planned situation as well as the transformative process set in motion through this policy. Research will aim to develop a science of mental health with knowledge co-produced with multiple stakeholders and disciplinary collaborations and convergences. Research initiatives will be linked to priority services such as screening, measures of the effectiveness of interventions, and health system functioning. Implementation and innovation will be thus informed by emerging evidence in context.

- **Research thematic priorities include:**

    - Clinical and social epidemiology of mental health conditions.

    - Ecosystems, contextual, socio-cultural formulations of mental health and ill-health (particularly of concerns such as ADHD and conduct disorder, and culture-bound syndromes).

    - Causes, risks, and protective factors for mental health conditions.

    - Understand disparities and associated mental health inequities in the state.

- Associations between socio-cultural factors and mental health epidemiology, health-seeking and access and recovery trajectories.
- Evaluations of the effectiveness of established practice and new approaches (for instance, use of storytelling and folklore) to gauge how well these meet recovery priorities in the local context.
- Understand social care applications and linkages to prevention, promotion and treatment of diverse mental health conditions.
- Support promotion and preventive initiatives for people's well-being.
- Access and choice to mental health among diverse communities and regions.
- Implementation science with particular focus on how new approaches can be put into practice in the health system and scaled for impact.

6.3 Key Outcomes

Through the Mental Health and Social Care Policy the state will bring focused energy to implementation of the following key inputs, to achieve the essential outcomes and impacts for transformational change of the mental health landscape.

Inputs	Outcomes	Impact
→ Increase in mental health human resources such as psychiatrists, psychologists and nurses. → All medical officers and community health workers trained on assessing and addressing mental health issues. → Streamlining of referral process. → Coordination across departments & policies under Human Development Council. → Expansion of mental health helpline. → Creation of support groups under VHCs, guided by community health workers.	→ Monthly IEC campaigns in all communities on mental health issues. → Annual school and community-based screening for mental health for every citizen. → Faster & cheaper referral process, with reduced out of pocket expenditure. → Increased access of schemes & programs by the mentally ill. → Increased number of initiatives targeted at preventive measures such as addressing stress among vulnerable groups. → Community support groups meeting for regular discussion & activities.	→ Higher rates of identification of mental health disorders. → Reduced wait times and costs for treatment. → Lower percentage of suicidal thoughts reported by adolescents. → High rates of care seeking among population. → Lower prevalence of substance use. → Lower rates of mental health disorders due to preventive programs. → Reduced stigma and greater social integration for those suffering from mental illness.

Table 8: Key Outcomes of the Mental Health Policy

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Annexure 1: Drafting Committee Notification Orders by the Governor, Meghalaya

GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT
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ORDERS BY THE GOVERNOR
N O T I F I C A T I O N

Dated Shillong, the 7lh March, 2022.

Drafting Committee for preparing the Mental Healthcare Policy for the State

No.Health. 180/2017/217. - The Governor of Meghalaya is pleased to notify the Drafting Committee for preparing the Mental Healthcare Policy for the State with the following members:-

			MEMBERS:
1.	Principal Secretary/Commissioner & Secretary. Health & Family Welfare Department.	-	Chairperson
2.	Principal Secretary/Commissioner & Secretary. Sport & Youth Affairs.	-	Co-Chairperson
3.	Secretary. Health & Family Welfare Department.	-	Member Secretary
4.	Mission Director. National Health. Mission (NHM).	-	Member
5.	Director of Health Services(Ml).	-	Member
6.	Director of Health Services (Research etc).	-	Member
7.	Joint Secretary, Law Department.	-	Member
8.	Director Social Welfare Department.	-	Member
9.	Director of Education.	-	Member
10.	Director Indian Institute of Public Health.Shillong	-	Member

Term of Reference:-

1. To prepare the draft policy for Mental Healthcare for the State.
2. To conduct consultative meeting with other related agencies pertaining to the Mental Healthcare issues.
3. Committee can co-opt expert members as deem fit for the purpose.
4. Any other matter relevant for the purpose.

M. N. NAMPUI,
Commissioner & Secretary to the Govt, of Meghalaya,
Health & Family Welfare Department.

Memo.No.Health.180/2017/217 Dated Shillong, the 7th March, 2022.

Copy forwarded to:-

1. P.S. to Minister i/c Health & Family Welfare Department for kind information of Minister.
2. P.S. to Principal Secretary, Health & Family Welfare Department for information.
3. P.S. to Principal Secretary/Commissioner & Secretary, Sport & Youth Affairs Department for information.
4. Secretary, Health & Family Welfare Department for information.
5. Mission Director, National Health Mission (NHM), Meghalaya, Shillong for information.
6. Director of Health Services(MI)/(Research etc), Meghalaya, Shillong for information.
7. Joint Secretary, Law Department, Meghalaya, Shillong for information.
8. Director Social Welfare Department, Meghalaya, Shillong for information.
9. Director of Education, Meghalaya, Shillong for information.
10. Director Indian Institute of Public Health, Shillong, Meghalaya, Shillong for information.

By Orders etc.,

Under Secretary to the Govt. of Meghalaya,
Health & Family Welfare Department.

GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

ORDERS BY THE GOVERNOR
NOTIFICATION

Dated Shillong, the 26th September, 2022.

Sub-Committee to draft, research, organise and liaison with stakeholders for the "Meghalaya State Mental Health Policy2022"

No.Health.180/2017/265:- In partial modification of this Department's Notification No.Health.180/2017/255, dated 11/8/2022, the Governor of Meghalaya is pleased co-opt more members to the Sub-Committee to draft, research, organise and liaison with stakeholders for the "Meghalaya State Mental Health Policy 2022".

In this connection, the list of members of the Sub-Committee are as follows:

Designation	Name	Contact details
Chairperson	Dr. Vandana Gopikumar, Co-founder, The Banyan and Banyan Academy of Leadership in Mental Health (BALM)	+91-9840527893
Chairperson	Dr KV Kishore Kumar, Director, The Banyan and Banyan Academy of Leadership in Mental Health (BALM)	kishore@thebanyan.org
Chairperson	Dr Sanjeev Jain, Former Dean, Department of Psychiatry, National Institute of Mental Health and Neurosciences (NIMHANS)	docsanjeev.jain@gmail.com
Chairperson	Dr Alok Sarin, Consultant Psychiatrist, Sitaram Bhartia Institute of Science & Research	aloksarin@gmail.com
Member Secretary	Dr. S.S. Nongbri, DHS (Research)	+91-9402327030
Member	Dr.PakhaTesia, MD Psychiatry, Senior Consultant Psychiatrist, Bethany Hospital, Shillong	+91-9436337949
Member	Dr. Sonali Shinde Tesia, MD Psychiatry, Mind and Wellness Clinic, Shillong	+91-9436337948
Member	Dr.RaajKonwar, MD Psychiatry, Head of Department Psychiatry, Nazareth Hospital	+91-961217667
Member	Dr. Arvind Nongpiur, MD, DPM Psychiatry, Head of Department & Associate Professor Psychiatry, North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences, Shillong	+91-8794713113

Member	Smti. ManiungNiangti, Founder, Listening Tree, Shillong	+91-7005176458
Member	Shri Anirban Paul, Policy Consultant, Office of the Hon'ble Health Minister	+91-8197424773
Member	Shri KerlangMalngiang, Policy Consultant, Office of the Hon'ble Health Minister	+91-9953432234
Member	Shri Dilshad Ahmad, Fellow, P.A. Sangma Fellowship for Legal and Policy Research	+91-8319872311
Member	Dr W.Shira,Sr Medical OfficerMIMHANS	wanes1e@gmail.com
Member	Shri Saurabh Sashi Ashoke, Policy& Law Team, SAMVAD	saurabh@nimhnaschildprotect.in
Member	Dr. B. Mawlong, Additional Superintendent MIMHANS.	
Member	Dr. A. K. Roy, Sr. Psychiatrist Civil Hospital Shillong, cum Nodal Officer National Mental Health Programme (NMHP).	ashokroy1980@gmail.com
Member	Dr. Andrecia, Psychiatrist, MIMHNAS.	
Member	Deepika Easwaran, The Banyan and BALM	deepika@balm.in
Member	Dr Barbara Regeer, Associate Professor, Athena Institute, Vrije Universiteit, Amsterdam	b.j.regeer@vu.nl
Member	Dr Lakshmi Narasimhan , Principal Consultant, TSI Consulting LLP	lakshmi@tsiconsulting.in
Member	Dr Archana Padmakar, The Banyan and BALM	archana.padmakar@thebanyan.org
Member	Dr Nev Jones, Commissioner for the Lancet Psychiatry Commission on the Psychoses in a Global Context	nevjones@pitt.edu
Member	Dr Andrew Willford, Professor of Anthropology, Cornell University	acw24@cornell.edu
Member	Dr Nachiket Mor, Visiting Scientist, BALM	nachiket@nachiketmor.net

Member	Mr Amrit Bakhshy, Managing Trustee, Schizophrenia Awareness Association	akbmail@gmail.com
Member	Dr Anirudh Kala, Psychiatrist & Chairman, Mind Plus, Ludhiana	anirudhkala@gmail.com
Member	Anjali Singla, Psychologist, The Insightful Mind Therapy, Certified Clinical Trauma Specialist, Member, International Society for the Study of Trauma & Disassociation (ISSTD)	anjalisingla17@gmail.com
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Member	Dr KS Ramesh, The Banyan and BALM	ramesh@balm.in
Member	Dr Lakshmi Sankaran, The Banyan and BALM	lakshmi.sankaran@balm.in
Member	Mrinalini Ravi, The Banyan and BALM	mrinalini@thebanyan.org
Member	Madhurima Ghosh, The Banyan and BALM	madhurima@thebanyan.org
Member	Namrata Rao, The Banyan and BALM	namrata@thebanyan.org
Member	Dr Deborah Padgett, Professor, NYU Silver School of Social Work	dkp1@nyu.edu
Member	Dr Lakshmi Lingam, Dean & Professor, School of Media and Cultural Studies, Tata Institute of Social Sciences, Mumbai	lakshmil@tiss.edu
Advisory Members	Dr Avani Shukla, Mental Health Advocate, Founder, Warriors Connect	avani@warriorsconnect.in
Advisory Members	Dr Raja Samuel, Principal, Madras School of Social Work	principal@mssw.in
Advisory Members	Dr Sonia Pereira Deuri, Professor & Head, Dept. Of Psychiatric Social Work, LGB Regional Institute of Mental Health, Tezpur, Assam	soniadeuri28@gmail.com

Advisory Members	Dr Joske Bunders, School of Public Health, MIT-World Peace University	joske.bunders@falw.vu.nl
Advisory Members	Dr Asha Banu Soletti, Professor, School of Social Work, Tata Institute of Social Sciences, Mumbai	ashabanu@tiss.edu

Terms of Reference:

1. To come up with a holistic draft of the Meghalaya State Mental Health Policy
2. To build upon the work done by SAMVAD(NIMHANS)Team by taking their assessments study/recommendations for child and adolescent mental Health.
3. To liaise and consult with relevant stakeholders.
4. To conduct fieldwork and research to assess and evaluate the state's current mental health scenario.

Sd/-
(Smti R.M. Kurbah, IAS.,)
Secretary to the Govt. of Meghalaya,
Health & Family Welfare Department

Memo No. Health. 180/2017/265-A **Dated Shillong, the 26th September, 2022.**

Copy to:

1. P.S. to Minister i/c Health & Family Welfare Department for kind information of Minister.
2. P.S. to Principal Secretary, Health & Family Welfare Department for information of the Principal Secretary
3. P.S. to Principal Secretary/ Commissioner & Secretary, Sports & Youth Affairs Department for information of the Principal Secretary/ Commissioner & Secretary.
4. Secretary, Health & Family Welfare Department for information.
5. The Mission Director, National Health Mission, Meghalaya, Shillong, for information.
6. The Director of Health Services (MI)/(Research), Meghalaya, Shillong.
7. Joint Secretary, Law Department, Meghalaya, Shillong for information.
8. Director Social Welfare Department, Meghalaya, Shillong for information.
9. Director of Education, Meghalaya, Shillong for information.
10. Director Indian Institute of Public Health, Shillong for information.
11. All Members of the sub-committee for information.

By order, etc.,

Under Secretary to the Government of Meghalaya,
Health & Family Welfare Department.

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