Mental Health & Social Care Policy, Meghalaya

(Draft Meghalaya State Mental Health Policy)

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GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

ORDERS BY THE GOVERNOR
NOTIFICATION

Dated Shillong, the 7th March, 2022.

Drafting Committee for preparing the Mental Healthcare Policy for the State

No.Health.180/2017/145 :- 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(MI)	-	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.

(Sd/-M.N.Nampui, IAS.,)
Commissioner & Secretary to the Govt. of Meghalaya,
Health & Family Welfare Department

Memo.No.Health.180/2017/145-A **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.
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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.

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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
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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.**

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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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Limited public mental health interventions

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Limited focus on flourishing and well-being

Poor multi-sectoral convergence that addresses disability-related concerns and barriers

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Early identification and appropriate care and referral for Common Mental Disorders and Severe Mental Disorders

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
DBT – Dialectical Behaviour Therapy
DMHP – District Mental Health Programme
GAD - Generalised Anxiety Disorder
GDP – Gross Domestic Product
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
MIMHANS – Meghalaya Institute of Mental Health and Neuroscience
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 – Post-natal 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
SMI – Severe Mental Disorder
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

Executive Summary

Advancing mental health has gained recognition as integral to achieving equity and vice versa, and increased acknowledgement of people being able to live the lives they value as an important population well-being parameter. Therefore, the theme of World Mental Health Day 2022 - 'Make mental health & wellbeing for all a global priority', is of utmost significance. The drafting committee of this policy joins persons with mental health concerns, care providers, mental health and social care practitioners, scientists, advocates, governments and various other stakeholders across the world, in reflecting on this vision and working towards making mental health a priority in our context, to positively impact people of the state of Meghalaya, particularly those disadvantaged and living in underserved contexts. Drawing from a Social Justice Framework and the World Health Organisation's (WHO) Global strategy on integrated people-centred health services, and guided by the National Mental Health Policy (NMHP) 2014, the UNCRPD and capabilities-based approaches, this policy focuses on strengthening mental healthcare systems and care pathways, addressing social determinants such as disadvantage, inequities and vulnerabilities and therefore aims to build enabling environments, and consequently, improve life satisfaction.

With about 150 million people in India estimated to live with a diagnosable mental health condition, and nearly 83% of individuals without access to mental healthcare services (Murthy, 2017), the magnitude of the mental health crisis in the country is undoubtedly immense. Further, the terrain of the state of Meghalaya, in combination with other socio-cultural factors are associated with other unique and complex challenges, which require culturally specific, feasible and sustainable interventions. Therefore, a comprehensive 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 from the health and social care departments, NGOs, service users, tribal leaders and healers and members from the Khasi, Jaintia and Garo tribes. A literature scoping exercise and analysis of secondary data also contributed to building the context based on which appropriate initiation of support systems were discussed.

The document presents information related to prevalence of mental health concerns based on three different sources - the Global Burden of Disease Study 1990–2017, anecdotal evidence from field staff in the state, and records of the District Mental Health Programme (DMHP) clinics. According to field reports from DMHP clinics, severe mental disorders (schizophrenia and other psychoses) and common mental disorders (mood and anxiety disorders, among adults and children), along with substance use disorders cause the most significant burden. Substance use concerns were particularly highlighted as rampant and challenging to address. The Global Burden of Disease Study also indicated a higher prevalence of conduct disorder and attention-deficit/hyperactivity disorder (ADHD) in Meghalaya, in comparison to most other regions of the country.

The policy adopts a transdisciplinary lens, beyond biomedical conceptualisations of mental health, to acknowledge other critical factors that shape health and wellbeing, including — physical health concerns, social health status, and key social determinants unique to the state. Lower life expectancy rates (compared to the national average), the burden associated with communicable & non-communicable diseases (particularly cancers, also linked to the high prevalence of substance use), high maternal and infant mortality rates and the high prevalence of HIV cases are highlighted, along with the bidirectional relationship between physical and mental health. Poverty (particularly in rural areas), high out-of-pocket expenditures and differential access pathways related to the terrain of the state are also presented as critical social factors linked to mental health. Additionally, complex challenges linked to deep-rooted, intergenerational practices are also highlighted relating to, for instance, the widespread use of substances and home births, which can contribute to different health concerns.

In this context, specific vulnerable groups are highlighted, as a result of unique challenges experienced by them. These include children and adolescents (particularly those with concerns of intellectual disabilities, substance use, teenage pregnancies, child sexual abuse and child labour), women (considering the high prevalence of single-women led households, and associated pressures, particularly in the matrilineal cultural context, experiences of intimate partner violence and their cooresponding impact on children), the elderly (facing mood and anxiety concerns, along with age-related comorbidities), migrant groups (including those from the state moving to other regions, experiencing racial micro aggressions), persons living in poverty across these different groups, persons requiring long-term care support, and those homeless.

In terms of available treatment pathways in the state, public mental health services are largely offered through the District Mental Health Programme (DMHP). The programme is run across all 11 districts, out of which, two district teams have a psychiatrist that treat common and severe mental disorders. In the other nine districts, medical officers are trained by psychiatrists to offer treatment, supported with tele-consultations offered by psychiatrists. In such cases, patients with SMDs requiring a more significant intervention are referred to MIMHANS or Tura Civil Hospital. Non-state actors such as traditional healers and village headmen also play important roles. However, as integration of these different actors is limited, it is noted that each of these pathways to care remains discrete.

Further, historical and persisting inequities that have contributed to precarity among tribal communities in the state – as with indigenous peoples in many other countries, that translate into sources of 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 is 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 and experiences of social defeat, particularly when health interventions have further pathologised them (categorising their behaviours as deviant, or as mental disorders).

In this background, crucial challenges and gaps in services are presented in detail, including -

limited public mental health interventions (and in association, knowledge asymmetry and limited mental health literacy, lack of accessible and comprehensive mental health services at primary, secondary and tertiary levels, and delayed identification of mental health concerns*),* inadequate human resources and limited training opportunities, limited health systems funding, lack of focus on social, economic and cultural determinants, and sub-par multi-sectoral convergence. Drawing from these findings, the policy then offers guidance for action. person- centred recovery planning , adoption of integrated care pathways, Cultural specificity, and diversity and plurality of needs form the foundation of these priorities, such that people's historical affiliations to traditions are validated and integrated into healing systems. Key strategic priorities detailed in this policy include:

1. **Strengthen health and social care systems:** Facilitate enabling environments, identify persons at high risk or with experience of vulnerabilities or distress at the earliest and link them with a service point.

   1.1 Focus on Person-centred care and well-being*:* Geared towards helping those using mental health services to attain states of health and well-being, regardless of the extent of disability; that effectively support individuals and their participation both in the care process and in socio-cultural and political life.

   1.2 Build accessible dissemination platforms for health information**:** Use of local culture, 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 to promote better help-seeking behaviour, address asymmetric knowledge and improve population-level health outcomes.

   1.3 Focus on life satisfaction, hope and cultivating constructive emotions: Foster meaningful relationships, authentic self-expression, nurture and advance positive engagement with individuals and communities, develop clear and kind communication, strengthen interpersonal relationships and empathy, with a focus on:

      1.3.1 *Peer-led knowledge-creation programmes and community-level mobilisation*: Spaces of collective processing through group work, art and play, reclaim indigenous identities through oral histories, document people's own experiences, build solidarity and group cohesion among the most vulnerable, especially for those living with mental health concerns. Sub-centres will further act as the nodal point for mental health promotion activities through information kiosks and public awareness campaigns.

      1.3.2 *Trauma-informed interventions:* Trauma-focused interventions understand the pervasive nature of trauma or negative life events and promote environments of healing and recovery, through structural, organisational and clinical changes to facilitate the individual's recovery and empowerment, increase participation and enhance social inclusion.

   1.4 Early identification and appropriate care and referral for CMDs

      1.4.1. *Systematic screening for CMDs*, and a careful examination of the diagnosis

of conduct disorder and forms of treatment, resist labelling conditions that may be of a more socio-cultural and political nature

1.5 Early identification and appropriate care and referral for SMDs

1.5.1 *Initiate a Helpline, First Responders' Team, Crisis Teams and Psychological First Aid* - Build training protocols to offer initial clinical and needs assessments, use reflective listening, reduce distress, prioritise needs and match care pathways, stabilise, and triage

1.5.2 *Triage and contact with services* - Use contextualised and adapted mental health triage, to assess a referral on the basis of nature of the need and its severity or urgency. Use sub-centres to help in early identification of mental health concerns and facilitate referrals to PHCs, CHCs or tertiary hospitals based on the need, and house first responder units and offer crisis support and psychological first aid when required. Build convergence between public health systems and the activities of the village health councils.

1.5.3 *More beds in primary car*e - 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.

1.5.4 *Inpatient care* - Use collaborative care planning to cultivate a climate of safety, restorative care and trust, with various therapeutic approaches or 'talking cures' (e.g. CBT, CBT(P), DBT, narrative therapy, dance and movement therapy, mindfulness techniques, arts-based therapies, compassion-focused therapy and Open Dialogue)

1.5.5 *Post-discharge self-management using Assertive Community Care (ACCT):* Assertive Community Care (ACCT), an adaptation of ACT, or Meghalaya ACCT (M-ACCT), which combine aspects of ACT adapted to the needs of the relevant population to reduce repeated hospitalisations, increase housing stability and participation in the labour force. Additionally, ensure availability of medication at sub-centres and PHCs, thereby reducing long travel and out-of-pocket expenditures.

1.5.6 *Long-term inclusive care options* - Implement approaches including halfway homes, Home Again or Housing First type approaches (both WHO-validated models), and make beds closest to home accessible through respite care centres.

2. **Human Potential**: Use task shifting as an approach with a focus on mental health and social care, to build an integrated and multidisciplinary workforce (that includes psychologists, social workers, nurse practitioners, local community members, village leaders, village council members etc), enable persons to access care close to home, harness the strength of the tribal leaders and their treatment modalities as well in addition to codified biomedical and therapeutic approaches, with the existing workforce comprising ASHA workers and Community based rehabilitation (CBR) workers. Additionally, a focus on developing dynamic training and mentorship programmes that combine classroom instruction and peer-review sessions with on-the-job supervision and training to support mental health professionals across disciplines to achieve the necessary practice competencies to provide high quality care.

3. **Convergence between the health and social sectors:** Departments of social welfare and justice, disability, women, child and tribal welfare will facilitate employment 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 will be introduced in all schemes and services (e.g. health care, housing, education, livelihoods, allowance/pension, or legal aid). The state government will offer incentives to employers in the private sector to employ persons with mental illness with benchmark disability. Village health councils will play a key role in promoting social health for all and alongside responding to distress, will 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 to nurture a sense of community and strengthen kinship ties**.**

4. **Address social determinants:** Focus on building equitable standards of living for vulnerable groups, establish pathways that identify and address the needs of those with experience of discrimination, segregation, disadvantage and oppression, including – 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 and immediate galvanising of *legal aid support.*

5. **Focus on vulnerable groups:** Promote practices and interventions specific to vulnerable groups, including support groups and self help groups for women, positive youth development approaches (such as GBG and life skills training) for children and adolescents, unique engagement models (such as Experience Corps and Cognitive Stimulation Therapy) for the elderly, stronger integration of Oral Substitution Therapy interventions for persons with substance use concerns, and promotion of safe spaces and distress helplines for vulnerable groups in general, including the LGBTQIA+ community.

6. **Ensuring quality standards of services:** Align quality standards with the WHO Quality Assurance Toolkit and the major themes of the UNCRPD, comprehensive assessments of facilities and services against quality standards, develop state rules and oversight processes to ensure commitment to the Mental Health care Act 2017 (in particular, procedures for admissions and discharge) and set up Mental Health Review Boards (MHRBs).

7. **Auditing quality and efficacy of the policy:** Focus on:

   7.1 Reflexive monitoring and evaluation (M&E): Ensure periodic, collaborative audits, to facilitate any necessary adaptations and improvements. The policy will undergo a review initially two years after implementation and every four years thereafter.
   7.2 Transdisciplinary research: Comprehensive transdisciplinary research agenda co-created with relevant stakeholders and comprising research themes 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.

8. **Sustainable funding options:** Ensure adequate budget allocations to implement and achieve the outlined strategic priorities.

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 - share information on well-being (eg. positive youth development, prenatal and postnatal care etc) ● Promote community education to aid in early identification of distress, address social determinants and identify CMDs and SMDs at the earliest ● Initiate a helpline and first responders team - to address distress and social crises as well as other mental health concerns ● Use contextualised and adapted mental health triage approaches outlining roles from the sub-centre level to tertiary hospitals, integrated with village health councils ● Strengthen therapeutic support offerings at in-patient settings ● Develop continuity of care protocols, promote self - management post discharge, using Assertive Community	● Build accessible dissemination platforms for health information (through local culture, street theatre, role plays etc) ● Work closely with village headmen and village councils, to use culturally resonant and enabling rituals to 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, and other social security schemes through multi-sectoral convergence to address social determinants of mental health	● 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 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. ● Ensure adequate budget allocations to achieve the outlined priorities

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		

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

The state aims to operationalise these recommendations and strengthen mental health outcomes for all persons in the state, across the lifespan and across socio-cultural locations.

Section I. Vision, Statement of Intent, Values and Conceptual Frameworks

Vision

The State Mental Health Policy, Meghalaya 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.

Statement of Intent

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. 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. 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. 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. Gaps in care and implementation that were highlighted in the Drafting Committee's situational analysis inform this policy to enable public mental health interventions and approaches that will prevent the exacerbation of stress and distress, achieve better coverage and access to mental health solutions for all, and 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). A related aim is to achieve information symmetry as part of health-promotion activities in order to foster better help-seeking behaviour. Similarly, 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. It also addresses the limited options that address the long-term needs of persons with severe disabilities in inclusive settings; insufficient trained personnel; unique and persistent problems among youth; and poor integration of culturally appropriate forms of healing. 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. Finally, to achieve the intended results, it is vital to operationalise the recommendations, and essential human resources and funding will therefore be needed to be allocated to achieve this vision.

Conceptual Frameworks

Five conceptual frameworks shape and guide the Meghalaya State Mental Health Policy, reflecting its commitment to the values and principles of justice, equity, fairness and respect, responsiveness, cultural security, capabilities, participation and non-discrimination.

The Policy therefore 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.

Underpinning Values and Principles

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.

2. *Justice*: Frameworks of justice are designed to ensure that exclusion on the basis of 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.

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 on the basis of our mutual responsibilities as equal members of 'humanity'.

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 in order 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.

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).

Key principles

1. *Mental health care*: In accordance with the NMHP, mental health care is a public good, deemed to be a basic right and hence should be accessible to all. It is therefore the state's responsibility to facilitate appropriate care and allocate adequate resources. Treatment to reduce symptoms is important, as is a comprehensive approach that takes into account social and other precipitating factors, and aims to be person-centred and enable 'personal recovery'.

2. *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 in order 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.

3. *Non-discrimination*: No one may be discriminated against as they seek care, irrespective of their status or position.

4. *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.

5. *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.

6. *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 in order to encourage social mixing, which may help reduce the social distance between communities and individuals.

7**.** *Peer-led participatory movements and action: Restorative Justice, co-creation of knowledge and collective liberation:* In order 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 the lead in guiding principles for change and 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, are able to use a community's strengths and assets to bring about change.

SECTION 2. Context and Situational Analysis

Meghalaya: A Socio-demographic Overview

Covering an area of 22,429 km^2 and divided into 11 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. Each tribe has its own language, but many also speak English as a lingua franca. 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. In 2022, Meghalaya's Gross Domestic Product (GDP) was reported at 0.160%, down from 0.175% in 2021, compared to India's GDP in 2022 of 7.3% (*Gross State Domestic Product Contribution to National Gross Domestic Product (GDP): Meghalaya*, n.d.)

In terms of the political structure, Meghalaya has traditional governance institutions alongside the state government systems. For example, at the village level the *dorbar shnong* is a village council headed by a headman, who is elected by the adult men.

Situational Analysis: Methodology

A situational analysis was conducted as a background to developing this policy. This was based on secondary data (reviews of academic literature and government reports), 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), 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. Key findings from the analysis are presented below.

Mental Health: National and Local Context

Findings from the Literature

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%. Compared to the latter, CMDs were nearly six times higher for lifetime prevalence and more than 12 times at the time of the study. 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 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. Hence, 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 that 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

Compared to national averages and prevalence rates in other Indian states, it is important to note the prevalence of attention-deficit/hyperactivity disorder (ADHD) and conduct disorder. The highest prevalence in the country for the latter 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.

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.

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.

Based on the records of the District Mental Health Programme (DMHP), prevalence rates of commonly observed mental disorders are presented in Table 2.

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 discrepancies 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.

Overall, it is recommended to conduct a comprehensive screening and identification exercise across the state, in combination with a strong data-management system, in order to determine the true prevalence and incidence rates and address any data gaps or discrepancies in different sources.

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 due to a porous border and resulting influx of illegal drugs. 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.

In general, 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.

Physical Health and Mental Health: A Two-Way Relationship

According to the Meghalaya Health Policy (2021), average life expectancy at 62.3 years is significantly lower than the national average of 68.8 (WHO, 2018), and the global average of 72.6 years. Up to 64.1% of all deaths in the state are premature (National Health Systems Resource Centre, 2021).

Data compiled by the NHM – NHSRC Health Dossier, 2021 suggests that NCDs such as ischaemic (coronary) heart disease, asthma and chronic obstructive pulmonary disease (COPD) account for 56.3% of all DALYs in the state. Behavioural factors (smoking, alcohol consumption), metabolic factors (high blood pressure, high-fasting plasma glucose – diabetes) and air pollution were suggested as major risk factors for all DALYs and years of life lost (YLLs). The Meghalaya Health Policy (2021) also highlights the maternal and infant mortality rates, registering 197 maternal deaths per 1,00,000 live births, and 34 infant deaths per 1,000 live births. Causes have been cited as teenage pregnancy, multiple pregnancies and untimely health interventions. Further, only 51.4% of births take place in an institutional setting. In addition to potential complications from home births (in the absence of trained staff, particularly for mothers at high-risk) leading to maternal and/or infant mortality, they may possibly also be linked to other adverse neonatal outcomes, such as the development of neurological problems.

Cancer Statistics, 2020: Report from National Cancer Registry Programme, India, 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). Overall, 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); 47% of all adults (59.8% of men, 34.2% of women) either smoke tobacco and/or use smokeless tobacco (GATS-2, 2016-17).

Cancer of the oesophagus is related to tobacco use (31.0% in men and 22.3% in women) (*Profile of Cancer and Related Health Indicators in the North East Region of India – 2021,* 2021).

Lower respiratory tract infection, malaria, pre-term birth, diarrhoeal diseases and drug-susceptible tuberculosis (TB) are the leading causes of death due to CMNND (communicable-malnutrition-maternal-newborn diseases) in the state. The Meghalaya Health Policy (2021) also highlights that the state has the third highest number of HIV cases in India, with 0.76% of the population living with the virus, and one of the highest rates of syphilis cases in the country. According to the HIV Surveillance Sentinal, 2017, 1.03% of all pregnant women tested HIV-positive.

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.

Mental Health, Health and Social Determinants

Poverty

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.

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)**,** Meghalaya, along with Assam, stands at 32.7% – among the top five multidimensionally poor states in India.

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 2).

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

Table 4: 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.***

High OOP 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.

Differential Access Pathways

Unlike most parts of the country where caste-based hierarchies and conflict are important social determinants of health, caste in Meghalaya bears little relevance in tribal cultures and norms, and the various tribes in the state generally co-exist in harmony. However, due to a scarcity of resources (educational institutions, health facilities, livelihood opportunities and so on), most facilities are concentrated in specific areas, mainly around the state capital, Shillong. This leads to differential access to resources based on proximity to the capital, and ultimately to disparities in socio-cultural capital.

Tribal Cultures

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.

Vulnerable groups experiencing mental health concerns and complex problems

Children and Adolescents

SAMVAD (2022) highlighted 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 family contribute to the early marriage of adolescent 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 a previous marriage when their mother remarries identified as being at particular risk of being sexually abused by the stepfather; 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.

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

In addition to the general health issues that women experience (high maternal mortality rates, low health awareness, high rates of anaemia etc), a pressing issue in the state is the prevalence of families headed by a lone mother, either because they are widowed or their husband has deserted the family. Sometimes women may prefer to separate for reasons such as the husband's infidelity, dependence on alcohol or a breakdown in the relationship. For various reasons, then, mothers shoulder the entire responsibility of raising their children. Further, given the matrilineal nature of society, women (particularly the youngest daughter) are also responsible for caring for their elderly parents. For many women these responsibilities result in high pressure and emotional distress. 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).

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.

Elderly

Some urban families who are unable to care for them place elderly family members in old people's homes and shelters for the elderly. These elderly adults often experience several mental health concerns, including loneliness, depression and anxiety. Several also have a combination of conditions such as hypertension, diabetes and dementia, and require focused interventions to better manage their physical and mental health.

Persons living in poverty

Safety-net populations are by definition at 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*).

Individuals and organisations working with vulnerable groups highlight poverty as a widespread but seemingly invisible issue in the state, largely because homelessness is uncommon. People who are sleeping rough are usually migrants who are homeless, or experience mental illness and lose their way as a result. In such cases, the police usually take them to local facilities such as the Meghalaya Institute of Mental Health and Neurosciences (MIMHANS). Among the local population, strong cultural values of collectivism and commitment to the family reduce the likelihood of people (particularly those with mental illnesses) being abandoned or left to care for themselves. Instead, they may be taken to shelters by the families, village members (with notes from the headmen) or volunteers. However, given widespread poverty, particularly in rural areas, as indicated by the Meghalaya State Legal Services Authority (2015), such people are highly vulnerable, particularly due to the terrain and the remoteness of these areas. Accessing services (health, education etc) is therefore far harder for those experiencing poverty and living in remote areas in view of the necessary out-of-pocket expenditure on transport. For instance, during the COVID-19 lockdown, the terrain and network issues, coupled with financial constraints and lack of resources for online learning, meant that many children had no formal education during that time.

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). Some studies have also shown linkages between positive thinking and a reduction in externalising behaviour. Attention to issues of identity and cultural influences should therefore be prominent in mental health care.

Existing services

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 MIMHANS, 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	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 5: Public health services in Meghalaya. Source: Department of Health and Family Welfare, Government of Meghalaya

District Mental Health Programme (DMHP)

The District Mental Health Programme (DMHP) is operational in all 11 districts of Meghalaya, and the PHCs are the basic unit. Through a combination of word-of-mouth referrals and those identified by Accredited Social Health Activists (ASHAs) supported by outreach and awareness programmes, persons with mental health concerns are likely to visit a PHC or a CHC, depending on the location and accessibility. 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 are referred to MIMHANS or Tura Civil Hospital for SMDs requiring a more significant intervention. For follow-up care and medication, patients are generally required to visit the same facility (CHC or tertiary-level centre). 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 lay counselling as they are trained only to identify distress and facilitate referrals.

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.

Role of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy)

While AYUSH departments work at public health centres, aiming to integrate 'traditional medicine', 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. Only about a third of households had even heard of AYUSH, and only 47 respondents (survey-adjusted prevalence estimate 10.5%) reported ever having used any of these systems of medicine. 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.

Role of non-state actors

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 in order 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. However, most such cases are settled between the perpetrator of the abuse and the victim's family without any legal action or involvement from the headman, as these are considered to be private family matters. It is when the child or other individual is being ill-treated, or not supported by their family, that they may intervene for support.

When a person experiences mental health issues, the headmen tend first to meet the family and observe what is happening. When the issues exceed their capacity to manage alone, 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: It is rare for health practitioners (such as psychiatrists) to work in private practice, although private and non-profit organisations offer important services related to mental health and social care. In terms of mental illnesses, SAN-KER plays a critical role in bridging the treatment gap, as one of the only two psychiatric hospitals in the state apart from MIMHANS. 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, homeless persons, de-addiction and rehabilitation centres. While some of these centres may also be partly funded by the government, they are largely sustained through donations from religious organisations and residents. Public–Private Partnerships should be explored to address some of the complex needs in the state in the absence of service providers and resources.

Section 3. Guidance for Action: An Overview

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; 2013; Shah et al., 2018; 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 – as with indigenous peoples in many other countries – which translate into sources of 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 and experiences of social defeat, particularly when health interventions have further pathologised them (categorising their behaviours as deviant, or as mental disorders). (King, Smith, & Gracey, 2009; Linklater, 2014). It is therefore 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. Aspirational and sustainable interventions are one and the same in many indigenous contexts, where the key to greater local engagement revolves around culturally meaningful forms of care that recognise their values of relationality and reciprocity, and the collective injustices that have affected them disproportionately.

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). 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 also with ancestors, local landscapes and the natural world (Bird-David, 2017). Collective historical trauma and injustice require collective healing. This would shift medical attention away from individual psychiatric care towards a restorative reckoning of unacknowledged and unaddressed and ruptures within indigenous life, which globally have contributed to high rates of substance abuse and depression. 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 take into account 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 (Daniel, 1984; Vasavi, 1999; West & Zimmerman, 1987). This has two implications. First, collaboration and partnership with each tribal community is paramount in order to bridge the divides between biomedical and traditional forms of care as a means 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. 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 pathologising.

Challenges and Gaps

1. Limited public mental health interventions and focus on well- being

    a. *Knowledge asymmetry and mental health literacy*: There are currently no 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.

b. *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 km^2) 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.
c. *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.
d. *Limited focus on 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.
e. *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.

2. Inadequate Human Resources

The main difficulty in all settings is a lack 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.

3. Inadequate (locally) 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.

4. Limited training opportunities focused on integrated care approaches

There is limited provision of training that would facilitate the provision of 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.

5. 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.

6. Health systems funding

Percentages of the health budget allocated to mental health are insufficient, and as a result, public mental health, especially investment in personnel and capacity building, may be inadequate. In addition, making medication, social support and services close to home are not given the appropriate level of significance.

7. Limited focus on flourishing and well-being

Most people wish to pursue capabilities, reach their potential, move towards their goals and enjoy being able to do so, and therefore feel a sense of purpose and worth. 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’. Social connections and feeling that ‘people care’ also contribute significantly to thriving ,feeling hopeful and well (Burns et al., 2022; Snyder, 1994). Cultivating an enabling environment is an essential function of primary mental health care but still not an essential focus in most Indian states, nor in high-income nations. This is owing to many systemic barriers, resulting in self-limiting designs of health systems and equally, self-limiting individual and community-level behaviour. Further, chronic scarcity has negative cognitive impacts. In this health and social landscape, the lack of intersectoral coordination, and the focus on social determinants to alleviate distress, may positively build the capacity to pursue higher-order goals and assume valued social roles using a capability lens.

8. Poor multi-sectoral convergence that addresses disability-related concerns and barriers

   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.

9. Limited focus on structural barriers and social, economic and cultural determinants and care for vulnerable groups

   a. *Poverty*: For persons living below the poverty line, high unemployment, and mental ill health intersecting with poor health access and out-of-pocket expenditure are linked to economic and social deprivation. The stress created by multidimensional poverty may also affect physical and mental ill-health. 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.
   b. *Intimate partner violence (IPV) and domestic abuse*: The situation analysis found that many women and young adults are exposed to violence. 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). The severity of IPV can seriously affect the victim’s physical and mental health and life

satisfaction. In Meghalaya, this may be a contributing factor to the high burden of disease associated with SUD and MDD.

c. *Child safety and growth*: 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). The 'matrix of disadvantage' in particular appears to exacerbate distress and amplify adult psychopathology and the onset of MDD, GAD, PTSD, suicidal ideation etc.
d. *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.
e. *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 woman 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.

10. Mental health of vulnerable groups

Given the structural barriers and social systems outlined above, and the multiplicity of social causes, the needs of those who experience greater distress owing to social determinants and disadvantage – women exposed to violence, disadvantage or living with the experience of trauma, children and adults with intellectual disabilities, children exposed to abuse and violence, vulnerable caregivers such as children dealing with parental mental illness,. pregnant women etc. should be prioritised from public mental health and social health perspectives. This is an integral part of public mental health and early identification protocols, especially for those with greatest risks and needs.

11. Focus on 'personal recovery' and capabilities-based approaches in mental health

In contrast to the idea of recovery being a single destination and approach, focused on reducing symptoms and fostering community 'integration', the concept of personal recovery is oriented towards identifying neurodiverse lives, whereby those who achieve a state of well-being that supports their goals in fact follow a non-linear process of healing and/or 'recovery' from not just the disease aspect of the mental health condition, but also from the assigned social role and the precipitating factors that affect ill-health – and therefore from adverse life events and triggers that induce trauma. The role of peer advocates and access to support groups is essential in building a sense of community and affiliation and are currently lacking in Meghalaya.

Strategic priorities - Guidance for Action

1. **Health and social care systems strengthening**

   The DMHP currently has limited focus on approaches to public mental health that address the most pressing issues, such as substance use, and provide easy and consistent access to medication at a health facility closest to home – in this case the Sub-centre or the PHC – identify distress in a timely manner and address social determinants such as abject poverty, and IPV and its impact on the mental health of women and their children. Furthermore, 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. This results in significant out-of-pocket expenditure on travel and also loss of wages, which impede access to mental health care. Moreover, 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.

   Given the significant implementation gaps and delayed identification and assessment, it is recommended that the Public Mental Health Focus should be strengthened. It is equally important to address social vulnerabilities and related barriers to well-being and the prevalence of mental ill-health in a timely manner. 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. Central to this approach is the need to facilitate enabling environments and the ability to identify persons at high risk or with experience of vulnerabilities or distress at the earliest and link them with a service point. The presence of locally trained personnel – using the strategy of task-shifting, focused on achieving maximum coverage, and trained in adopting effective care protocols, and 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. Moreover, it will have a positive impact on help-seeking behaviour thanks to better approaches to promoting mental health literacy being embedded in primary care. **To augment this approach, 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.** In such a set up, Care teams, including community mobilisers and lay counsellors, would be 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. It is recommended to review CMDs,

which are largely based on outpatient treatment, with rigorous protocols on follow-up care or continuity of care that is mainly home- or community-based. The same applies to those with SMDs, where there may be a need for referrals to acute care centres for brief periods. Caregiver and peer-support groups are an active component and contribute to both training, system-level governance, collaboration with mental health service users, and caregivers, and in sharing expertise on the basis of lived experience.

It is recommended that the State pursue the following actions to strengthen the health and social care system using a public mental health approach:

a. **Focus on Person-centred care and well-being – cultivating enabling environments:** 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.

   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).

   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 effect 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.

b. ***Build accessible dissemination platforms for health information*****:** 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, 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 forum 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. Besides awareness, freedom of expression, community bonding, and so on are protective factors and help build social cohesion. In addition, 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. Sub-centres will operate as information kisoks and share information on well-being (eg. nutrition and healthy eating, positive youth development and parenting, pre- natal and post-natal care, mental health care, social health etc) and on problem solving, acting as the nodal point for mental health promotion. Collaborations with traditional healers and headmen are imperative as traditional systems of healing and contemporary approaches of care are combined to serve local populations. 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.

c. ***Focus on life satisfaction, hope and cultivating constructive emotions:*** Improved mental health also improves social health. Fostering meaningful relationships, authentic self-expression, nurturing and advancing positive engagement with individuals and communities, developing clear and kind communication, strengthening interpersonal relationships and empathy and therefore being able to address conflicts and work towards their resolution all help in achieving life satisfaction. 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. These approaches inspire the development of constructive emotions that build community resilience and establish a strong sense of connectedness that helps address feelings of loneliness and alienation. The impact of loneliness and isolation on the development of cardiovascular diseases, poor quality of life and mortality is well documented.

Despite this knowledge, this aspect of public mental health is relegated to the periphery and not fully integrated to assist people who are vulnerable, such as those who experience loneliness and social withdrawal or self-stigma and hopelessness. A simplistic understanding of 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. In the process, the scope and range of personal goals of such persons diminish, limiting their 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. Towards building social health interventions for mental health, the state aims to do the following:

- *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.
- *Community-level mobilisation and connectedness***:** Healing could be viewed as both a personal and collective process in tribal and minoritised 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.

- *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.
- *Use of trauma-informed interventions:* Trauma may arise from adverse childhood experiences, intergenerational distress and historical segregation, or socio-political contexts that discriminate against minoritised 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.

d. **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). Injustices and health and social vulnerabilities typically associated with these groups, if identified and addressed in a timely manner, have the potential to arrest the descent of these individuals into states of emptiness and alienation, which may also lead to hopelessness and suicidal ideation. In addition, the state will aim to do the following:

Early identification and appropriate care and referral for CMDS and SMDS

There is a need to better understand the multiple factors resulting in the higher incidence of CMDs in order to arrest this pattern. This depends on being able to identify risk factors, especially social precipitants (much of which is addressed under the sections focusing on social determinants and vulnerable groups.). Their impact on the quality of life, on stress and related negative physiological outcomes in different settings need to be considered carefully. In general, there is little or no systematic screening for CMDs in most of the country, including in Meghalaya. People who experience persistent feelings of sadness, inability to feel pleasure (anhedonia), anxiety, guilt and somatic concerns may access primary care facilities or traditional healers if these conditions do not improve on their own. The link between racial microaggression and depression has also been established in the section on migrants and identity). Individuals working in other states and/or who have experienced racism and alienation may suffer CMDs and be unable to seek help. In the case of pregnant women, the potential impact on their baby’s development needs to be taken into account. There is no data on postnatal depression (PND), which should be identified and addressed to improve outcomes for mothers and babies. It is imperative to address the social determinants that contribute to an increase in disease and disability. Care pathways and the duration or periods of ill-health also have to be examined to understand possible recovery patterns and associated factors that influence a

better prognosis or a reduction in disability and an improvement in health and well-being. Among children and adolescents, it is important to give careful examination of the diagnosis of conduct disorder and forms of treatment, and likewise for the diagnosis of personality disorders irrespective of age. It is important to resist labelling conditions that may be of a more socio-cultural and political nature; labels tend to be based on stereotypes that may have negative repercussions.

Approaches associated with early intervention in emerging serious mental illness are based on the assumption that the more quickly those experiencing the initial signs and symptoms of potentially severe conditions can be identified and supported the greater the chance of reducing the secondary impacts, potentially including major disruptions to family and broader community relationships, loss of employment, and even suicide. Specialised early-intervention strategies have been developed for a range of conditions including psychosis, bipolar disorder, major depression, trauma-related conditions and personality disorders.

In the Meghalaya context, as elsewhere, community education to assist in the early identification and development of clear referral pathways is likely to reduce the time between onset and support. While the effectiveness of early-intervention strategies is well developed there are significant gaps in knowledge and understanding regarding adaptation for minoritised cultures and in incorporating cultural healers. Holistic services are also essential, since much research suggests that purely clinical support (medications and therapy or counselling) generally fail to support functional recovery. These include:

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.

Triaging and contact with services: A first responder would use contextualised and adapted mental health triage, the clinician would assess a referral on the basis of 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 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 approaches or 'talking cures' (e.g. CBT, CBT(P), DBT, narrative therapy, dance and movement therapy, mindfulness techniques, arts-based therapies, 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 on the basis of 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, financial security, spiritual support, access to activities that induce 'flow states' etc.

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 in order 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.

Reducing death by suicide: 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 minoritised 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).

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).

e. *Strengthen public mental health approaches by harnessing local traditions and tribal cultures:* Intrinsic strengths around community-level cultural practices and kinship systems in tribal communities (and therefore relevant in the Meghalaya context) lend themselves by their very structure and ethos to developing culturally congruent public mental health systems. This policy therefore makes the most of preexistent structures and customs to foster integrated approaches to enhance health and well- being gains that draw from the deep sense of community that is evident amongst most tribes in Meghalaya. The definition of pathology has largely been western or urban. The State of Meghalaya can use this opportunity to recalibrate its thinking on psychopathology, using participatory approaches to design a comprehensive, culturally sensitive care plan, integrating local knowledge within care paradigms beyond codified biomedical structures to build a strong workforce; and provide seamlessly integrated mental health and social care, supported by mental health literacy initiatives, effective screening, early identification, effective escalation and de-escalation pathways and multi-sectoral coordination that support a focus on continuity of care, community inclusion and participation, reduced disability, effective support for caregivers and hence, reduced social suffering.

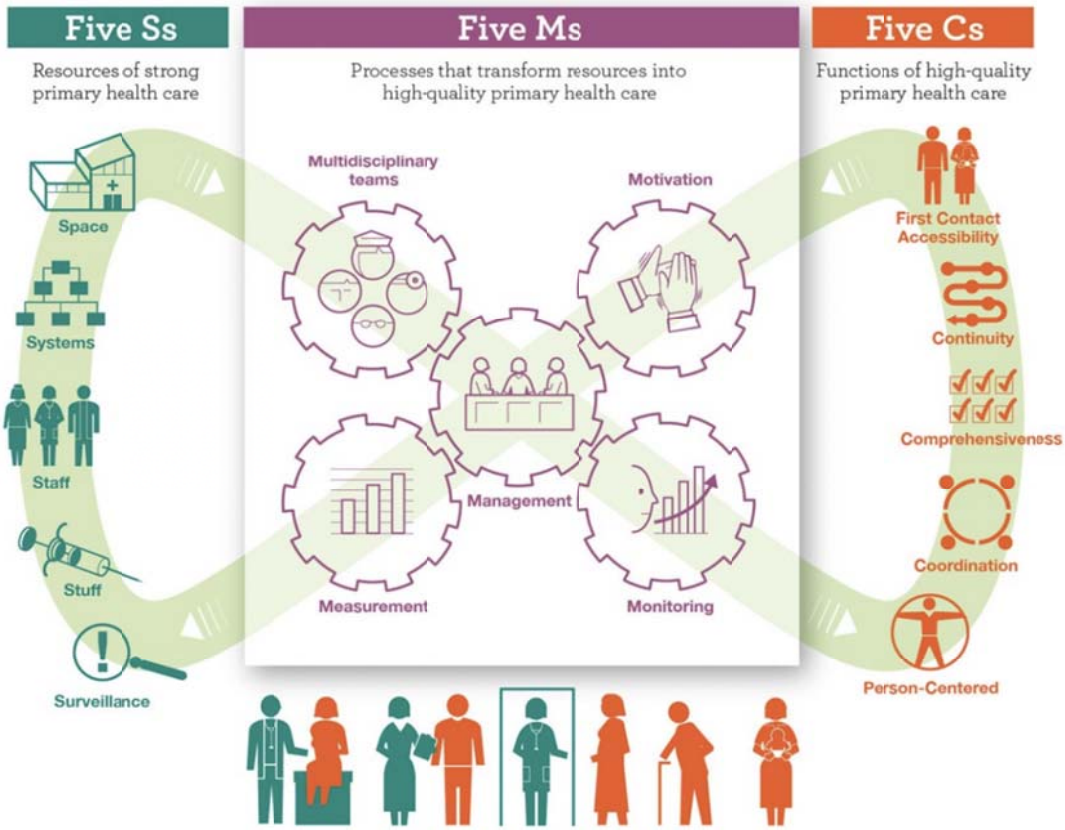

Figure 1: The 5S-5M-5C schematic - Key Components of Primary Care. (Bitton et al., 2018).

2. Building Human Potential: 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.

In addition, the state aims to do the following:

a. Align service-delivery standards with the convergence of health and social interventions and necessary **interdisciplinary mental health professionals**, including psychiatrists, social workers, psychologists, nurses and community health workers. This will include a cadre of social care facilitators or social prescribers across health and social care access points to ensure this convergence, along with village health councils, tribal leaders, ASHA workers, youth and women's groups, peer advocates etc. Psychiatric nurses who could anchor nurse practitioner-led units and services could be integrated into the mental health systems. Collaboration with global networks that adopt this approach may support this approach across public mental health in India.
b. Develop standards of recruitment and ensure that the composition of staff in mental health programmes is representative of diverse communities being served.
c. Align 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.
d. Support staff with practice standards derived from (and continually upgraded) contextual research and evidence.
e. Develop dynamic training and mentorship programmes that combine classroom instruction and peer-review sessions with on-the-job supervision and training to support mental health professionals across disciplines to achieve the necessary practice competencies to provide high quality care.
f. Develop and deliver training modules, establish peer-learning mechanisms and expand professional resources based on contemporary standards.
g. Increase the availability of culturally relevant professional services, including nurses and community health workers.
h. Develop standards of interdisciplinary collaborative care that outline essential practice processes, knowledge, skills and ethics among mental health workers.
i. Develop continuing professional development plans.

j. Cultivate anchor networks in service delivery via community-based institutions such as SHGs, youth clubs, panchayats and other social networks that may aid in providing mental health services.
k. Develop a data framework and monitoring mechanisms to evaluate experiences and outcomes of practice across cadres and link the findings to service expansion/reorganisation.
l. Create specific roles and responsibilities, with decision-making protocols across cadres to promote collaborative care and action.
m. Develop mechanisms for experiential expertise to engage with the service-delivery system and create a repository of practice experiences and narratives that can inform and support practitioners in the local context.

4. Promoting convergence between the health and social sectors – facilitating community inclusion

Community inclusion: 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 defense 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.

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, 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).

Using a centralised and coordinated approach to individual care makes it possible to bring many stakeholders together, each of which makes a distinct contribution in enabling well-being and inclusion in their community for persons with mental health concerns who face enduring barriers.

Multi Sectoral coordination and convergence : Departments of social welfare and justice, disability, women, child and tribal welfare will facilitate employment, 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 will be introduced in all schemes and services (e.g. health care, housing, education, livelihoods, allowance/pension, travel concessions, or legal aid). The state government will offer incentives to employers in the private sector to employ persons with mental illness with benchmark disability. Village health councils will play a key role in facilitating social entitlements, and will 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**.**

Monitoring bodies will evaluate impact and feed relevant data into service planning, policy and public messaging to promote help-seeking behaviour, outreach and volunteerism in the mental health sector. 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. Awareness programmes on mental illness will be organised across all sectors, and meet the needs of persons with mental illness, their caregivers and family members, especially children with parents living with mental illness and elderly parents of adult children living with mental illness.

Steps in enabling convergence will include:

- Arrive at a problem statement – what is the range of mental health issues that concern the state? (Badgett, 2022)
- Establish a mind-map for problem solving, with targets and timelines – prioritise responses to issues that are persistent, complex, affect a large number of people across demographics.
- Define metrics that will measure not just the impact of each stakeholder, but how they communicate with one another and come together in concretising the common vision. Are health and social welfare programmes collaborating to prevent the recurrence of ill health and destitution? Does the policy reflect realities on ground and interdepartmental plans to promote mental health? How many people does public health messaging reach? Are there more referrals as a result of particular dissemination platforms? Is there greater participation by local governments and civil society partners as a result of public health messaging? (See the section on transdisciplinary research on impact measurements and streamlining implementation.)
- Identify teams that will come together periodically to review processes. Build a system hierarchy to accelerate problem solving and responsiveness, minimising bureaucratic hurdles that delay access to care. (See the section on Quality Standards)

5. Address social determinants – build equitable standards of living 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 Megahlaya. 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.

a. *Address poverty traps and disparities:* Poverty traps, gender-related concerns, disability and hierarchical tribal discrimination can all be pernicious. 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. The 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. In addition, ***crisis teams*** may intervene to ensure timely, appropriate and comprehensive responses and facilitate legal aid and social care in order to build a sense of stability and ontological security to the extent possible. These actions are integral to achieving basic goals of safety, belonging and self-esteem that support the pursuit of higher-order goals of self-actualisation and capabilities.

b. *Basic Income pilots*: Benefits associated with social security, such as the introduction of enabling projects 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 in order 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. This, in combination with social entitlements such as gains from the Public Distribution System (PDS), housing access, ihealth access and insurance etc., may address the experience of fragility and the formidable task of living with the backdrop of innumerable systemic barriers.

6. Focus on the rights and needs of vulnerable groups

a. *Strengthen women's support and affinity groups***:** 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.

Economic independence, for example, may not be limited to property rights but could, especially in the case of lone women-headed households, also include home-based businesses that are culturally rich and based on traditional skills and indigenous heritage. Schemes such as the Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) should be extended to women, to promote health, social welfare and rural development. In 2012 this scheme was initiated in Tamil Nadu for PLWMIs across four districts and its impact measured in a time-and-motion study. The findings showed increased self-esteem, and feelings of enhanced physical well-being through doing manual work. People enjoyed greater financial stability, and concessions such as slightly reduced hours and more frequent breaks also motivated more people to remain in work. The opportunity to access the scheme helps to foster social mobility, autonomy on expenditure, and increased social capital.

In addition, it is recommended to encourage self-help groups (SHGs), which function as peer-support groups as they 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.

In situations where women are lone parents, the tension between their personal needs and aspirations and parenting may affect mothers and their child(ren), exposing both to emotional and potentially physical and sexual harm and exploitation. Well-organised care pathways that support mothers and children and prevent harm should be made available at the Sub-centre level, via health assistants or social workers and psychologists or/ and peer advocates using Open Dialogue, counselling and other techniques based on non-judgmental support and confidentiality. In case of pregnant women, birthing companions help challenge obstetric violence and offer support to the soon to be mother in multiple ways. This may be introduced to enhance prenatal care and postnatal support for the mother and child and may suppress the probability of the occurrence of postnatal depression.

b. *Focus on positive youth development:* Children and adolescents may also be vulnerable, exposed to many forms of distress ranging from poverty, to bullying and early exposure to substances, which places them in situations of physical and psychological precarity, including the risk of developing NCDs, even cancer.

Children in Meghalaya face complex problems if they live in a household with only one parent or the parent lives with a different partner(s). The greatest danger is of sexual abuse. These situations may co-exist as substance use makes it more likely that children will be lured into illicit activities, evident in the case of conduct disorder, characterised by excessive aggression and other unhealthy behaviour, and of being removed from their family and placed in juvenile homes.

In terms of existing structures, the state aims to use the Integrated Child Development Scheme (ICDA) and *anganwadi* infrastructure to ensure that young children have access to socio-emotional care, protection and opportunities for early learning. It will provide training for staff working in childcare centres, focusing on equipping them with knowledge and skills related to knowledge of child and adolescent mental health issues from both a clinical as well as a public health perspective (including standardised assessments, child interviewing and case-management skills), the recognition of child-protection issues (such as violence, abuse and neglect), their linkages with child mental health problems, and compliance with legal provisions regarding children's rights.

The state aims to create convergence guidelines at the block level to serve various purposes, including clarifying roles and ensuring more efficient and regular implementation of child-related schemes. In recognition of the regular interface between Community Health Centres (CHCs), families and children, the state will ensure that CHC staff are equipped to provide first-level support to vulnerable children via assessment and referral services.

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. 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.

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.

c. *Elderly:* 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).) In view of the age-related physical health concerns and co-morbidities, the strong integration of general health services is also recommended at all levels.

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.

d. *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, panchayats 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 schoolteachers 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.
- 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.

e. *Caregivers:* The provisions directly or indirectly related to family caregivers in the National Mental Health Policy 2014 will be adopted and implemented as soon as possible. Similarly, the provisions in the Mental Healthcare Act 2017 which directly or indirectly provide financial or non-financial relief to the family caregivers will be swiftly implemented. The state government will streamline these procedures to avoid undue delays in issuing disability certificates to the persons with benchmark mental illness. The state government 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 government will 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. It will also find ways to support and promote Caregivers' NGOs working for persons with mental illness.

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). 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. Similarly, elderly caregivers are often concerned about leaving behind someone with a mental health concern, particularly if the disability is of a severe nature. These issues have to be addressed, balancing and managing the health and rights of the patient and caregiver.

f. *Homeless persons with severe mental issues:* Meghalaya does not have beggary or anti-vagrancy laws that have historically been used to incarcerate homeless persons, 35% of whom have severe mental health issues or co-morbid substance-use conditions. However, according to 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 homeless persons with mental health issues to the appropriate care services. There are no precise numbers of homeless persons, 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 the homeless mentally ill. In areas where such people are more concentrated, such as border districts, it is recommended that Meghalaya also allocates a few beds in district hospitals for short-term emergency and acute care, and crisis support, as recommended above that may service this population as well. 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 could be run directly by the government or through PPPs with local CBOs or civil society organisations (CSOs). In such facilities, social-care kiosks may be situated where people can also seek entitlements and financial incentives that help sustain well-being and promote livelihoods and independent living. These facilities should also be made available for the larger non-clinical homeless population to access medical and psychological care as needed.

g. *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.

In terms of 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.

h. *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 will not face discrimination on the basis of their gender and sexual identity. Mental health professionals will not recommend practices such as so-called conversion therapy, nor pathologise queer identities.

Further, 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.

i. *Migrants:* 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.

7. 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.

11. 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 in order to seek support to address violations, grievances and expressed needs.

<u>Compliance with the Mental Health Care Act (MHCA):</u>

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.

(i) 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.

(ii) 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:

(i) recently threatened/attempted or is threatening/attempting to commit self-harm

(ii) has behaved/is behaving in an aggressive manner towards another person or causing them to fear bodily harm

(iii) they are at risk to their own well-being as they are unable to take care of themselves.

2 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.

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 Mental Health Review Board (MHRB) is a district-level quasi-judicial body, whose role is to 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 MHRB for redressal of their grievances. The MHRB will conduct a review and after hearing both authorities will pass a binding order (*Tamilnadu Mental Health Care Policy & Implementation Framework*, 2019). The MHRB is also authorised to register advance directives and appoint/revoke/modify a nominated representative.

8. Auditing quality and efficacy of the policy and programmes: reflexive monitoring and evaluation (M&E), and transdisciplinary research

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.

<u>Reflexive monitoring and evaluation</u>

- 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 should 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, policy-makers) at the same time. Meaningful measurements should encompass the strategic priorities and the quality standards (see previous section).
- Periodic, collaborative audits: an annual audit 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).

- Adapting policies: 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 achieve an integrated response to current social care and mental health challenges in Meghalaya (i.e. the policy and its associated programmes, facilities, approaches, amendments to laws, rules and regulations), 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 identified 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 and crosses disciplinary and sectoral boundaries. It echoes the aim of the Meghalaya State Mental Health Policy to work in a cross-sectoral manner on overall well-being. The state aims to develop and implement a comprehensive transdisciplinary research agenda on important, but less understood, areas of concern. 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 over the course of a life
- Ecosystems, contextual, socio-cultural formulations of mental health and ill-health
- 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 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 factors and initiatives associated with people's well-being
- Access and choice to mental health among diverse communities and areas in the state
- Implementation science with particular focus on how new approaches can be put into practice in the health system and scaled for impact

9. Sustainable Funding Options:

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 in order 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.

In addition to offering insurance for general health concerns, all public and private hospitals offering inpatient psychiatric services need to 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.

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