Announcement

We are pleased to inform you that the draft of the "*Integrated Mental Health & Suicide Prevention Strategy* "has been uploaded on ***https://sikkim.gov.in/***

This strategy was co-developed and co-designed with a diverse range of stakeholders, including community members, international and national experts on mental health from AIIMS, the Ministry of Health & Family Welfare, the Ministry of Social Justice, McGill University, as well as experts from the state. It also involved stakeholders such as government representatives, students, panchayats, SHGs, teachers and educators, NGOs, LGBTQ+ representatives, PWDs, persons with lived experience, media personnel, social media influencers, youth, civil society members among many others.

The process was highly inclusive, involving multi-stakeholder consultations, gap and needs assessments, focus group discussions, survey and visits to community-based intervention sites that included 'Atmiyata,' in Mehsana, Gujarat. The Centre for Mental Health Law and Policy, Indian Law Society provided technical support throughout the process of building this document. What makes this strategy particularly noteworthy is it's participatory and bottom-up approach—handcrafted by the community, for the community.

The draft is open for public comments and inputs from 07.05.2025 -12.05.2025, after which we will finalize the Strategy for official release on State Day. Your participation is vital to ensure this initiative truly reflects the voices of our community.

Anyone interested in providing feedback, comments, or suggestions can send their inputs to us at ***inspiresimhp@gmail.com***

Integrated Mental Health & Suicide Prevention Strategy, 2025-2030
State of Sikkim
Draft Strategy for Consultation

1. Introduction

Socio-demographic and economic overview of Sikkim

Sikkim is one of India's smallest states both in terms of population (approximately 6 lakhs) and area (7096 sq. km). Located in the northeast of India, Sikkim shares borders with Bhutan, West Bengal, Nepal and Tibet Autonomous region of China. Predominantly a hill state, Sikkim is known for its syncretic culture, geographical landscape, and biodiversity. A part of the Eastern Himalayan region, Sikkim hosts the majestic Kanchenjunga, the highest peak in India and the third highest on Earth. Almost 35% of the state is covered by the Kanchenjunga National Park, home to a rich variety of flora and fauna, as well as the globally recognised endangered red panda. Previously a monarchy, the state is also known for its art, architecture and historical monuments.

Sikkim has the highest per capita income among the northeastern states and is economically one of the fastest-growing states in India[1,2]. Between 2005 - 2021, the state successfully reduced its poverty rate from 30.9% to 3.82%. In 2023, Sikkim was recognised by the NITI Ayog as holding the position of the third lowest Multi-dimensional Poverty Index (MPI) in the country, determined by measures of health, education, and standard of living in the state[3].

With favourable climatic conditions that support agriculture, horticulture, and forestry, Sikkim was certified by the Central Ministry of Agriculture as the world's first fully organic state in the year 2016. With progressive policies to encourage participation, nearly 80% of Sikkim's workforce are employed in agriculture sector. The state also has one of the highest rates of female labour force participation in the country at 58%[1,2]. Along with agriculture, there is increasing growth and investment in other sectors such as tourism, hydropower, and pharmaceuticals, and there is potential for the state to create quality jobs in these sectors[4].

Much like India's demographic composition, nearly 30% of Sikkim's population consists of young people, with 1,98,873 young people between the ages of 15-29 residing in Sikkim[5]. As citizens of one of India's fastest growing states, youth in Sikkim have the potential to contribute to the overall development of the state, particularly in developing a sustainable economy.

In 1975, Sikkim renounced its status as a monarchy to join India as its 22nd state, with the year 2025 marking fifty years of statehood for Sikkim. Over the past fifty years, the state has undergone significant transformation across political, social, economic and cultural landscapes, while trying to strike a balance between modernisation and maintaining its unique historical and cultural identity. As any society in transition, Sikkim is confronted with various challenges including those related to unemployment, inclusive growth, climate change, and access to quality healthcare. These factors affect the state of mental health and suicides in Sikkim.

Mental health and suicides in Sikkim

Mental health and suicides are a serious public health concern in Sikkim, where the state has the highest suicide rate among all states in the country since 2008. The National Crime Records Bureau (NCRB) reported a total of 1,70,924 deaths by suicide in the country in 2022, corresponding to a suicide rate of 12.4 per 1 lakh population. The same year, Sikkim reported 293 deaths by suicide in the state, corresponding to suicide rate of 43.1 per 1 lakh population[6].

This is more than three times the national suicide rate for the year and the highest rate of suicide in the country, though the high rate may be attributable to Sikkim's small population among other factors. Sikkim also has high rates of mental health conditions, namely anxiety, depression as well as substance use. According to a national report on substance use in India, published by the Ministry of Social Justice & Empowerment, Sikkim has reported prevalence of substance use as high, particularly alcohol use (26.4%), opioid use (more than 10%), sedatives (8.6%) and cannabis use (charas or ganja) (7.3%)[7].

As per NCRB records, a majority of the deaths by suicide in 2022 were by men, with deaths by men and women accounting for 77% and 23% of total deaths by suicide respectively, for the year 2022. When analysed by profession, a majority of persons who died by suicide were found to be unemployed (28%), daily wage earners (14%), salaried professionals (13%) and housewives (13%)[6]. Young people across the globe are particularly vulnerable to suicides as well as mental health conditions. Data from a 10-year retrospective study conducted between 2006 and 2015 in Sikkim found that individuals aged 21–30 years were the most affected age group on suicides, accounting for 24.4% of the total suicides in the state during this period, consistent with global and national records on the vulnerability of the age group[8]. A qualitative survey by the Government of Sikkim and the World Bank found 6% of youth in Sikkim reported experiencing symptoms of anxiety or depression during the last two weeks prior to the baseline assessment[9]. Mental health issues and suicides do not occur in isolation and are linked to various social and environmental factors, including gender, age, identity, social and community factors as well as employment and financial stability which further the need for an integrated and intersectoral response.

At the country level, the treatment gap for mental illness or the percentage of people who require treatment but do not receive the same, stands at 86%, which is a significant gap[10]. While estimates suggest that there are 2.3 psychiatrists per 100,000 population in Sikkim, the state lacks other trained mental health professionals such as psychologists or psychiatric social workers. Existing services by the state include the District Mental Health Program, implemented in four of the six districts of the state, as well as youth services through the Adolescent Friendly Health Clinics through the Rashtriya Kishor Swasthya Karyakram (RKSK). Aligned toward fulfilling its obligations under the Mental Healthcare Act 2017, Sikkim also constituted its State Mental Health Authority and Mental Health Review Board in 2022 and 2023 respectively to further rights-based care for individuals with mental illness in the state[14].

Law & Policy Framework for Mental Health & Suicide Prevention in India

India's law and policy framework for mental health and suicide prevention are guided by the Mental Healthcare Act, 2017 (MHCA), the Rights of Persons with Disabilities Act 2016 (RPDA), National Mental Health Policy, 2014 (NMHP), and National Suicide Prevention Strategy, 2022 (NSPS). Together, they lay down the vision for advancing mental health and suicide prevention programs and services in the country.

The MHCA enacted in pursuance of India's obligations under the United Nations Convention on the Rights of Persons with Disabilities (CRPD), regulates the treatment and care of persons with mental illness through a rights-based approach. The MHCA recognises, protects and fulfils the rights of people with mental illness, including the right to make informed decisions about their treatment, confidentiality, and protection from abuse, and supported decision making. It decriminalises attempt to suicide and mandates governments to provide care, treatment and rehabilitation to a person who has attempted suicide. The MHCA also highlights the obligations of the central and state governments to plan, design and implement programs

to promote mental health and prevent mental illness and suicides, while ensuring accessible, affordable, available and culturally acceptable mental health services for all.

The NMHP lays the vision and strategic approach for a rights-based, inter-sectoral and holistic approach to mental health in India. The NMHP outlines a range of strategic interventions to promote mental health, prevent mental illness and suicides, reduce stigma, and ensure comprehensive community-based care for all with a focus on the social determinants impacting specific vulnerable groups such as poverty, homelessness, violence and other factors. The NMHP also prioritises the need for inter-sectoral collaboration between the health sector and other sectors such as education, employment, housing and social care along with non-governmental sectors (non-profit and private).

The NSPS aims to reduce suicide mortality by 10% in the country by 2030 and provides a framework for multi-stakeholder action and collaboration. The NSPS objectives are to reinforce leadership and institutional capacity for suicide prevention in the country; enhance the capacity of health services to provide suicide prevention services; develop community resilience and social support for suicide prevention and stigma reduction and strengthen suicide surveillance and evidence generation; to design and implement activities for prevention of suicides and attempted suicides in India. The NSPS's vision is aligned with the WHO's recommendations to reduce suicides through strategies including reducing access to means, address substance use, improve media reporting, implement community-based suicide surveillance, and focus on early identification, support and referral of persons vulnerable to suicide.

UN Sustainable Development Goals & WHO's Comprehensive Action Plan for Mental Health, 2012-2030

Additionally, the WHO's Comprehensive Action Plan for Mental Health 2012-2030 aims to reduce premature mortality by suicide by one third of its current rate by 2030 and promote mental health and wellbeing. This is aligned with Goal 3 of the United Nations Sustainable Development Goals (SDGs) is to: Ensure healthy lives and promote well-being for all at all ages. Target 3.4 of this goal is to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being with suicide rate as an indicator.

2. Multi-Stakeholder Consultations on Mental Health & Suicide Prevention in Sikkim

Between September - December 2024, the Government of Sikkim, through the Sikkim Integrated Service Provision and Innovation for Reviving Economies Program (Sikkim INSPIRES) and in collaboration with the Centre for Mental Health Law & Policy, Indian Law Society (CMHLP), undertook a series of scoping activities and multi-stakeholder consultations to understand Sikkim's mental health landscape and build an action plan for mental health and suicide prevention in Sikkim.

The Sikkim INSPIRES program is a flagship initiative of the Government of Sikkim, supported by the World Bank, that aims to deliver improved economic opportunities and boost economic inclusion for women and youth. The Department of Planning & Development (DoPD) is the nodal authority for the program. CMHLP is providing technical support to Sikkim INSPIRES to identify and develop evidence-based interventions and strategies for mental health and suicide prevention in the state, including the development of a strategic action plan. CMHLP, founded in the year 2007, is a charitable organisation under the Indian Law Society, Pune,

that aims to strengthen and transform the mental health of communities to be holistic and responsive in addressing individual and collective well-being. CMHLP adopts a rights-based and inter-sectoral approach to focus on mental health and suicide prevention through implementation research, law and policy reform, and capacity building.

The Government of Sikkim, through the Sikkim INSPIRES program and technical support from CMHLP, adopted a multi-pronged approach to understand the current context of youth mental health and suicides in Sikkim. The methodology comprised (1) formative scoping interviews and field visits, (2) an online qualitative survey, (3) multi-stakeholder consultations, and (4) a theory of change workshop with key government and non-government stakeholders.

The formative scoping interviews took place with 10 stakeholders working across government departments, including nodal representatives from the Department of Health and Department of Education in Gangtok and Pakyong. The interviews aimed to understand Sikkim's current mental health landscape as well as understand on-ground challenges in implementation of mental health and suicide prevention programs.

On the 9th and 10th of September, the DoPD and the DoFHW, Government of Sikkim hosted the 'Multi-Stakeholder Consultations on Youth Mental Health & Suicide Prevention' under Sikkim INSPIRES in Gangtok, Sikkim. The multi-stakeholder consultations engaged key stakeholders (n=100) including government officials, civil society organisations, young people, mental health professionals, media and other stakeholders at the state-level. The consultations focused on three primary themes: (1) identifying the common mental health problems and factors that contribute to young people's mental health in Sikkim; (2) addressing challenges in developing and implementing mental health and suicide prevention policies and; (3) exploring good practices to develop a comprehensive mental health and suicide prevention strategy for Sikkim. The two-day consultations were followed by a Theory of Change workshop with a select group of stakeholders (n=24). Informed by a rapid synthesis of the consultations, the workshop was conducted to identify and shortlist key priorities areas and co-develop a theory of change framework with outcomes, activities, and pathways to inform a roadmap for mental health and suicide prevention under Sikkim INSPIRES.

The findings from the consultations were also informed by an online qualitative survey, disseminated by the DoPD to capture state-level perspectives from the public on stressors, gaps and challenges, and key strategies to address mental health and suicide prevention in Sikkim. The survey was disseminated for approximately 4 weeks and received 84 responses.

Thematic synthesis of all scoping and consultative activities led to the identification of the following thematic areas for action in Sikkim: governance, policy and service gaps for mental health and suicide prevention including appropriate response for substance use, unemployment, and inclusive policies for persons with disabilities; issues linked to education and academic challenges among young people; stigma and discrimination around mental health, as well as issues surrounding diverse gender, cultural or religious identities; changing lifestyles linked to consumerism and technology and digital environments; family, relationship and community issues including communication patterns, comparison, bullying and domestic violence; and individual issues around building coping strategies among young people, physical illness and financial difficulties.

Strategic recommendations for mental health and suicide prevention for Sikkim were developed based on the consultations as well as review of existing evidence and best practices in India and globally. The recommendations were centred around 11 thematic areas, including the foremost need to develop an integrated mental health and suicide prevention strategy tailored to state-level context in Sikkim. Other recommendations were centred around improving availability and access to mental health services in the state; strengthening

initiatives for suicide prevention and substance use prevention; strengthening mental health initiatives in community settings, education settings and family settings; improving skill development opportunities for persons with mental illness; strengthening monitoring and evaluation efforts across programs and initiatives; and focused and disaggregated research on mental health and suicide prevention in the state.

Integrated Mental Health & Suicide Prevention Strategy, 2025-2030

The Integrated Mental Health and Suicide Prevention Strategy, 2025-2030 for the State of Sikkim draws on the state's mental health system, systemic gaps and priorities identified by multiple stakeholders, and the vision of the Government of Sikkim for advancing mental health and suicide prevention service delivery in the state. The strategy outlines key strategic areas of action with expected outcomes and is aligned with the Mental Healthcare Act 2017, National Mental Health Policy 2014, National Suicide Prevention Strategy 2022, Ayushman Bharat 2018, state-level policies, as well as UN Sustainable Development Goal 3 and the World Health Organisation's evidence-based recommendations for mental and suicide prevention.

3. Vision

The vision of the Integrated Mental Health and Suicide Prevention Strategy, 2025-2030, is to promote the prosperity and well-being of the people of Sikkim, and to prevent mental ill-health and suicidal behaviours. This will be achieved by providing accessible, affordable, acceptable and good quality mental health and social care using a recovery-oriented and a rights-based, intersectoral, and social justice informed approach to Sikkim's diverse population.

4. Guiding Principles

4.1 Comprehensive approach to mental health and suicide prevention

Mental health and suicide are complex issues shaped by a range of factors. There is a need to shift from a purely biomedical approach to a comprehensive and holistic framework that recognises the social, economic, cultural and political determinants of mental health and suicides. Such an approach moves beyond the *treatment gap* to recognising and addressing the *psychosocial care gap* which includes treatment, social care and psychosocial support for promoting, prevention and recovery from mental health problems and suicidal behaviours.

4.2 Rights, equity and social justice

A rights-based approach implies that the rights of persons with mental health problems must be respected, protected and fulfilled. It places obligations on service providers and duty bearers to fulfil the autonomy and liberty of persons with mental health problems and prevent violations of their rights. Equity implies preventing discrimination and facilitating equal opportunities for accessing social welfare services, and other entitlements such as education, housing and employment for persons with mental health problems or experiencing distress. A social justice approach also recognises and addresses structural inequalities and social determinants which disadvantage and oppress certain groups and communities which further results in violations of rights and denial of equal opportunities.

4.3 Participation and Social Inclusion

The involvement of service users, caregivers and community members is essential in the design, delivery and evaluation of mental health and suicide prevention services. Further, the

active engagement and inclusion of individuals and groups who have been historically and structurally disadvantaged in the development and evaluation of mental health services is critical to ensure that policies and services are rights-based, equitable and address the systemic factors which make individuals vulnerable to mental health problems and suicide.

4.4 Evidence-based

A scientific approach and evidence-based decision making must inform the design, delivery and evaluation of mental health and suicide prevention support. All policies, programs and activities should be informed by evidence, research data and feedback from relevant stakeholders.

5. Strategic Areas of Action

This strategy is envisioned to guide policies, programs and activities across the following strategic areas of action:

5.1) Strengthening governance and leadership for mental health and suicide prevention
5.2) Ensuring comprehensive, integrated and community-based mental healthcare
5.3) Promotion of mental health and suicide prevention
5.4) Evidence-based suicide prevention interventions
5.5) Prevention, treatment & recovery for substance-use, alcohol & other addictions
5.6) Research for mental health and suicide prevention

5.1 Strengthening Governance and Leadership for Mental Health and Suicide Prevention

5.1.1 Increase budgetary allocation for mental health and suicide prevention

Adequate and equitable budgetary allocations are crucial for ensuring quality, accessible and affordable mental healthcare for all. There is a need to proportionally increase funding allocations based on the current population and prevalence of mental health problems in Sikkim's context. This includes promotion, prevention and treatment for mental health and suicide prevention, in addition to ensuring social benefits and entitlements for individuals experiencing mental health problems.

Currently, Sikkim's mental health budget is X% of the state's total health budget. The Government is committed to increasing the budgetary allocation to a minimum of X% of the state's total health budget to ensure mental health service delivery, promotion and prevention across the state. Additionally, there is a need to prioritise mental health funding across non-health sectors, such as social welfare, education, women & child development, law enforcement, etc, to integrate mental health and suicide prevention in programs and ensure persons with mental health problems are beneficiaries of existing programs.

Specific Outcomes:

a) X% or more of the state health budget is allocated to mental health and suicide prevention.

5.1.2 Implement the Mental Healthcare Act, 2017 and relevant state rules and regulations

The MCHA protects, promotes and fulfils the rights of persons with mental health problems in alignment with India's obligations under the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The MHCA recognises the right to access mental health and treatment from a range of services run or funded by the Government provided across all levels of the public health system. The legislation is to be implemented in accordance with Sikkim's state rules and regulations to ensure accessible, affordable, available, acceptable and good quality mental health services for all. This requires establishing statutory bodies, training relevant stakeholders and building awareness about its provisions in the community.

Specific Outcomes:

a) The State Mental Health Authority and Mental Health Review Boards are established and functional.
b) Awareness and education sessions are conducted for mental health professionals, law enforcement officials, service users, caregivers, and civil society organisations.
c) Mental health services recognised in the legislation are provided across all levels of the public health system.

5.1.3 Ensure active participation of persons with lived experience of mental health problems, youth, families, caregivers, panchayats, civil society organisations and other community representatives in policy-making processes for mental health and suicide prevention

It is a well-established principle to actively engage persons with lived experience of mental health problems (PLE), young people, families, caregivers and other community representatives through formal policy-making processes in the development, implementation and evaluation of laws, policies and programs for mental health and suicide prevention. It is crucial to draw upon the local wisdom and expertise of individuals and communities that form a part of Sikkim's rich social, cultural, linguistic and geographical diversity to ensure that laws, policies and programs are culturally acceptable and aligned with their local contexts and needs. Additionally, engaging community representatives such as panchayats, urban governance bodies, *samaj* groups, civil society organisations and self-help groups, can facilitate the timely implementation of policies and programs, improve mental health services, address systemic gaps and barriers, and facilitate last-mile delivery of services to the most vulnerable across Sikkim's diverse context. The National Mental Health Policy, 2014 further recommends that PLE and caregivers should also be involved in Village Health, Sanitation, Water and Nutrition Committees and Rogi Kalyan Samiti to participate in community planning, action and monitoring for health.

Specific Outcomes:

a) PLE, young people, families, caregivers and community representatives are actively engaging in policy-making processes through formal mechanisms and their leadership capacity is developed through educational and training programs.
b) Panchayats and urban governance bodies are actively engaged in the design and implementation of policies and programs for mental health and suicide prevention.

5.1.4 Inter-sectoral coordination

To achieve this strategy's vision, inter-sectoral coordination will be essential between departments ranging from health, planning & development, education, social welfare, law enforcement, rural development, women & child development, employment, tourism, etc. Additionally, collaboration will be needed within departments and between the government and non-government sectors (civil society and private) for design, implementation and evaluation of mental health activities and service delivery.

Specific Outcomes:

a) Intersectoral coordination committees will be set up at the state, district and block levels to ensure responsible departments and functionaries will work together for timely implementation of programs and activities.

5.1.5. Monitoring & evaluation through mental health information system

Regular monitoring and evaluation through a robust mental health information system is essential to implement and evaluate the impact of this strategy through evidence-based decision-making. Systematic and reliable data is crucial for identifying existing gaps and improving the delivery of services and care. This will be achieved through strengthening the existing mental health information system to collect quantitative and qualitative indicators at the community, block, district and state levels. Further, regular reviews of facilities and services and feedback from beneficiaries will inform the evaluation of implementation and outcomes of programs and activities envisioned under this strategy.

Specific Outcomes:

a) The state's mental health information system is strengthened to collect indicators at the community, block, district and state level annually.
b) Regular audits of facilities and services are conducted, and feedback is obtained from beneficiaries annually.
c) Monitoring and evaluation data is utilized for decision-making in improving design, implementation and delivery of programs, activities and services.

5.2 Ensuring Comprehensive, Integrated and Community-Based Mental Healthcare

5.2.1 Integrate mental health services into primary and secondary care

Integration of mental health services in primary and secondary care is an evidence-based strategy recommended by The WHO's Mental Health Gap Action Program (mhGAP) for increasing access to mental healthcare in low-resource settings. As a large proportion of Sikkim's population lives in rural and geographically complex areas, there is a need to reduce the gap between the requirement and availability of trained mental health personnel and provide accessible mental health services in the community. As part of the Ayushman Bharat scheme, the government aims to provide holistic health & mental health care services at the primary, secondary, and tertiary levels. To ensure integration at the primary level, it is crucial to train health personnel such as general practitioners, nurses, social workers and community health workers at sub-health centres (SHCs), primary health centres (PHCs), community health centres (CHCs) and health & wellness centres (HWCs) to provide mental healthcare in the community and make appropriate referrals to secondary and tertiary care units such as district hospitals and state hospitals for specialised care. Primary care personnel should be provided with ongoing mentoring and supervision for developing competencies to deliver mental health services at the primary care level.

At the same time, it is crucial to strengthen the District Mental Health Program, secondary care facilities such as district hospitals and tertiary care facilities such as state hospitals to provide specialised mental healthcare including outpatient and inpatient services across all districts. Health personnel including mental health professionals such as psychiatrists, psychologists, social workers, nurses, occupational therapists, etc. will be trained to provide specialised care to patients referred to the facilities.

Specific Outcomes:

a) Number of primary care personnel trained in and providing mental health services and make referrals in primary care facilities.
b) Number of patients being treated at primary care level and referred to secondary and tertiary care facilities for specialised care.
c) Number of primary care personnel mentored and supervised through regular sessions and refresher training (number of sessions, number of refreshers).
d) Number of health professionals in secondary and tertiary care facilities trained and providing specialised care in proportion to the population as per internationally accepted standards.

5.2.2 Increase availability of community-based rehabilitation services for recovery & independent living

The Mental Healthcare Act, 2017 and National Mental Health Policy, 2014 recognise the importance of living in one's community as essential for the rehabilitation, recovery and integration of persons with mental health problems in society. In pursuance of these commitments, the Government will increase availability of community-based rehabilitation facilities such as day care centres, open shelters, half-way homes, supported and sheltered accommodations to facilitate recovery and independent living of persons with mental health problems who are homeless, abandoned by families or are require other forms of support.

Additionally, people with mental health problems may require access to social care including clothing, community kitchens medical support, and other social entitlements such as disability pensions, identity documents, bank accounts, scholarships, health insurance and other benefits. This requires inter-sectoral coordination between the health department, social welfare department and local self-government institutions to facilitate delivery of social care and entitlements to beneficiaries.

Specific Outcomes:

a) Community-based rehabilitation services are established in proportion to the number of persons with mental health problems requiring the same.
b) Social benefits and entitlements including disability pensions, identity documents, health insurance and other benefits are provided to the beneficiaries.
c) Health personnel are trained to make referrals for appropriate social entitlements and benefits.
d) IEC material on existing social benefits and entitlements is disseminated through health facilities, government offices, websites, social media and other channels to increase awareness.

5.2.3 Implement community-based programs for informal and peer support

Informal care and peer support are evidence-based strategies to reduce the social-care gap and improve mental health outcomes in communities. This involves training community volunteers to provide mental health support to individuals experiencing common mental health problems. Such strategies are particularly relevant for Sikkim's context where communities live across complex geographical terrains (rural and urban), practice culturally diverse customs, speak different languages. In this context, community-based programs can reduce the care gap by ensuring culturally acceptable, preventive and community-based care and reducing dependence on mental health professionals. Community-based programs should focus on training community health workers, *samaj* groups, self-help groups, religious leaders, elders, teachers, volunteers and youth to provide emotional support, psychological first aid and referral linkages to individuals experiencing mental health problems or emotional distress.

Specific Outcomes:

a) Number of community members trained in, mentored, and supervised through regular sessions and refresher training, and are providing informal mental healthcare and peer support.
b) Number of persons who have sought support from trained community members.
c) Number of persons who have been referred for specialised care.

5.3 Promotion of Mental Health and Suicide Prevention

5.3.1 Implement interventions to strengthen family relationships for promoting mental health

Families play a crucial role in shaping the mental health and well-being of its members, particularly children, adolescents and young adults. Stable family environments, healthy communication and parenting skills can positively impact mental well-being. Similarly, unstable environments due to domestic violence, substance use, or socio-economic conditions can lead to mental health problems among older and young family members. As these factors are prevalent in Sikkim's context, family-based interventions will be promoted to focus on strengthening parenting skills, empathetic communication and social care for families to address challenges faced by youth. Such interventions can be implemented in collaboration with parents, ASHA workers, panchayats, religious leaders, self-help groups, community associations and *samaj* groups to support families in addressing their challenges, facilitating access to social entitlements, and shaping attitudes around mental health and well-being.

Specific Outcomes:

a) Interventions to strengthen family environments, parenting skills, and communication are implemented in collaboration with families and key community stakeholders.
b) Capacities of religious leaders, community associations, panchayats, *samaj groups*, community elders, law enforcement officials, and leaders are strengthened to sensitise and support families experiencing challenges.
c) IEC resources are developed in multiple formats and languages for families on navigating conflicts, improving communication and referral linkages for accessing social entitlements.
d) Sensitisation sessions are conducted for families to create awareness about mental health and suicide prevention (number of sessions, families engaged, etc.).
e) Health personnel at primary, secondary and tertiary care units are trained to counsel families and caregivers.

5.3.2 Implementing interventions for promoting mental health and suicide prevention in schools and higher educational institutions

There is sufficient evidence that life-skills and social-emotional learning enable adolescents and young adults to handle life challenges and crisis situations which can prevent mental health problems and prevent suicides. Additionally, in Sikkim, there is a need to focus on interventions which enable adolescents and young adults with skills to deal with challenges such as family conflicts, career-related stress, substance use, lack of support, etc. and promote mental health.

To achieve the above, the Department of Health & Family Welfare, Department of School Education and Department of Higher Education will collaborate to:

1) Issue guidelines to schools and colleges to implement systemic initiatives and safeguards to ensure a safe, supportive and holistic learning environment to promote mental well-being of students, teachers and staff.
2) Strengthen the Ayushman Bharat School Health & Wellness Program (SHWP) to address existing gaps in content and delivery of life-skills curriculum for adolescents in the state's context. The SHWP's modules on mental health will be strengthened to include suicide prevention, peer support skills and linkages with other themes of adolescent health and wellness in an age-appropriate and culturally contextual manner.
3) Mainstream life-skills in the curricula and pedagogy for schools and colleges using interactive learning methods which are age and context appropriate. Life-skills curricula for students and young adults should also address age-appropriate themes such as coping with challenges related to sexual and reproductive health, inter-personal relationships, social exclusion, gender & sexuality, bullying, etc. which impact the mental health of adolescents and young adults. Similarly, teachers and staff in schools and colleges will be trained in mental health promotion, life-skills education and providing emotional support. Further, life-skills education will be provided to adolescents and young adults who have dropped out of school and colleges through fora such as civil society groups, youth clubs, National Service Scheme, Niyukti Kendras, Nehru Yuva Kendras, etc.
4) Ensure academic and career guidance support in schools and colleges to support adolescents and young adults in managing academic stress and identifying viable career pathways as mentioned in the National Education Policy, 2020.
5) Strengthen the Rashtriya Kishor Swasthya Karyakram's nutrition and peer educator program (RKSK) by training adolescents in peer support skills such as active listening, emotional support and making referral linkages for adolescents experiencing emotional distress. Additionally, the Adolescent Friendly Health Clinics will be reviewed and strengthened to provide services in youth-centric community settings which meet the preferences of adolescents.
6) Develop and implement with young people, peer support programs in schools and colleges to train adolescents and young adults in skills such as active listening, providing emotional support, crisis support and referral linkages for peers who are in distress or vulnerable to attempting suicide.

Specific Outcomes:

a) Number of teachers and peer educators trained, mentored, and supervised, and are providing life-skills training to adolescents and young adults.
b) Number of peers trained, mentored, and supervised, and are providing peer support to adolescents and young adults.
c) Number of adolescents and young adults who have (1) received life-skills training (2) peer support (3) adolescent friendly health services

5.3.3 Promoting skill development, vocational training and employment opportunities for youth.

In Sikkim, unemployment is a major factor which impacts mental well-being of young people. Strategies such as skill development and vocational training with a focus on emerging job markets across different sectors can provide young people and persons with mental health problems with diverse pathways to employment. Further, it is crucial to refer youth who have dropped out from schools and colleges to these opportunities through community fora such as Niyukti Kendras, National Service Scheme, Nehru Yuva Kendras, etc., if they cannot be reintegrated back to school and college.

Specific Outcomes:

a) Number of youth and persons with mental health problems who have received skill development and vocational training.
b) Number of youth and persons with mental health problems who have been benefited from skill development and vocational training programs.

5.3.4 Addressing stigma and discrimination related to mental health and suicides

Mental health and suicides are stigmatised issues. Stigma is a barrier to help-seeking and timely prevention of mental health problems and suicides. Prevalent myths and superstitions in communities add to the stigma and further lead to discrimination against persons with mental health problems. It is important to engage community stakeholders through public awareness campaigns to de-stigmatise and prevent discrimination. Additionally, there are other groups who are stigmatised based on their identities such as ethnicity, gender, sexuality, disability and are vulnerable to mental health problems and suicides. The Government will ensure inter-sectoral coordination with different departments to address stigma and discrimination through the following activities:

1) Implement a public awareness campaign for mental health and suicide prevention across different community fora such as schools, colleges, workplaces, panchayats, health facilities, public spaces, remote and rural areas. The campaign will disseminate information on helplines, mental health services, dispelling myths, lived experience stories and timely help-seeking through different channels such as multi-lingual IEC resources, contact programmes, cultural events, performative and fine arts, social media and other media formats.
2) Collaborate with and incentivise young social media influencers to develop appropriate content to disseminate messages promoting mental health and suicide prevention.
3) Conduct sensitisation programmes for elderly to reduce isolation and promote community interactions.
4) Amending policies, programs and regulations which discriminate against persons with mental health problems.
5) Train health personnel and community stakeholders to provide affirmative and non-stigmatising mental health care to stigmatised and vulnerable groups such as gender and sexual minorities, persons living with HIV, persons with disabilities, ethnic and religious minorities, etc.

Specific Outcomes:

a) Number of campaign activities designed and implemented.
b) Number of people reached through the campaign activities across different community settings and groups.
c) Number and type of campaign materials, IEC resources prepared.
d) Number of health personnel trained to provide affirmative and non-stigmatising mental health care.

5.3.5 Promote community development for mental health and well-being

1) Develop community programs in public spaces for recreation and engaging with nature.

It is important to facilitate access to public spaces such as playing grounds, green spaces, sports clubs and other spaces which can foster creativity and recreation to promote mental health and well-being. There is a need to develop or leverage existing spaces in urban and rural areas of Sikkim in collaboration with different civil society groups and community associations to promote activities for people of all ages such as arts-based practices, health

melas, cultural activities and physical activities. Such interventions can promote mental health by fostering social connection, increasing awareness and destigmatising mental health and suicide prevention.

Specific Outcomes:

a) Community-based programs promoting recreation, creativity, sustainable living and sports are developed and implemented in various public spaces in urban and rural areas of Sikkim.

2) Develop community-based spaces to promote youth mental health and wellbeing.

It is well accepted that community-based programs to promote youth mental health must engage young people based on their needs and preferences. To achieve this, youth-centric spaces in urban, rural and remote areas, such as shopping malls, gyms, sports centres, cafes, parks, or playgrounds, etc. will be leveraged to provide adolescents and young adults with youth mental health services such as information resources, counselling, peer support and referral linkages. Further, to promote social connectedness and life-skills, community-based programs will be developed to engage young people as active participants and beneficiaries through 1) sports based-interventions and 2) skill development and arts-based practices drawing on Sikkim's rich cultural heritage and practices.

Specific Outcomes:

a) Community-based programs to promote youth mental health are developed and implemented in youth-centric spaces in Sikkim.
b) Number of youth benefiting from the community-based programs and youth mental health services.

5.4 Evidence-Based Suicide Prevention Interventions

5.4.1 Improve suicide, attempted suicide and self-harm data through a surveillance data system

It is essential to collect reliable data on suicidal behaviours to plan effective suicide prevention strategies. However, there are challenges in collecting data on suicidal behaviours due to various factors such as stigma or fear of reporting and more needs to be done. The WHO recommends community-surveillance systems as a best practice for collecting adequate and reliable data on suicides and attempted suicides and also provide important data on contributing factors which can ensure accurate classification of suicidal behaviours. Such a community-surveillance system should be adapted and integrated within the public health system to inform the planning and implementation of suicide prevention strategies for population sub-groups who are vulnerable to suicidal behaviours in the Sikkim's social context.

Specific Outcomes:

a) A community-surveillance system is developed and collecting reliable and accurate data on suicide deaths, attempted suicides and self-harm.
b) Data is informing the planning and implementation of suicide prevention strategies for different population sub-groups.

5.4.2 Provide gatekeeper training for early identification, assessment, management and follow-up for persons having suicidal thoughts/ideation

The WHO LiveLife implementation guide for suicide prevention (2021) recommends early identification, management, and follow-up for persons vulnerable to suicide. Gatekeeper training programs are an effective suicide prevention strategy which provides community members with the skills and knowledge to identify, support and refer persons having suicidal thoughts and feelings. Gatekeeper training programs can be adapted for a range of community members and first responders including police officials, prison authorities, teachers and young people (schools and colleges), frontline workers and community volunteers.

Additionally, health personnel across primary, secondary and tertiary care units need to be trained to conduct suicide risk assessments and provide suicide prevention support to patients showing signs of suicide and self-harm.

Specific Outcomes:

a) Number of gatekeepers (teachers, police personnel, religious leaders, panchayat members etc.) across different stakeholder groups trained to provide suicide prevention support.
b) Number of health personnel such as general practitioners, nurses, community health workers trained in suicide risk assessments and providing support to patients showing signs of suicide and self-harm.

5.4.3 Implementing guidelines for responsible media reporting of mental health, suicides and attempted suicides

Existing evidence points to the role of media reporting in impacting suicides and attempted suicides positively and negatively. Irresponsible media reporting and providing sensitive details can increase imitative suicides, whereas improved media reporting which dispels myths and provides supportive information can increase help-seeking and prevent suicides. Media reporting impacts the understanding and perception of mental health and can reduce stigma, increase help-seeking behaviour and affects overall well-being. The WHO guide for mental health professionals recommends evidence-based strategies for responsible media reporting of suicides and mental health for print publications, and further, the Press Council of India (PCI) has issued guidelines to media professionals. The NSPS also highlights the role of the media in implementing advocacy efforts for suicide prevention through strict implementation of PCI guidelines, promoting safe internet usage and preventing cyber bullying, and addressing portrayal of substances in media.

In Sikkim, there are various media organisations disseminating news in English and regional languages. There is a need to adapt these media reporting guidelines across relevant languages, in collaboration with media organisations working in different media such as print, television and social media. Further, a monitoring and evaluation framework should be developed with media organisations to build capacity of media professionals on implementing the guidelines and monitoring whether media reporting follows these guidelines.

Specific Outcomes:

a) Media reporting guidelines are adapted in relevant languages for Sikkim’s context and disseminated to media organisations.
b) Number of media professionals trained to report stories on mental health and suicides in accordance with the media reporting guidelines.
c) Monitoring and evaluation framework to track the implementation of guidelines by media organisations.

5.4.4 Implementing targeted suicide prevention interventions for specific vulnerable groups

There is sufficient evidence that structural factors such as domestic violence, substance use, identity-based discrimination, etc. can increase the risk of suicide among vulnerable groups due to the distress caused by such factors. In Sikkim's context, these groups include persons with substance use and addiction disorders (SUDs), sexual and gender minorities, persons living with HIV, women experiencing domestic violence, daily wage earners, prisoners, medical, and first responders such as law enforcement officials, and others. Therefore, there is a need for suicide prevention interventions which focus on vulnerable groups and the factors which impact their specific contexts.

Specific Outcomes:

a) Evidence-based suicide prevention interventions focusing on specific vulnerable groups and factors impacting them are implemented.
b) Integrate suicide prevention in programs for women experiencing domestic violence, persons living with HIV, elderly persons, persons with SUDs, informal workers, tribal populations, prisoners, etc.
c) Health personnel in primary, secondary tertiary care units are trained to maintain regular contact and do safety planning for at least 18 months with persons who have attempted suicide.

5.5 Prevention, Treatment & Recovery for Substance-Use, Alcohol & Other Addictions

5.5.1 Prevention of substance-use, alcohol and other addictions

In Sikkim, there are higher rates of substance use such as opioids (more than 10%) and cannabis (2.9%) compared to the national average. Substance use and addictions have a significant impact on the physical and mental well-being of individuals. There is sufficient evidence that substance-use and alcohol addiction are a contributing factor of suicides and domestic violence. The WHO recommends population-level interventions for prevention, treatment, recovery and harm reduction.

There is a need to prevent substance use and addictions among youth in and out of schools and colleges and other vulnerable populations, while ensuring harm reduction among those who already have substance use and addiction disorders (SUD). To achieve this, intersectoral coordination between departments of health, education, social welfare, employment will be required to do the following:

1) Develop a behavioral change campaign to disseminate IEC resources, conduct training programs and sensitisation sessions across community settings including schools, colleges, community fora, workplaces in urban and rural areas in collaboration with DMHP, panchayats, self-help groups, peer educators, teachers, *samaj* groups and other civil society partners.
2) Develop de-addiction programs for schools and colleges to sensitise and train students and teachers in prevention, identification and making referrals to primary, secondary and tertiary care units.
3) Sensitise persons with SUDs in harm reduction techniques and provide counselling for harm reduction.
4) Review and amend existing laws, rules and policies for ensuring harm reduction, curb advertising of alcohol, and restrict points of sale of alcohol specially around schools and colleges.

5) Develop and disseminate guidelines on safe usage of internet, social media and online gaming in educational institutions, health facilities, youth clubs, media, panchayats and other community spaces.

Specific Outcomes:

a) Number of persons reached through the behaviour change campaign.
b) Number of adolescents and young adults reached through the de-addiction programs in schools and colleges.
c) Number of persons who have received harm reduction counselling.
d) Relevant laws, rules and policies which are implemented, reviewed or amended.

5.5.2 Treatment of substance-use, alcohol and other addictions.

The provision of evidence-based treatment, de-addiction facilities and rehabilitation services are crucial strategies for treatment and care of persons with SUDs. This will be achieved by:

1) Training health personnel such as community health workers, general practitioners, nurses, social workers, etc. in primary, secondary and tertiary care units to provide evidence-based treatments including counselling, crisis management and referrals for persons with SUDs and persons in emergency situations who are intoxicated and experiencing withdrawal symptoms.
2) Increasing availability of de-addiction and rehabilitation facilities in proportion to the persons with SUDs (in different population groups) requiring the same.
3) Integrating suicide prevention support by training health personnel in de-addiction and rehabilitation facilities.
4) Strengthening and increasing availability of psychosocial and peer support groups (such as Alcoholics Anonymous, Narcotics Anonymous) in a structured and supervised manner through the DMHP and de-addiction facilities.

Specific Outcomes:

a) Number of persons who have received treatment and care for SUDs.
b) Number of health personnel who have been trained to provide treatment and care for SUDs in primary, secondary and tertiary care units.
c) Increase in de-addiction and rehabilitation facilities in proportion to persons with SUDs requiring the same.
d) Number of persons accessing psychosocial and peer support.

5.5.3 Recovery and reintegration of persons with SUDs in the community.

It is important to prevent relapses and reintegrate persons with SUDs who have received treatment into their community by facilitating social care, peer support and pathways to employment. This will be achieved by:

1) Continued implementation of psychosocial and peer support groups (such as Alcoholics Anonymous, Narcotics Anonymous) in a structured and supervised manner through the DMHP and de-addiction facilities. Training persons who have recovered to develop skills to provide peer support in the community.
2) Developing vocational training and skill development programs followed by employment opportunities.
3) Providing counselling services for families and caregivers through the DMHP, secondary and tertiary care units.

4) Addressing stigma through IEC resources, sensitisation sessions and contact programs to facilitate reintegration of persons with SUDs in the community.
5) Facilitating access to social care such as housing, assistance for independent living and social entitlements (identity documents, allowances, bank accounts, etc.).

Specific Outcomes:

a) Number of persons accessing 1) psychosocial and peer support 2) reintegrated into families and communities.
b) Number of persons trained in skill development and vocational training.
c) Number of persons who have benefitted from skill development and vocational training programs.
d) Number of families and caregivers who have received counselling support.
e) Number of persons reached through de-stigmatisation activities.

5.6 Research for Mental Health and Suicide Prevention

The development of an inter-disciplinary research agenda to advance mental health and suicide prevention is a state priority. Considering Sikkim's social, economic and geographical uniqueness, it is crucial to use multiple research methodologies to generate good quality evidence on different thematic areas including health systems, epidemiology of mental health problems, implementation research outcomes for interventions, and mental health impact of social determinants unique to Sikkim's context. It is important that the research agenda is developed and fulfilled with the active participation of community members including persons with lived experience, families, caregivers, civil society partners, local self-government institutions and other community representatives. To achieve this, research capacity within the state will be augmented by fostering partnerships with domestic and international research institutions, Centres of Excellence, DMHP, medical college departments, mental health professionals and civil society partners. The research findings and evidence generated will be translated into the design, implementation and delivery of mental health and suicide prevention services and programs for different population groups in the state.

Specific Outcomes:

a) An inter-disciplinary research agenda which reflects the priorities and needs of the state is developed for mental health and suicide prevention.
b) Research collaborations between the government, research institutions, civil society partners, persons with lived experience and health personnel are established.
c) Adequate funding is allocated for research collaborations.

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